Kids Count IN NEBRASKA

2010 REPORT

A PUBLICATION OF VOICES FOR CHILDREN IN NEBRASKA

Credits

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Dillon, 4-years-old

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Kids Count 2010

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

Kids Count in Nebraska is a children's data and policy project of Voices for Children in Nebraska. An important component of this project is the Technical Team of Advisors who provide data and expertise on child well-being in Nebraska. The Kids Count Technical Team, comprised of representatives from numerous agencies and organizations in Nebraska and other research experts, provides important information about child well-being. 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 eighteenth report in Nebraska. Additional funding for this report comes from Wells Fargo and Dr. Thomas Tonniges and Jane Tonniges.

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

Additional copies of the **2010 Kids Count in Nebraska** report, as well as reports from 1993 through 2009, are available for $11.00 from:

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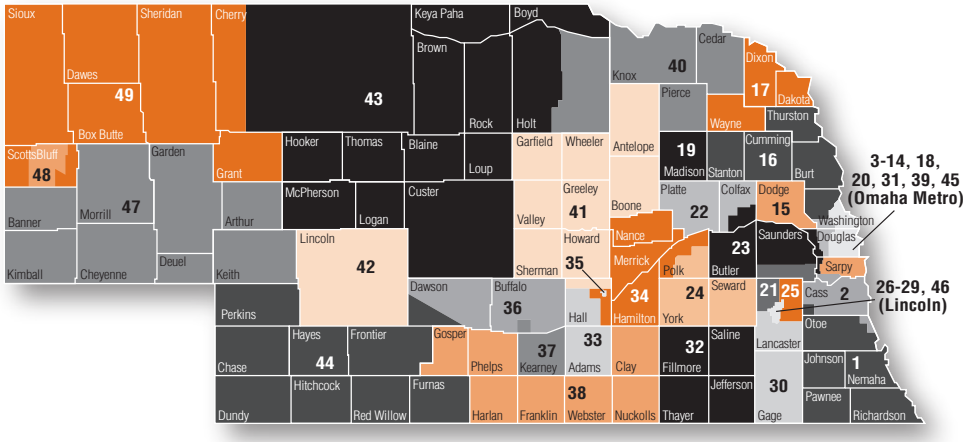

Note: For more complete district information, see www.nebraskalegislature.gov.

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

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How KIDS COUNT Data Center Can Benefit You

- Strengthen the needs assessment portion of grant proposals
- Determine community assets and needs
- Create community/state comparisons
- Promote community awareness

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1. Visit Voices for Children in Nebraska homepage at www.voicesforchildren.com/kidscount.
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Children's Behavioral Health in Nebraska

An 8-year-old girl with a history of aggressive behavior is having "an episode" at home. She has just returned from a week-long hospital stay after making suicidal threats. Her mother is scared. Nothing is working to calm her daughter down, and mom is worried about the safety of her two younger kids too. Reaching out, the mother calls the Nebraska Family Helpline. A Helpline counselor, staying on the phone as long as it takes, talks the mom through more strategies to calm her daughter. One of the strategies eventually works. The girl agrees to take her medicine, sits quietly and watches television. For now, the crisis subsides.[1]

Caring for children with behavioral health problems is challenging even for families who have resources and know where to turn for help. For families who do not, getting help is an even greater struggle. In 2008, Nebraska found itself at the center of a crisis that highlighted this struggle: Families, recognizing a window left open in a 'safe haven' policy that had no age limit, relinquished to the custody of the state 36 children – most of whom suffered from behavioral health problems. Thirty-four of the children had received prior mental health treatment. Almost two-thirds were teenagers.[2]

The debacle prompted the governor to convene a special session of the Legislature, where policymakers closed the loophole and limited the safe abandonment law to infants less than 30 days of age. A few months later, in May 2009, legislators passed LB 603. This law called for the creation of services intended to connect families with resources to help them through child behavioral health issues (see Policy Box). These services included a hotline, a peer-support network and a post-adoption/guardianship program. Further, eligibility for Kids Connection, Nebraska's public health insurance program for children, was expanded to reach all low-income children up to 200% of the federal poverty level. An additional $1.5 million was appropriated for behavioral health services provided through Nebraska's six Behavioral Health Regions. LB 603 also created the Children's Behavioral Health Oversight Committee and charged it with monitoring the law's implementation.

On January 1, 2010, three key pieces of the law went into effect. The Nebraska Family Helpline, a 24-hour hotline available year-round, began service through a contract with Boys Town. Family Navigator Services, the peer-support network, began operating under a contract with Boys Town and its subcontractors: the Healthy Families Project, National Alliance on Mental Illness Nebraska (NAMI), and the Family Support Network. The post-adoption/guardianship program Right Turn also was implemented through a joint contract with Lutheran Family Services and the Nebraska Children's Home Society. LB 603 called for evaluation of the above services. Data collection efforts coincided with the startup of all

three programs, as did activation of the Children's Behavioral Health Oversight Committee. Nine legislators serve on the committee.

Through the implementation of LB 603 and the nearly concurrent reform of Nebraska's child welfare system, children and families have experienced many changes in the public systems created to serve them. Complicating these changes are ongoing budget problems faced by families and the state. This commentary examines the behavioral health needs of Nebraska's children, the state's public behavioral health system, the system's strengths and gaps, efforts to reform the system and recommendations for future efforts.

Understanding the Need

There is no question that many children and youth in Nebraska face behavioral health problems. Putting exact numbers to this population, however, is difficult due to both underreporting and changing interpretations of what constitutes a behavioral health disorder, particularly among children. For the purposes of this commentary, the term "behavioral health disorder" will be used broadly to describe problems experienced by children that disrupt their ability to develop normally, to form healthy relationships, and to effectively cope with problems.[3] This includes a range of mental health and substance abuse problems.

Behavioral health problems are relatively common and encompass a wide variety of disorders. In Nebraska, it has been estimated that as many as 90,000 children and youth have a behavioral health disorder. More than half of these 90,000 experience significant impairment from such problems, and about 21,000 suffer extreme impairment.[4] The most recent National Survey of Children's Health indicated that about 11% of Nebraska children ages 2 to 17 have at least one emotional, behavioral or developmental condition. Of those children, almost half (46%) have at least two such problems. These conditions include attention deficit hyperactivity disorder (ADD/ADHD), anxiety, depression, oppositional defiant disorder (ODD)/conduct disorder, autism spectrum disorders, developmental delay and Tourette Syndrome.[5] About 8% of children ages 12 to 17 have suffered at least one major depressive episode.[6]

The most recent National Survey of Children with Special Health Care Needs estimated that in Nebraska:

- 11,075 children have depression, anxiety, an eating disorder or other emotional problem;[7]
- 14,191 children have ADHD or ADD;[8]
- 1,388 children have autism or autism spectrum disorder.[9]

Both biological and environmental factors have been shown to influence childhood mental health disorders. Such risks may be physiological and include genetic predisposition, prenatal exposure to toxins, and low birth weight. Environmental factors like poverty, abuse and neglect, poor relationships, a parent's mental health disorder, and traumatic events also may influence a child's risk of behavioral disorders.[10] These and other factors can also impact children's access to needed behavioral health services.

Geography Matters

With vast areas of sparse population, Nebraska is limited in its offerings of behavioral health services that are diverse enough to satisfy a large variety of needs, close enough to access, and affordable enough for all. Even living in a more populated area, however, does not guarantee that the right services will be accessible.

About 57% (291,585) of Nebraska's children live in counties determined to be Health Professional Shortage Areas (HPSAs) for mental health. Another 29% (147,246) live in a county deemed a partial mental health HPSA, while only 14% live in counties with no official shortage.[11] The counties with no mental health HPSA designation were Cass, Dodge, Sarpy and Washington – all concentrated in the easternmost part of the state. Douglas County, also in the eastern region of the state, received a partial HPSA designation.

Table 1.1 illustrates the utilization of the Nebraska Family Helpline, Family Navigator Services and Right Turn by region during the programs' first nine months of operation.

Families from Region VI, which contains the Omaha metro area, used all three programs most often. Families from Region V in the state's southeast corner and Region III in south-central Nebraska recorded the second and third highest utilization rates, respectively. For more information on the location of behavioral health services, visit our Kids Count Special Features page on the web at www.voicesforchildren.com/kidscount.

Table 1.1: Utilization of LB603 Programs by Region (January-September 2010)

	Nebraska Family Helpline		Family Navigator Program		Right Turn	
	Number of Calls*	Percent of Calls	Number Families Served	Percent of Families Served	Number of Children in New Cases	Percent of Children in New Cases
Region I	24	1.8%	17	2.2%	2	0.6%
Region II	36	2.6%	21	2.7%	14	4.1%
Region III	150	10.9%	84	10.9%	52	15.1%
Region IV	80	5.8%	44	5.7%	9	2.6%
Region V	231	16.8%	129	16.7%	60	17.4%
Region VI	819	59.7%	432	56.0%	154	44.8%
Out of State	0	0.0%	0	0.0%	27	7.8%
Unknown	31	2.3%	45	5.8%	26	7.6%
Total	1371	100.0%	772	100.0%	344	100.0%

Source: Nebraska Dashboard, http://nebraskadashboard.hornbyzeller.com/

** Includes only calls "resulting from a precipitating event involving someone under the age of 19 in which intervention strategies, resources, and/or parental support are provided"*

Out-of-Home Care Matters

Children who are in out-of-home care experience a higher rate of behavioral health problems than their peers who are not. Such problems include conduct, anxiety, attention deficit and posttraumatic stress disorders, as well as increased aggressive, delinquent and withdrawn behavior.[12] Rates of mental health problems may increase based on multiple foster care placements, age of entry into care and placement with non-relative foster parents.[13] This is of particular concern in Nebraska. Among all states, Nebraska's rate of children in out-of-home care is the highest at 13.9 compared with 6.8 for the nation.[14] In 2009, 8,677 of Nebraska's children were in out-of-home care at some point during the year.[15]

According to the Nebraska Foster Care Review Board, federal findings indicate that service provision to children in the foster system with mental health care needs is an area of concern. In 2009, 70% of children with mental health needs in out-of-home care received services – leaving 30% who did not.[16]

Gender and Age Matter

Research indicates that girls are less likely than boys to have a mental health problem; however, prevalence of disorders differs along gender lines. For example, boys are more likely to be diagnosed with disruptive and autism spectrum disorders. Girls, on the other hand, are more likely to be diagnosed with anxiety and depression. As severity of mental health disorders increases, boys' and girls' interactions with different systems also play out. While boys' disruptive behavior may put them at risk of contact with the juvenile justice system, girls' anxiety and depression may increase the likelihood of hospital visits due to suicide attempts.[17]

During the first two quarters of 2010, more than half of the calls, 55%, to the Nebraska Family Helpline were about problems with boys. In the third quarter, that share rose to 61%. Among families served through Family Navigators, however, the ratio of boys to girls was split more evenly: 47.3% were male, 44.4% were female, and 8.3% were unknown.[18]

"Transition-aged youth" – adolescents with a mental health or substance abuse disorder who are aging into the adult behavioral health system for care – are a priority for the Division of Behavioral Health in Fiscal Year 2011. The Division has noted a statewide shortage of providers and evidence-based practices appropriate for these youth. Enhanced services addressing physical, social and emotional needs could help transition-aged youth avoid the adult emergency system.[19]

Poverty Matters

Though poverty alone does not cause behavioral health disorders, children in poverty experience increased environmental stressors and their parents are less likely to have the resources to address behavioral issues. Economic hardship increases the likelihood that parents themselves will experience behavioral health problems or even become abusive.[20] A parent's mental health problems, exacerbated by the stress of poverty, or substance abuse are "strong predictors of children's mental health needs."[21] Moving out of poverty can ease behavioral disorders among children but has not been shown to decrease anxiety or depression.[22]

Nebraska children in poverty are more likely to experience an emotional, behavioral or developmental condition than their peers at higher income levels. The National Survey of Children's Health reported a 28% rate of prevalence among our state's children living under the poverty line, compared with rates of less than 9% for children at higher income ranges.[23]

This is particularly troubling in light of increasing rates of child poverty. In 2009, just over 66,000 children in Nebraska, or 15.2%, lived in poverty, an increase over the 2000 rate of 10.0%. Knowing that children in poverty face increasing risks of behavioral health disorders and that child poverty is on the rise, it is even more critical to ensure that all children have access to affordable treatment.

Contact with Juvenile Justice

Youth involved in the juvenile justice system are often more in need of mental health services than detention. This is especially true for the majority of youth in detention or involved with the system who committed non-violent crimes and minor offenses.[24] An overwhelming majority of Nebraska youth arrested each year are arrested for non-violent crimes. Only 1.8% of youth arrests in 2009 were for violent offenses, a rate consistent with past years.[25]

About 65-70% of youth involved in the juvenile justice system have diagnosable mental health disorders; of those youth, it is estimated that 25% have disorders that are so severe that they impair a youth's ability to function.[26] In applying these estimates to the 15,109 Nebraska youth who were arrested in 2009, it is probable that about 10,000 have diagnosable mental health disorders and about 2,500 of those youth have trouble functioning.

Youth committed to Nebraska's Youth Residential Treatment Centers (YRTCs) for law violations also have high rates of mental and behavioral health disorders. A state report indicated that 73% of girls at Geneva have serious mental health disorders, and 73% of boys at Kearney have behavioral disorders.[27] Leading offenses that resulted in commitment for both girls and boys are assault, theft and drug possession. Girls at Geneva also have high rates of shoplifting offenses, while boys at Kearney also have high rates of burglary and criminal mischief offenses. Nebraska's Regional Centers at Hastings and Lincoln also serve youth. Youth who are admitted to these centers have been in contact with the legal system due to chemical dependency or sex offenses, respectively.

The safety of the community and of the youth must be considered the top priority when determining a youth offender's placement. However, due to the high rates of mental and behavioral health disorders in this population, increased attention to treatment and preventive care is advisable. These statistics suggest that increased community services for behavioral health have the potential to decrease the number of youth who enter the juvenile justice system.

The Current System

Nebraska's Division of Behavioral Health (DBH), part of DHHS, coordinates public behavioral health services provided by regional centers in Lincoln, Hastings and Norfolk; the six Behavioral Health Regions; and contractors providing treatment for problem gambling.[28] Children who lack any or enough private insurance may also benefit from public behavioral health funding provided through the Division of Medicaid and Long-Term Care, the Division of Children and Family Services, or other state and federal agencies.[29]

The Regions receive the largest share of the Division of Behavioral Health's funds, which they use to support mental health and substance abuse service contracts for children and adults. For fiscal year (FY) 2011, $10.1 million was allocated for children's behavioral health services. Of this, $7.5 million was to be distributed among the Regions.[30] All six Regions funded the Professional Partners Program, which uses a "wraparound" approach to coordinate the services and supports children and families.[31] In addition, all Regions dedicated funds to children's outpatient mental health and substance abuse services, while additional services were funded in certain regions. Regions 4, 5 and 6 used funding for assessment services; Region 3 for day treatment; and Region 6 for respite care.[32]

Among the three regional centers, only Hastings and Lincoln provide services to youth. At Hastings Regional Center, a 40-bed chemical dependency program serves male youth who are paroled from the YRTC in Kearney. The Whitehall Campus at the Lincoln Regional Center serves male youth who have committed sexual offenses through 16-bed residential and 8-bed treatment group home programs.

YRTCs in Kearney and Geneva serve boys and girls, respectively, who have committed a law violation. The facilities operate under the Division of Children and Family Services by the Office of Juvenile Services (OJS). Youth who are admitted to the YRTCs receive treatment for a variety of problems, including mental health and substance abuse disorders, with the goal of the youth becoming law-abiding community members.

Many more services are operated by private and nonprofit organizations, some of which receive DBH funding for certain programs. The Substance Abuse and Mental Health

POLICY BOX

The Programs of LB 603

Nebraska Family Helpline

The 24-hour, year-round Nebraska Family Helpline is intended to provide families facing a child behavioral health issue with increased access to available services through recommendations or referrals. This occurs after an operator works with the caller to assess immediate safety needs and level of crisis. Some callers may be referred to Family Navigators for additional services. Boys Town, through a contract with the state, operates the Helpline. Cost of the program was projected at $1,015,000 for FY 2010 and $1,700,000 for FY 2011, with costs to be paid from general funds.[i]

http://www.nebraskafamilyhelpline.ne.gov/
888-866-8660

Family Navigator Services

Accessed through referral by Helpline operators, Family Navigators help eligible families connect with behavioral health resources in their communities. Family Navigators meet with families within 24-72 hours of a Helpline referral and may have up to eight hours of contact with each family over a 45-60 day service period. Like the Helpline, Family Navigators is operated through a contract with Boys Town, which partners with the Healthy Families Project, NAMI Nebraska and the Nebraska Family Support Network. Costs, to be paid through general funds, were estimated at $611,984 for FY 2010 and $1,056,047 for FY 2011.[ii]

Right Turn

Created to support families who have completed an adoption or entered a guardianship, Right Turn provides assistance with case management services, respite care, mentoring, mental health services, parent training, and support groups for youth and parents. Services are provided through a contract with Lutheran Family Services and Nebraska Children's Home Society. Including both services and contracts, Right Turn was expected to cost $1,198,800 in FY 2010 and $2,027,970 in FY 2011. These costs were to be covered through general funds with the potential for offset through a federal match.[iii]

http://www.rightturnne.org/
P: 888-667-2399

Services Administration (SAMHSA), part of the U.S. Department of Health and Human Services, lists 87 organizations that provide mental health services in Nebraska and 106 that provide substance abuse services.[33, 34] In FY 2009, 70 community-based substance abuse programs received funding from DBH.[35] For a list of these services and a map of their locations throughout the state, please visit the Kids Count Special Features page on the web at www.voicesforchildren.com/kidscount.

Plugging into Services

Many callers to the Nebraska Family Helpline report that their child has a history of known mental health problems. The 8-year-old girl whose aggressive behavior prompted her mother to call the Helpline, for example, had previously been diagnosed with ADHD and depression. With symptoms ranging from aggressive behavior to suicidal ideation, behavioral health problems can lead to crisis situations – and families struggling to find help.

The Helpline, Family Navigator Services and Right Turn were created to connect families with needed resources as well as comfort and support. After the Safe Haven crisis, stakeholders hoped that such programs would help families navigate crisis situations or prevent them altogether.

Behavioral issues drive a majority of Helpline calls. The top three concerns discussed among Helpline callers were the child's disobeying of family rules, behaving aggressively at home, and arguing with an authority figure (see Table 1.2).[36] Of all calls, 1% were considered high risk, indicating that professional intervention resulted from the call. Such intervention could have been conducted by child protective service, police, fire or other emergency personnel.[37] In the

Service Evaluation

LB 603 called for the evaluation of the three services it created. Hornby Zeller Associates, Inc. was contracted to provide evaluation of the Helpline, Family Navigator and Right Turn, with publicly-accessible data available at http://nebraskadashboard.hornbyzeller.com/. General funds were to cover the amount of $75,000 in the first fiscal year and $150,000 in the second.[iv]

Children's Health Insurance Program (CHIP) Expansion

About 11,000 children received access to health insurance when eligibility was increased from 185% to 200% of the federal poverty level ($40,792.50 to $44,100 in 2009- 2010).[v] Costs to be paid through general funds were estimated at $2,188,166 in FY 2010 and $3,005,553 in FY 2011, with federal funding projected at $5,736,969 and $7,880,187, respectively.[vi]

Behavioral Health Education Center

Intended to improve quality and access for behavioral health care, the Behavioral Health Education Center was created by LB 603 and is administered by University of Nebraska Medical Center. The center is charged with providing funding for eight psychiatric residents by 2013. Residents will participate in rural training for at least a year. In addition, the center will train professionals on the state's telehealth network. Six sites will be developed for interdisciplinary behavioral health trainings, and multi-organizational partnerships will be formed to develop curriculum and training for behavioral health professionals.[vii] General funds were appropriated to UNMC for $1.4 million for FY 2010 and $1.6 million for FY 2011.[viii]

Funding to Regional Behavioral Health Regions

For the years 2009-2010, $500,000 in general funds was appropriated to the six behavioral health regions. The appropriation increased to $1 million for the years 2010-2011. Funds are to be used for children's behavioral health services, including expansion of the Professional Partners program.[ix]

[i] LB 603 Fiscal Note.
[ii] *Ibid*.
[iii] *Ibid*.
[iv] *Ibid*.
[v] Federal Register, Vol. 74, No. 14, January 23, 2009, p. 4199-4201, http://aspe.hhs.gov/poverty/index.shtml.
[vi] LB 603 Fiscal Note.
[vii] Nebraska Behavioral Health Oversight Commission, *Behavioral Health Oversight Commission Final Report*, June 2009.
[viii] LB 603 Fiscal Note.
[ix] *Ibid*.

Table 1.2: Top 10 Child Issues Identified in Nebraska Family Helpline Calls (January-September 2010)

Issue	Number
Family Rules	1,056
Aggression at Home	852
Arguing	817
School Authority	611
Grades	553
Sibling Relations	351
Aggression at School	321
Runaway	324
Absenteeism	264
Depression	287

Source: Source: Nebraska Family Helpline & Family Navigator Services Quarterly Report: July-September 2010

Note: More than one issue may have been identified in each call.

third quarter of operation, the Helpline received 38% of its calls from families who reported that their children had received at least one form of mental health treatment, generally counseling or therapy; 23% of callers indicated that their children had received a mental health diagnosis. The top five diagnoses reported were ADHD (41%), bipolar disorder (13%), oppositional defiant disorder (12%), depression (10%), obsessive compulsive disorder (3%) and Asperger syndrome (3%).[38]

Table 1.3 highlights the top services requested by Helpline callers and the top services referred to callers in July-September 2010. Outpatient services were the most requested and most referred. Residential treatment also was frequently requested but was suggested less often, in part because Helpline counselors identified other options such as in-home care or intensive outpatient programs. Respite services were slightly more frequently suggested than requested; however, a shortage of respite care was noted.[39] In the first nine months of operation, Helpline counselors provided 334 referrals to Family Navigator Services for peer support and ongoing case management. They also made 1,944 referrals to other services.[40]

Even when services exist, however, many children and families face barriers and gaps in their search for appropriate behavioral health care. Families cite challenges such as cost, service interruption, wait lists, distance and age restriction by agencies.[41] Private insurance may not cover the service desired, yet families at a high enough income level are not eligible for Medicaid assistance either. Some families who are eligible for Medicaid report that getting approval for certain services is a struggle.[42] The Division of Behavioral Health attempts to bridge the financial gap for children who are neither state wards nor eligible for Medicaid. Funds for this group may only be used if the child meets clinical guidelines for mental health or substance abuse disorders.[43]

Other families may find that there is simply a shortage of professionals available nearby. The Nebraska Legislature, in LB 603, clearly acknowledged that many residents – adults and children alike – lack access to behavioral health professionals, particularly those trained in evidence-based practices. Some people wait a long time for services or end up receiving services that are inappropriate for their needs. The bill went on to say, "As a result, mentally ill patients end up in hospital emergency rooms which are the most expensive level of care or are incarcerated and do not receive adequate care, if any."[44]

Children with behavioral health problems sometimes end up in foster care. Long before 36 children were dropped off at Nebraska hospitals during the Safe Haven crisis, research showed that many families con-

Table 1.3: Top Services Requested by and Referred to Nebraska Family Helpline Callers (July-September 2010)

Top Requested Services		Top Referred Services	
Service	**Percent**	**Service**	**Percent**
Community Based (Outpatient)	22.8%	Community Based (Outpatient)	21.0%
Residential Treatment	22.4%	Evaluation/ Assessment/Diagnostic	11.3%
Formal Respite	6.6%	Formal Respite	9.3%
Housing	6.2%	Residential Treatment	8.6%
Evaluation/ Assessment/Diagnostic	5.4%	Juvenile Legal Services	5.7%
Total	259	Total	558

Source: Nebraska Family Helpline & Family Navigator Services Quarterly Report: July-September 2010

sidered relinquishing custody of their children so they could access behavioral health care, due at least in part to the high cost. A national survey conducted by NAMI revealed that among parents of children with serious mental illness, 23% reported having been told that relinquishment would be necessary for the child to access services; 20% gave up custody.[45]

Although data aren't available on exactly how many Nebraska families have relinquished custody for the purpose of accessing care for their children, assumptions can be drawn by studying entry into foster care. In 2009, 23% of cases reviewed by the State Foster Care Review Board listed the child's behavior as a reason for entering foster care, and 3% of cases gave the child's mental health as a reason. Table 1.4 provides these data for the past five years.

Children with behavioral health disorders also are more likely to make contact with the juvenile justice system. However, overall admissions at more restrictive settings, such as YRTCs, decreased across fiscal years 2008-2010. Both the Geneva and Kearney YRTCs have experienced overall decreases in admissions since FY 2000, though Kearney's admissions steadily increased from FY 2005-2009 to a peak of 489 and then fell in FY 2010 to 449 (see Figure 1.1). The Geneva YRTC's admission rate in FY 2008, 153, was at its highest for the decade. Numbers dropped to 114 the following year and then rose to 143 in FY 2010.

Comparison across years for the regional centers in Hastings and Lincoln is less reliable due to reorganization of the centers; however, existing data do suggest a decreasing trend in recent years (see Table 1.5). In looking at statistics from a narrower timeframe, one study noted a decrease in residential treatment admissions from 75 to 54 between the first and last quarters of 2009.[46] The study also indicated a drop in authorized requests for residential treatment for children from 95% to 89% between the years of 2007-2008 and late in the year of 2009.[47]

Such reductions in use of more restrictive settings could be in line with efforts to serve more children in their own homes.[48] However, the number of children in community-

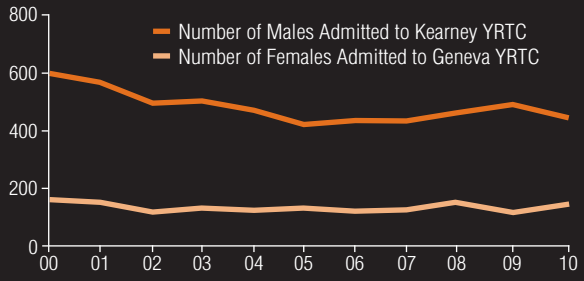
Table 1.4: Number of Times Child's Behaviors or Mental Health Were Given as Reasons for Entering Foster Care (2005-2009)

	2005	2006	2007	2008	2009
Child's Behaviors	569 17.2%	454 17.0%	739 19.4%	554 17.1%	784 22.9%
Child's Mental Health	133 4.0%	97 3.6%	137 3.6%	92 2.8%	113 3.3%
Total Children Reviewed	3,309	2,668	3,806	3,236	3,430

Source: State Foster Care Review Board, as cited in Kids Count

Note: Up to 10 reasons for entering foster care could have been given per child. Multiple reasons may be selected for each child.

Figure 1.1: Admissions to Youth Rehabilitation and Treatment Centers (Fiscal Years 2000-2010)



Source: Nebraska Department of Health and Human Services (DHHS), Division of Children and Family Services, Office of Juvenile Services.

Table 1.5: Youth Served by Nebraska Regional Centers (FY 2008-FY 2009)

	FY 2008	FY 2009
Hastings Regional Center	160	145
Lincoln Regional Center	27	26
Outpatient Evaluations	12	0
Total Youth Served	199	171

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

based services funded by the Division of Behavioral Health also decreased from fiscal years 2008 to 2009, from 3,698 to 2,930. The Division projected that during FY 2010, 2,688 children would receive services; for fiscal year 2011, the target decreases to 2,500.[49] Table 1.6 provides the number of children who received community-based services, by type, in FY 2008 and FY 2009.

Changing methods of data collection may explain some of this drop. Beginning with FY 2010, counts no longer included people receiving substance abuse services with a mental health diagnosis for the purpose of providing a more accurate count. The database also underwent a cleanup in January 2009, eliminating 18,000 old records with no activity in the previous year. It is therefore difficult to identify an accurate picture of how many children are accessing services compared with previous years. Nonetheless, with the overall decrease in admissions in more restrictive settings, one would hope to see an increase in children accessing community-based services.

LB 603 does not call for collection of data about reasons families relinquish child custody, including for the purpose of accessing behavioral health services. Therefore, it will prove difficult to measure any increases or decreases in child relinquishment relating to the implementation of this bill. However, anecdotal evidence suggests that families are benefiting from the LB 603 programs. Helpline callers have expressed more positivity about the situation they called about, due to the moral support and many service referrals made by Helpline counselors. Families who received more in-depth service from Family Navigators reported overall positive experiences in a limited study by evaluator Hornby Zeller Associates, Inc.[50] Right Turn, the program that serves families who have completed an adoption or guardianship, can be credited with helping families better understand and respond to children's behaviors. In addition, Right Turn provides outreach to the juvenile court system with the goal of assisting parents who are considering child relinquishment. Only two of the 154 families participating in Right Turn during its first six months relinquished custody.[51]

Table 1.6: Children Served Through Community-Based Organizations Funded by Division of Behavioral Health (FY 2008-FY 2009)

	FY 2008	FY 2009
Mental Health Only	2,731	2,281
Substance Abuse Only	810	619
Both Mental Health and Substance Abuse	75	30
Other Service	82	0
Total Children Served	3,698	2,930

Note: Includes children ages 18 and under

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

Reform Efforts

Passage of LB 603 wasn't the first time Nebraska examined its shortcomings in behavioral health services. Efforts in the late 1990s and early 2000s led to juvenile service studies and strategic plans. In 2004, Nebraska's Behavioral Health Reform Act, LB 1083, established a community-based philosophy of care for all services but emphasized those for adults. The bill also called for the creation of the Behavioral Health Oversight Commission, charged with ensuring implementation of the reform.

In 2007, legislation focused on a similar plan for children. LB 542 created the Children's Behavioral Health Task Force, a group charged with creating a children's behavioral health plan and overseeing its implementation.[52] The Task Force drafted 17 recommendations relating to: the coordination of an integrated system of care; the development of appropriate service capacity; the identification of diverse funding streams; and the passage of legislation supportive of these recommendations.[53]

LB 928 created the Behavioral Health Oversight Commission II in 2008. Finding that many of the goals of the Behavioral Health Reform Act remained unaccomplished or unaddressed, the Commission prioritized several targets. These aims included enhanced consumer involvement in service planning and delivery, creation of a statewide plan for behavioral health services, development of a data management system and improved quality of service.[54]

In late 2010, using these recommendations as a starting point, the Division of Behavioral Health posted on its web site a draft strategic plan for the years 2011-2015. The plan applies to children and adults in Nebraska's behavioral health system and discusses five key strategies: insisting on accessibility, demanding quality, requiring effectiveness, promoting cost efficiency and creating accountable relationships.[55]

Cause for Concern

It is encouraging that the Division of Behavioral Health has worked toward developing a new strategic plan, released in draft form in late 2010, for public comment, which will guide its efforts over the next few years. Feedback was collected from a variety of stakeholders, leading to a plan that emphasizes a recovery-oriented system that is driven by consumers and their families. Many similar plans have been developed during the last 30 years. Unfortunately, successfully implementing such plans has historically proved challenging.

The recent economic downturn presents additional challenges for implementing improvements in Nebraska's child behavioral health system. As the state attempts to strengthen its services, projected budget shortfalls threaten even existing programs. Already, the Nebraska Family Helpline and Family Navigator Services – implemented in 2010 – have been listed as potential programs to cut in an effort to reduce the DHHS budget.[56]

It is likely that limited funding will hamper additional efforts to successfully implement behavioral health reform. The strategic plan acknowledges the uncertainty of future resources. In doing so, it calls for balanced levels of state and federal funding streams; performance-based contracting; and mechanisms to ensure service quality and efficiency.[57] Diversified funding and careful monitoring of systemic successes and shortfalls will be critical components of successful system reform.

Recommendations

Improving children's access to and utilization of behavioral health services in Nebraska will require the efforts of multiple systems, agencies and stakeholders. Though the Division of Behavioral Health coordinates public behavioral health services, other factors also affect how and if children receive appropriate help. Private entities including insurance companies and health providers play significant roles, as do other public agencies overseeing child welfare, juvenile justice, Medicaid and public health. With this in mind, a few recommendations are as follows:

- Protect the programs established by LB603. Though budget shortfalls threaten the continuation of the Nebraska Family Helpline and Family Navigator Services,

these programs have been positive steps toward connecting families with existing behavioral health services. Further, these programs provide a rich source of data that can help identify service needs – information that is critical if more children are to be effectively served in their own communities.

- Monitor effects of federal health care reform package, called the Patient Protection and Affordable Care Act (PPACA) on children's access to behavioral health services. Passed in 2010, the package calls for enhanced public insurance plans, training of behavioral health care providers, prohibition of discriminatory insurance coverage based on health status and integration of physical and mental health care services, among others.[58] Because of its scope, PPACA's implementation will require much attention and expertise to ensure that children benefit from the reform as intended. Full implementation is planned by 2014.
- Ensure equal insurance coverage of behavioral health disorders. Nebraska law requires that people receive a "minimum level of coverage" for mental health conditions if they are part of a group health insurance plan that provides coverage for mental health conditions. However, insurers are not required to provide coverage for mental health conditions. Consider full parity for behavioral health care funded by both private and public insurance.[59]
- Identify funding streams to provide preventive and early intervention services to children who are not state wards or eligible for Medicaid. Such services may allow more children to stay at home and out of higher levels of care.[60]
- Ensure that children have access to the appropriate level of care without becoming a state ward. Access to services at a level higher than outpatient but lower than inpatient therapy, including multi-system therapy (MST), should be available for all children when appropriate, regardless of type of insurance or custodial status.[61]
- Utilize telehealth when it is appropriate and when in-person services are not available locally or would require extensive travel.
- Restore prenatal care access for all pregnant low-income women. When more than 1,500 women lost Medicaid access to prenatal care in 2010, new Nebraska babies faced increased risks to both their physical and behavioral health. Prenatal exposure to drugs, alcohol and tobacco as well as low birth weight increase a child's risk of developing a mental or behavioral disorder.[62] Prenatal care serves a critical role in connecting women with addiction-cessation services and is linked to higher rates of babies born at a healthy weight.[63]

Final Note

For more information on children's behavioral health in Nebraska, visit our Kids Count Special Features page on the web at www.voicesforchildren.com/kidscount.

[1] Nebraska Family Helpline & Family Navigator Services, *Annual Report: Fiscal Year 2010*, (August 25, 2010).

[2] Voices for Children in Nebraska, *Kids Count in Nebraska 2009 Report* (2010).

[3] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), *Mental Health: A Report of the Surgeon General*, (1999).

[4] Nebraska Department of Health and Human Services (DHHS), *Creating Change and Providing Hope for Nebraska's Children, Adolescents and Their Families: Pursuant to LB542 (2007)*, (January 4, 2008).

[5] Child and Adolescent Health Measurement Initiative. *2007 National Survey of Children's Health, Data Resource Center for Child and Adolescent Health website*, http://www.nschdata.org.

[6] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), *National Survey on Drug Use and Health, 2005 and 2006*.

[7] Child and Adolescent Health Measurement Initiative. *2005/06 National Survey of Children with Special Health Care Needs*, Data Resource Center for Child and Adolescent Health website, www.cshcndata.org.

[8] *Ibid*.

[9] *Ibid*.

[10] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), *Mental Health: A Report of the Surgeon General*, (1999).

[11] Figures are based on the U.S. Census Bureau's 2009 Population Estimates Program – Age, Sex, and Race/Ethnicity Estimates for Counties and HPSA designations according to *Area Resource File (ARF) Access System 2009-2010*, U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Rockville, MD.

[12] Elizabeth M.Z. Farmer, Barbara J. Burns, Mimi V. Chapman, Susan D. Phillips, Adrian Angold and E. Jane Costello, "Use of Mental Health Services by Youth in Contact with Social Services," *Social Service Review*, The University of Chicago (December 2001).

[13] *Ibid*.

[14] Casey Family Programs, "Rate and Number: 2020 Data Brief," http://www.casey.org/Resources/Publications/DataBriefs/pdf/RateAndNumber.pdf. Rate is calculated using the number of children in out-of-home care per 1,000 children in the population.

[15] Data provided by the Nebraska Foster Care Review Board.

[16] Nebraska Foster Care Review Board, *Report on Child Welfare Reform*, (December 2010).

[17] Stacey McMorrow and Embry Howell. *State Mental Health Systems for Children: A Review of the Literature and Available Data Sources*, Urban Institute, (August 2010).

[18] Nebraska Dashboard, Nebraska Family Helpline, Family Navigator and Right Turn (Post-Adoption Services) Performance Measures, http://nebraskadashboard.hornbyzeller.com/.

[19] Nebraska Department of Health and Human Services, Division of Behavioral Health, *Nebraska Uniform Application 2011: State Plan Community Mental Health Services Block Grant*, (August 30, 2010).

[20] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), *Mental Health: A Report of the Surgeon General*, (1999).

[21] Stacey McMorrow and Embry Howell. *State Mental Health Systems for Children: A Review of the Literature and Available Data Sources*, Urban Institute, (August 2010).

[22] Stacey McMorrow and Embry Howell. *State Mental Health Systems for Children: A Review of the Literature and Available Data Sources*, Urban Institute, (August 2010).

[23] Child and Adolescent Health Measurement Initiative. *2007 National Survey of Children's Health, Data Resource Center for Child and Adolescent Health website*, www.nschdata.org.

[24] Voices for Children in Nebraska, *Spare Some Change: An Account of the Nebraska Juvenile Justice and Children's Behavioral Health Care Systems*.

[25] Data provided by the Nebraska Commission on Law Enforcement and Criminal Justice.

[26] Skowyra, Kathleen R., and Joseph J. Cocozza, Ph.D. "A Blueprint for Change." National Center for Mental Health and Juvenile Justice. Delmar, NY: Policy Research Associates, Inc., 2007, as cited in *Spare Some Change*.

[27] Chinn Planning, Inc. in association with Carlson West Povondra Architects, *Nebraska Juvenile Correctional Facilities Master Plan Update*, (June 15, 2007).

[28] Nebraska Department of Health and Human Services, Division of Behavioral Health, *DRAFT Nebraska Division of Behavioral Health Strategic Plan 2011-2015*.

[29] *Ibid*.

[30] Nebraska Department of Health and Human Services, "DBH FY11 Funding for Children's Behavioral Health Services," prepared by Karen Harker, (July 28, 2010).

[31] Nebraska Department of Health and Human Services, Division of Behavioral Health, "Nebraska Youth Professional Partner Program," http://www.dhhs.ne.gov/beh/mh/profpart.htm.

[32] Nebraska Department of Health and Human Services, "DBH FY11 Funding for Children's Behavioral Health Services," prepared by Karen Harker, (July 28, 2010).

[33] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), "Mental Health Services Locator," http://store.samhsa.gov/mhlocator.

[34] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), "Substance Abuse Treatment Facility Locator," http://findtreatment.samhsa.gov/ufds/locchoices.

[35] Data provided by Nebraska Department of Health and Human Services, Division of Behavioral Health.

[36] Nebraska Family Helpline, *Nebraska Family Helpline & Family Navigator Services Quarterly Report: July-September 2010*, (October 15, 2010).

[37] *Ibid*.

[38] Nebraska Family Helpline, *Nebraska Family Helpline & Family Navigator Services Quarterly Report: July-September 2010*, (October 15, 2010).

[39] *Ibid*.

[40] Nebraska Dashboard, Nebraska Family Helpline, Family Navigator and Right Turn (Post-Adoption Services) Performance Measures, http://nebraskadashboard.hornbyzeller.com/.

[41] Nebraska Family Helpline, *Nebraska Family Helpline & Family Navigator Services Annual Report: Fiscal Year 2010*, (August 25, 2010).

[42] Hornby Zeller Associates, Inc., *Fiscal Year 2010 Evaluation Report: Nebraska Family Helpline, Family Navigator and Right Turn Post Adoption/Post Guardianship Services*, (September 2010).

[43] Nebraska Department of Health and Human Services, Division of Behavioral Health, *Nebraska Uniform Application 2011: State Plan Community Mental Health Services Block Grant*, (August 30, 2010).

[44] Nebraska Legislature, LB 603.

[45] The National Alliance for the Mentally Ill (NAMI), *Families on the Brink: The Impact of Ignoring Children with Serious Mental Illness*, (1999).

[46] JoAnne Young. "Children admitted to Nebraska residential treatment dropping," *Lincoln Journal Star*, (June 16, 2010).

[47] JoAnne Young. "Children admitted to Nebraska residential treatment dropping," *Lincoln Journal Star*, (June 16, 2010).

[48] Nebraska Department of Health and Human Services, Division of Behavioral Health, *Nebraska Uniform Application 2011: State Plan Community Mental Health Services Block Grant*, (August 30, 2010).

[49] *Ibid*.

[50] Hornby Zeller Associates, Inc., *Fiscal Year 2010 Evaluation Report: Nebraska Family Helpline, Family Navigator and Right Turn Post Adoption/Post Guardianship Services*, (September 2010).

[51] *Ibid*.

[52] Nebraska Department of Health and Human Services (DHHS), *Creating Change and Providing Hope for Nebraska's Children, Adolescents and Their Families: Pursuant to LB542 (2007)*, (January 4, 2008).

[53] The Children's Behavioral Health Task Force Pursuant to LB 542 (2007), *Children's Behavioral Health Plan*, (December 2007).

[54] Behavioral Health Oversight Commission, *Behavioral Health Oversight Commission Final Report*, (June 22, 2009).

[55] Nebraska Department of Health and Human Services, Division of Behavioral Health, *DRAFT Nebraska Division of Behavioral Health Strategic Plan 2011-2015*.

[56] Martha Stoddard, "Can HHS services be saved?" *Omaha World-Herald*, (September 22, 2010).

[57] Nebraska Department of Health and Human Services, Division of Behavioral Health, *DRAFT Nebraska Division of Behavioral Health Strategic Plan 2011-2015*.

[58] Rebecca A. Clay, "What health-care reform means to you," *Monitor on Psychology*, American Psychological Association, (June 2010), http://www.apa.org/monitor/2010/06/health-reform.aspx.

[59] *Nebraska Revised Statutes*, sec. 44-791 – 44-795.

[60] Nebraska Department of Health and Human Services, Division of Behavioral Health, *Nebraska Uniform Application 2011: State Plan Community Mental Health Services Block Grant*, (August 30, 2010).

[61] Hornby Zeller Associates, Inc., *Fiscal Year 2010 Evaluation Report: Nebraska Family Helpline, Family Navigator and Right Turn Post Adoption/Post Guardianship Services*, (September 2010).

[62] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), *Mental Health: A Report of the Surgeon General*, (1999).

[63] Voices for Children in Nebraska, *Prenatal Care Issue Brief*, (June 2010).

Child Abuse and Neglect / Domestic Violence

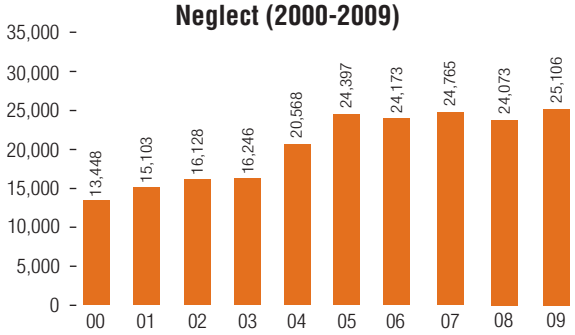
Voices for Children in Nebraska believes that all children should have protection from physical, emotional and sexual abuse, neglect and exploitation. The maltreatment of children affects those individual children, their families, their communities and our society. Violence, whether observed or directly felt by a child, can disrupt growth and development, lower self-esteem, perpetuate a cycle of violence and cause or exacerbate mental health problems. This often results in academic underachievement, violent behaviors, substance abuse and low productivity as adults.[1]

Investigated and Substantiated Cases

Nebraska Department of Health and Human Services System (DHHS) received 30,309 calls to the Child Abuse and Neglect Hotline in 2009. Those calls included 25,106 reports of child abuse and neglect (CAN), an increase from the 24,073 calls alleging CAN in 2008. As demonstrated in Figure 2.1, reports alleging abuse or neglect in 2009 were at their highest in the last ten years.

Of the 25,106 child abuse and neglect reports received in 2009, 14,039 (55.9%) were accepted for investigation, also referred to as safety assessment. This is the same percentage of reports accepted for safety assessment in 2008. From the 14,039 reports accepted for safety assessment, 13,376 assessments were completed as of March 7, 2010. The assessment process determined that from 13,376 reports for which assessment was completed, a total of 10,431 (74.3%) cases were 'safe,' 2,261 (16.1%) were 'unsafe' and 1,347 (9.6%) were undetermined. Of those assessed as 'unsafe,' 1,226 ended up as 'court involved,' 762 ended up as 'non-court involved' and 273 are pending case status determination as of March 7, 2010.

Figure 2.1: Number of Calls to Child Protective Services (CPS) for Alleged Child Abuse and Neglect (2000-2009)



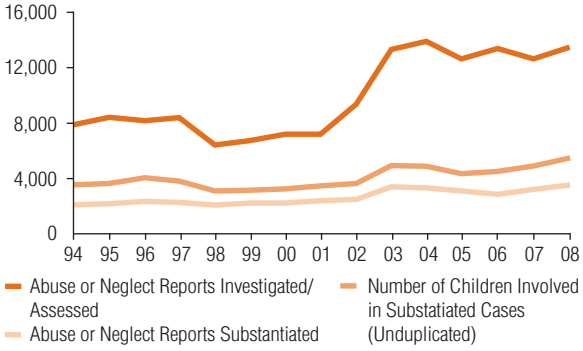
Source: Nebraska Department of Health and Human Services (DHHS).

Of those 13,376 completed assessments, 3,520 reports were substantiated, a 26.3% substantiation rate. There was a total of 5,437 children identified as victims in one or more of the substantiated reports. This is an increase of 535 children from 4,902 in 2008. The number of child victims is an unduplicated total, meaning each child was counted only once, even if the child was involved in more than one substantiated reports. Of the 5,437 victims in 2009, 51.3% (2,787)

Sydney, Katelyn and Nolan

were female and 48.7% (2,650) were male. Figures 2.1 and 2.2 present detailed views of abuse and neglect cases over time.

Figure 2.2: Statewide Abuse and Neglect Cases (1995-2009)



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

Data show substantiated cases are more likely to involve young children. In 2009, 3,546 (65.2%) of the children involved as substantiated victims were ages 8 and under. Children, ages three and under, represented 1,904 (35.0%) of the children involved as substantiated victims. Children aged two and under accounted for 1,504 (27.7%) of the children involved in substantiated cases. Younger children often display stronger evidence of abuse, which is therefore more likely to be reported.

Table 2.1 presents a complete summary of child abuse and neglect reports for 2005-2009. Total reports received are broken down into those alleging CAN. Of those reports alleging CAN, totals are given according to those that were selected for assessment, for which assessment was completed, and those that were in process at the time of reporting. Among completed assessments, further data are providing for those that were substantiated, unfounded and unable to locate. It should be noted that there is a considerable decrease in the number of 'in process' reports out of the total number of CAN reports accepted for assessment (14,039) from 6.2% in CY 2008 to 4.7% in CY 2009.

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 DHHS through the Child Abuse and Neglect Hotline at 1-800-652-1999.

Less than 1% of child abuse reports to DHHS or law

Table 2.1: Child Abuse and Neglect Reports (2005-2009)

	2005	2006	2007	2008	2009
Total Reports Received	28,009	28,358	30,135	29,269	30,309
Reports Alleging Child Abuse or Neglect (CAN)	24,397 *87.1%*	24,173 *85.2%*	24,765 *82.2%*	24,073 *82.2%*	25,106 *82.8%*
Reports in Process, of Those Alleging CAN	579 *2.4%*	595 *2.5%*	1,775 *7.2%*	833 *3.5%*	663 *2.6%*
CAN Reports Selected for Assessment*	13,897 *57%*	12,629 *52.2%*	13,319 *53.8%*	13,460 *55.9%*	14,039 *55.9%*
CAN Reports, Completed Assessments	13,318 *54.6%*	12,034 *49.8%*	11,544 *46.6%*	12,627 *52.5%*	13,376 *53.3%*
Substatiated Reports, of Completed Assessments**	3,324 *25%*	3,065 *25.5%*	2,894 *25.1%*	3,260 *25.8%*	3,520 *26.3%*
Unfounded Reports, of Completed Assessments	9,691 *77.8%*	8,738 *72.6%*	8,412 *72.9%*	9,075 *71.9%*	9.522 *71.2%*
Unable to Locate, of Completed Assessments	303 *2.3%*	231 *1.9%*	238 *2.1%*	292 *2.3%*	334 *2.5%*

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

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

*** Substantiation Rate – Percent of reports selected for investigation/assessment of child and abuse that were substantiated. For 2009, the number of investigations completed was 13,376. Thus, the 2009 substantiation rate was calculated using the completed investigation total and not the total number of cases selected for investigation (3,520/13,376).*

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

Types of Abuse

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

Table 2.2 lists types of abuse that took place in substantiated cases of child abuse in Nebraska in 2009. A single child can experience more than one type of abuse. That explains why there are 5,437 child victims in 2009, while the total number of abuse types totals 6,578.

Child Abuse Fatalities

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

- Caused by an injury resulting from abuse or neglect, or where abuse or neglect was a contributing factor;[2]
- 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.);[3]

Table 2.2: Types of Substantiated Abuse (2009)

Abuse Type	Gender		Total Substantiated Allegations
	Male	Female	
Physical Abuse	355	336	691
Emotional Abuse	19	23	42
Sexual Abuse	90	349	439
Emotional Neglect	118	143	261
Physical Neglect	2,573	2,571	5,144
Medical Neglect of Handicapped Infant	0	1	1
Total Substatiated Allegations	3,155	3,423	6,578
Total Victims	2,650	2,787	5,437

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

Note: Numbers based on substantiated allegations. The 5,437 unique children involved may have been a victim of more than one alleged abuse type in more than one substantiated case. The table above provides a count of abuse types that were substantiated. The 5,437 victims are included in a total of 6,578 allegations of abuse.

- 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);[4]
- 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);[5]
- 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.

Data on child death for 2009 were not available in time for this report. According to data provided by DHHS' Vital Records, there were 14 youth deaths in 2008 that were officially classified as homicides. Of these, three appear to be a result of child abuse and neglect, and the remaining 11 appear to be homicides by peers or unrelated adults, according to the review and analysis of Voices for Children in Nebraska.

However, at the time of this report, the Child Death Review Team (CDRT) within DHHS was finalizing its separate review of the deaths of 258 children, ages 17 and under, that occurred in 2008. The CDRT found seven additional cases that it considered resulted from abuse or neglect, bringing the total to at least 10 child abuse and neglect deaths in 2008. Two more cases are still being reviewed. In six of the deaths in 2008, the child's parents were the perpetrators, in two cases the alleged perpetrator was the mother's boyfriend, one death was attributed to inattention by a babysitter, and another was caused by the child's grandmother.

In previous years, the number of child deaths due to abuse and neglect was reported as 14 children in 2007, 11 children in 2006, 12 children in 2005, 9 children in 2004, 10 children in 2003, and 7 children in 2002. The CDRT expects the number of abuse and neglect designations to increase over time as the team gains access to more diverse sources of information about each death.

In 1993, the Nebraska State Legislature mandated formation of a CDRT to review all child deaths. The team is required by statute to review all deaths of children ages 0 to 17 in the state and make recommendations for reducing future deaths. In July 2009, the CDRT released its sixth report, encompassing findings on 539 child deaths that occurred in 2005 and 2006. We would like to see more resources devoted to producing these reports. More frequent reporting would provide an accurate record of the number of child abuse deaths, to begin to identify strategies to prevent these deaths, and to monitor child death trends.

Domestic Violence/Sexual Assault Programs

Domestic violence, sexual assault, and stalking are prevalent

IMPACT BOX

Primary Prevention in Nebraska: Lindsey Ann Burke Act

By Rachel Olive
Prevention Coordinator, Nebraska Domestic Violence Sexual Assault Coalition

In 2009 the Nebraska Unicameral passed the Lindsey Ann Burke Act. This legislation states that "The Legislature finds and declares that all students have a right to work and study in a safe, supportive environment that is free from harassment, intimidation, and violence. The Legislature further finds that when a student is a victim of dating violence, his or her academic life suffers and his or her safety at school is jeopardized."[1]

With the passage of the Lindsay Ann Burke Act, Nebraska is seeing a greater focus placed on teen safety. As each school across the state creates a policy for how to effectively address dating violence, the Nebraska Domestic Violence Sexual Assault Coalition and the local domestic violence/sexual assault programs are working to effectively prevent dating violence.

Primary prevention is stopping violence before it occurs. The ap-

in every country, in every state, and in every community. In Nebraska, there are 22 community based domestic violence/sexual assault programs and 4 tribal programs serving the Ponca, Winnebago, Omaha, and Santee Sioux nations. These programs offer a range of services for 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.

The 22 local programs endeavor to meet the needs of victims/survivors and empower them. Programs also work to hold offenders accountable, and partner with other agencies to increase community awareness and support.

Between October 2008 and September 2009, 20,134 people received direct services, including shelter, crisis support, and medical and legal advocacy.[6] Of those, 7,687 were children and youth. Among the 3,529 people receiving shelter, 1,608 were children and youth. A total of 85,134 shelter beds and 255,402 meals were provided, with beds and meals provided to children and youth. Program staff and volunteers responded to 54,432 crisis calls through the programs' 24-hour hotlines.

Programs also provided 39,371 hours of individual supportive counseling and advocacy, and 6,872 hours of group supportive counseling and advocacy. Further, 14,642 hours of supportive counseling related to services and assistance for children and youth were provided. Children and youth received 5,543 hours of activities.

The need for community education and awareness continues to grow. The local programs strive to meet this demand. During this reporting period, the programs provided a total of 2,372 educational presentations, with 1,514 provided to youth. Nearly 50,000 individuals attended these presentations, including 24,888 youth. An additional 1,265 awareness activities were also provided. Many of the educational presentation and awareness activities focused on prevention of domestic violence, sexual assault, and stalking.

[1] "The Costs of Child Abuse and the Urgent Need for Prevention," Prevent Child Abuse New York, January 2003, http://preventchildabuseny.org/pdf/cancost.pdf

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

[3] 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.

[4] *Ibid.*

[5] *Ibid.*

[6] This section includes the statistics compiled by the Nebraska Domestic Violence Sexual Assault Coalition (NDVSAC) using data provided by local domestic violence/sexual assault programs. These numbers reflect only the services provided by the programs to the NDVSAC. They do not include services provided to victims/survivors by other agencies (i.e., police, medical). Therefore, this information should be seen as a conservative estimate. The actual number of victims, survivors, and services provided in Nebraska is likely to be much greater.

proaches that are being taken to stop violence before it occurs include working with youth ages 11-17 to instill healthy relationship skills. In this way, programs are challenging societal, cultural, and gender norms and encouraging the youth to become critical consumers of the media. When people challenge these norms, they challenge a culture that in many ways glorifies abuse in relationships.

Other strategies that are being utilized incorporate conversations with the youth about what it means to be an active bystander. To be an active bystander means to step up and speak out against not only violence, but also inappropriate jokes, flirting and harassment. Bystander engagement creates a culture of help and support. Rather than allowing the "locker room humor" or the harassment to perpetuate, youth are encouraged to speak out against it, which will help defuse a culture of violence.

By promoting these strategies, the Nebraska Domestic Violence Sexual Assault Coalition and the local domestic violence/sexual assault programs are changing the landscape of Nebraska.

[1] Nebraska Statute 79-2, 138 to 9-2, 142.

Early Childhood Care and Education

Voices for Children in Nebraska believes that all children should have access to safe, affordable, and high-quality early childhood care and education that strengthens their developmental potential. During this critical period, children grow and learn more than at any other time in their lives. By investing in quality, developmentally appropriate experiences for young children, we can increase a child's opportunities to develop intellectually, socially, and emotionally to reach his or her potential. Early experiences create the foundation upon which a child's future success and productivity are built.[1] Whether receiving care in a home-based or center-based program, children require a high quality, nurturing environment in order to make the most of this developmental stage. Young children who receive quality care increase their chances of achieving success in adulthood.[2] This investment in early childhood is a critical part in ensuring children grow up to become effective and valued members of our society.

Head Start and Early Head Start

Head Start and Early Head Start are federally-funded programs that provide comprehensive services in child development, health and wellness, nutrition, and social services to support low-income families who have infants, toddlers, and preschool children. Early Head Start also serves pregnant women. There are four cornerstones of Head Start: child development, family development, staff development and community development.

Head Start serves preschool-age children, while Early Head Start focuses on children from birth to age 3. Children participate in program formats that focus on the cognitive, social and emotional development in preparation for the transition to school. Programs also 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.

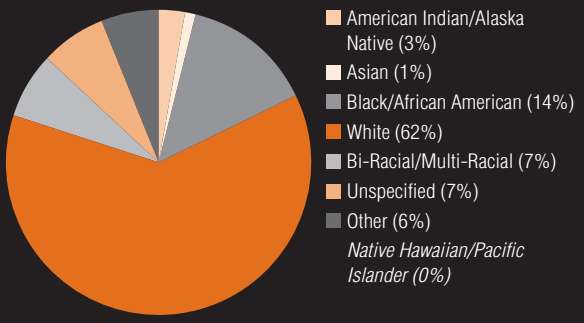
National research has shown that both children and parents benefit from Early Head Start and Head Start programs. Three-year-olds who participated in Early Head Start performed significantly better on a range of measures of cognitive, language and social-emotional development than

a randomly assigned control group. In addition, their parents scored significantly higher than control group parents on many aspects of the home environment and parenting behavior. Thus, Early Head Start programs had positive impacts on parents' progress toward self-sufficiency.[3] Evidence also shows that Head Start children experience cognitive, social and physical gains in the short-term, which have meaningful implications for long-term academic performance.[4] Unfortunately, neither Head Start nor Early Head Start has enough funding to reach all children in need of services.

During the 2008-2009 program year, 22 Head Start and 11 Early Head Start programs provided services for young children and their families in 74 of Nebraska's 93 counties. Out of 22 Head Start programs, there were 15 grantee programs, one migrant program, 3 delegate agencies, and 3 American Tribe programs. Head Start and Early Head Start services were offered in a variety of settings in the state. Services were provided for children in Head Start centers, in partnership with school districts, in community early childhood centers and family child care homes, as well as in the child's own home. Children and their families were served in full-day, part-day and home-based programs. Head Start programs served 1,145 Nebraska children six or more hours per day, 4-5 days a week. An additional 3,799 children were served in part-day programs, which are less than six hours a day, 4-5 days a week.

According to the Head Start Program Information Report for the 2008-2009 program year, Nebraska Head Start/Early Head Start programs served 6,188 children from birth through age 5. Of these, 874 had determined disabilities. Early Head Start programs served 124 pregnant women. Figures 3.1, 3.2, and 3.3 present the racial, ethnic, and age breakdowns of children served. Figure 3.4 provides historical data on the number of 3- and 4-year-old children enrolled in Head Start and Early Head Start. Previous editions of *Kids Count in Nebraska* included data on number of pregnant women under 18 served, number of children served who needed child care for full days and/or the entire year because their

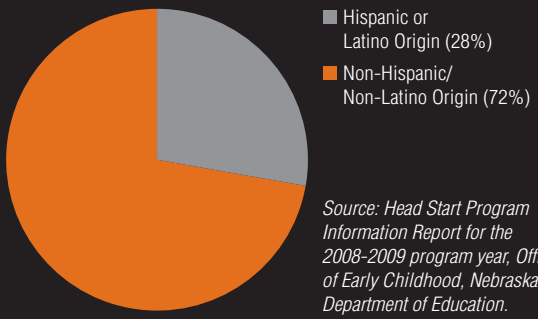
Figure 3.1: Head Start/Early Head Start Enrollment by Race (Program Year 2008-2009)



Source: Head Start Program Information Report for the 2008-2009 program year, Office of Early Childhood, Nebraska Department of Education.

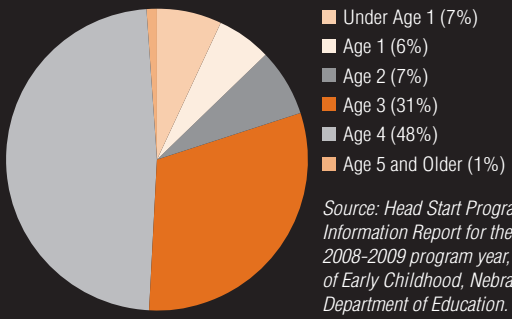
Note: The race of 402 children enrolled in Head Start/Early Head Start was "unspecified."

Figure 3.2: Head Start/Early Head Start Enrollment by Ethnicity (Program Year 2008-2009)



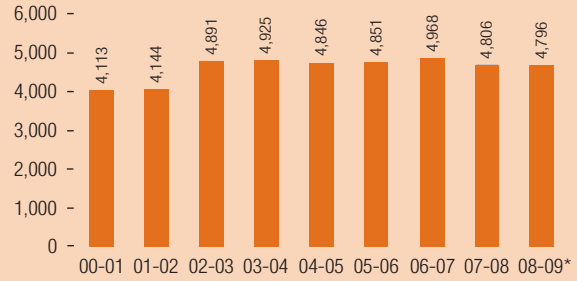
Source: Head Start Program Information Report for the 2008-2009 program year, Office of Early Childhood, Nebraska Department of Education.

Figure 3.3: Ages of Children in Head Start and Early Head Start Programs (Program Year 2008-2009)



Source: Head Start Program Information Report for the 2008-2009 program year, Office of Early Childhood, Nebraska Department of Education.

Figure 3.4: Number of 3- and 4-Year Old Children Enrolled in Head Start/Early Head Start Programs (2000-2001 – 2008-2009)



Source: Office of Early Childhood Education, Nebraska Department of Education.
** Actual number may be higher, as ages for 124 children were not reported.*

parents were working or in job training, and number of children served who spoke a language other than English as a primary language. However, due to changes in reporting requirements by the Head Start Bureau, these data are no longer available.

Further details about the programs and their participants are provided in Tables 3.1 and 3.2.

State Early Childhood Education Grant Program

Nebraska's Early Childhood Education Grant Program, administered by the Nebraska Department of Education (NDE), is designed to award state funds to school districts 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. Of the 2,723 children served during the 2008-2009 school year, 97% were either 3- or 4-years-old.

In 2008-2009, as in the previous program year, 52 school districts or ESUs across the state received grants that fully funded early childhood education programs. Twenty received partial funding through Early Childhood Education grants. Grantees were required to collaborate with existing local providers, including Head Start and existing early childhood programs. The collaborative groups combined grant funds with existing resources to operate integrated early childhood programs, thus improving access to services for young children in those communities.

A majority of the 2,723 children served in the Early Childhood Education Grant Program were from low-income families, as 59% of children served were eligible for free or reduced school lunch. While the number of children served increased from 2,299 in the 2007-2008 school year, the percentage served who are eligible for free or reduced lunch decreased from 77% in the previous year. English was not the primary language used in the home of 27% of the children served. Of the children served by the Early Childhood Grant Programs in 2008-2009, 61% were White, 28% were Hispanic, 6% were Black or African American, 3% were American Indian/Alaskan Native, and 2% were Pacific Islander/Asian.

Even Start Family Literacy Programs

The Even Start Family Literacy Program is a program of the U.S. Department of Education, administered through NDE, that aims to improve the educational opportunities of low-income families. It integrates intensive early childhood education with adult literacy and adult basic education. Even Start also includes support for English language learners and parenting education. Eligible participants in Even Start programs are parents who qualify for participation in an adult education program with their children, birth through age 7. 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.

In the 2008-2009 grant year, four Even Start programs were funded across Nebraska. This marks a decrease from six Even Start programs funded last year and eight programs funded in 2006-2007, due to cuts in federal funding. Nebraska's Even Start programs served 88 families, including 123 adults and 151 children during the 2008-2009 program year. Of all parents served, 76% or 94 parents were English language learners. Of the 47 newly enrolled families, all were

living at or below the federal poverty level (see page 35 for federal poverty guidelines).

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 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 3) or an Individualized Education Program (for children ages 3 to 21) must be developed. Service coordinators with the Early Development Network are available to assist families with children from birth to age 3 who have disabilities. In 2009, a total of 6,807 children from birth to age 3 were served by the Early Development Network. On October 1, 2009, there were 1,567 children, birth to age 3, receiving special education services and 3,794 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 3 and in inclusive environments for children ages 3 to 5. The terms "natural" and "inclusive" environments are defined as settings that would be natural or normal for the child if he/she did not have a disability. To the greatest extent possible, the early education experience is to be provided for children in partnership with community preschools, child care centers, Head Start programs and other community settings.

Child Care Facilities and Subsidies

To be able to fully participate in the workforce, families need safe, high quality child care that supports a full range of children's developmental needs. According to the U.S. Census

Table 3.1: Families Utilizing Head Start and Early Head Start (Program Year 2008-2009)

Family Involvement	Number	Percent
Two-Parent Families	2,788	49.75%
Single-Parent Families	2,816	50.25%
One or both parents employed	4,224	75.37%
Families receiving emergency/crisis intervention services*	2,032	36.24%
Families receiving adult education (GED programs, college selection, etc.)	1,065	19%
Families receiving parenting education	4,325	77.18%
Families receiving at least one family service	4,747	84.71%

Source: Head Start Program Information Report for the 2008-2009 Program Year, Office of Early Childhood, Nebraska Department of Education.

** Emergency/crisis intervention services means meeting immediate need for food, clothing or shelter.*

Note: Percentages are based on 5,604 families served.

Table 3.2: A Closer Look at Head Start and Early Head Start (Program Year 2008-2009)

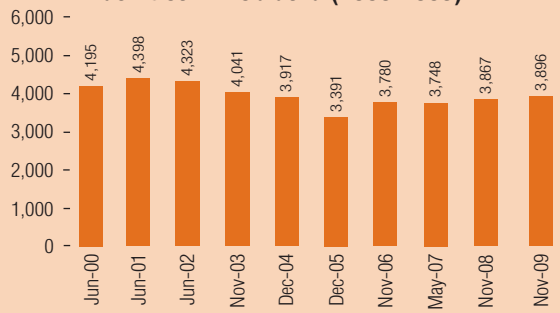
Children	Head Start	Early Head Start
Percent receiving medical treatment	91.1%	95.8%
Percent of preschool children completing professional dental exams	88.6%	N/A
Classroom and Staff		
Percent of preschool teachers who meet current federal degree/credential requirements*	97.6%	N/A
Percent of preschool teaching assistants who meet federal degree/credential requirements that become effective September 2013*	55.5%	N/A
Staff who are Current or Former Head Start Parents (both HS/EHS and contracted)	21.2%	20.7%

Source: Head Start Program Information Report for the 2008-2009 Program Year, Office of Early Childhood, Nebraska Department of Education.

** As indicated in Section 648A of the Head Start Act.*

Note: Percentages are based on 5,604 families.

Figure 3.5: Number of Licensed Child Care Facilities in Nebraska (2000-2009)



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 from previous years for the same month each year. We hope to obtain data in November from 2008 forward and correct this problem.

Bureau, 134,717 children were under age 5 in Nebraska in 2009.[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 age 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 the Nebraska Department of Health and Human Services (DHHS). Data pulled from the Nebraska Department of Health and Human Services in November 2009 indicate that Nebraska had a total of 3,896 child care facilities with a total capacity of 104,876 children. In 2009, as in 2008, both the number of licensed providers, as well as their total capacity, increased; this is a diversion from a trend of past years in which the number of licensed child care providers decreased while the total capacity in licensed child care programs increased. The number of facilities over time is presented in Figure 3.5.

In 2009, families who had previously received Aid to Dependent Children (ADC) with incomes at or below 185% of the federal poverty level, could utilize child care subsidies.[7] Families who had not received ADC were eligible only if their income was at or below 120% of the federal poverty level. Throughout SFY 2009, DHHS subsidized the child care of 32,748 unduplicated children, a slight decrease from 32,793

IMPACT BOX

Early Head Start Expansion Grants

By Mai Nguyen, Voices for Children in Nebraska

Early Head Start is a vital program that helps provide a strong foundation for which children may develop socially and intellectually. Research on child development shows that skill begets skill and learning begets more learning. Advantages accumulate early in life and so do disadvantages; early disadvantages, if not remedied, lead to academic and social difficulties later in life.[1] It is necessary to invest in early childhood programs, such as Early Head Start, so that we may catch problems early on and prevent them from extending into adulthood.

Under the American Recovery and Reinvestment Act, many grants were awarded to create new and expand existing Early Head Start programs across the country. In Nebraska, eight different agencies were awarded grants to expand current Early Head Start Programs. The agencies that received additional funding from Early Head Start Expansion Grants included: the Northwest Community Action Partnership, Central Nebraska Community Services, Community Action Partnership of Mid-Nebraska, Blue Valley Community Action, Community Action Partnership of Lancaster and Saunders Counties, Sarpy County Cooperative, Salvation Army Early Head Start in Omaha, and Boys and Girls Home of Nebraska Inc. in Dakota City.[2]

The eight agencies received in total over $9 million of additional federal funding through these grants.[3] The funds were put towards recruiting families, creating public awareness, increasing the number of program participants, expanding infant and prenatal services, facilities renovation and maintenance, purchasing classroom supplies and playground equipment, creating new part-day/part-year center-based classrooms and expanding home-based Early Head Start services. Additionally, funds were allocated towards hiring and training staff, increasing compensation cost of living adjustments for staff, providing training material for Early Childhood Education endorsements and ultimately, creating

children in SFY 2008. An average of 17,003 children received a subsidy each month. This is an increase from 16,857 children served monthly in 2008. A total of $75,469,630 in federal and state funds was used for child care subsidies in Nebraska, for an average annual payment of $2,282 per child. Subsidies were paid directly to the providers. While not all children received the subsidy for all 12 months of the year, DHHS paid an average subsidy of $366 per child per month in SFY 2009. DHHS rates for SFY 2009 ranged from $2.00 to $5.50 per hour for infants ($13.00 to $36.00 per day) and $2.00 to $4.25 per hour for toddlers, preschool and school-age children ($13.00 to $31.00 per day). For in-home care, in which the child care provider comes to the home of the child, DHHS used the federal minimum wage rate, $6.55 per hour in SFY 2009.

Early Childhood Data Coalition

The Early Childhood Data Coalition, represented by both the public and private sectors, has identified 15 indicators to track over time to inform the state about the status of children from prebirth through age 8. The coalition will track such areas as slots for licensed child care, out-of-home care, health care and access, injury rates and maternal health. The coalition aims to report data in the upcoming Bi-Annual Governor's Report on the Status of Early Childhood, to be disseminated in April 2011. For a complete list of Early Child Data Coalition indicators, please see page 83.

[1] Neal Halfon and Moira Inkelas, "Optimizing the Health and Development of Children," *Journal of American Medical Association* 290, 23(December 2003) 3136-3138.

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

[3] *Ibid.*

[4] 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.

[5] U.S. Census Bureau, 2009 Population Estimates Program – Age, Sex, and Race/Ethnicity Estimates for Counties.

[6] U.S. Census Bureau, 2009 American Community Survey, Table B23008.

[7] See page 35 of this report for poverty levels.

50 new jobs across the state to improve Early Head Start programs.[4]

The grant money has already had a significant impact as many agencies were able to increase the number of Early Head Start participants and serve more children and families. Central Nebraska Community Services used funding to enroll an additional 34 participants in Colfax and Platte counties. The Community Action Partnership of Lancaster and Saunders Counties used funding to serve an additional 78 infants, toddlers and pregnant women, and also help an additional 36 children and families through the creation of 2 new part-day/part-year center-based programs. Overall, the eight Nebraska agencies that received grants were able to help more families in need and expand services to those already participating in Early Head Start.[5]

Early Head Start programs are crucial in providing comprehensive services to low-income children and families. Studies have shown that enriched pre-kindergarten programs geared towards helping disadvantaged children have a strong track record of promoting achievement, improving labor market outcomes and reducing involvement with crime.[6]

Despite its successes, Early Head Start programs still face many challenges such as lack of adequately paid staff or incapacity to provide more intensive services for all families in need. Additional funding, such as that provided by Early Head Start Expansion Grants, is essential in addressing these challenges to improve the reach of these programs. As budget cuts loom for Nebraska – and all states across the nation – it is imperative to keep in mind the importance of these programs and fight for their continued existence and development. Investing in early childhood programs such as Early Head Start ensures that all children have a strong foundation in which to develop socially and intellectually and is a sound investment in the safety and productivity of our society.

[1] James J. Heckman and Dimitriy V. Masterov, "The Productivity Argument for Investing in Young Children," University of Chicago, October 2004.

[2] *U.S. Department of Health and Human Services*, "ARRA Program Locator," Early Childhood Learning and Knowledge Center, Office of Head Start, http://eclkc.ohs.acf.hhs.gov/hslc/arra-locator.

[3] All expenditures reported under the American Recovery and Reinvestment Act were found at http://www.recovery.gov using the Recipient Reported Data Search.

[4] *Ibid.*

[5] *Ibid.*

[6] Heckman and Masterov, 2004.

Economic Well-Being

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

Poverty in Nebraska

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

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

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

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

Bennet

Table 4.1: Poverty Rate in Nebraska (2000 and 2009)

	2000	2009
Child Poverty Rate	10.0%	15.2%
Family/Household Poverty Rate	6.5%	7.0%
Overall Poverty Rate	9.6%	12.3%

Source: U.S. Census Bureau, 2009 American Community Survey, Tables B17001, B17010, and B17001, respectively.

Table 4.2: Poverty Rate by Race and Ethnicity* (2009)

Race	Child Poverty Rate (Under 18)	Overall Poverty Rate
White Alone	11.2%	10.3%
Black or African American Alone	48.4%	33.8%
American Indian and Alaska Native Alone	34.5%	30.9%
Asian Alone	19.5%	16.9%
Some Other Race Alone	33.8%	25.1%
Two or More Races	25.5%	25.9%
Ethnicity		
White Alone, Not Hispanic or Latino	9.4%	9.6%
Hispanic or Latino	29%	23.1 %

Source: U.S. Census Bureau, 2009 American Community Survey, Tables C17001A-C17001I.

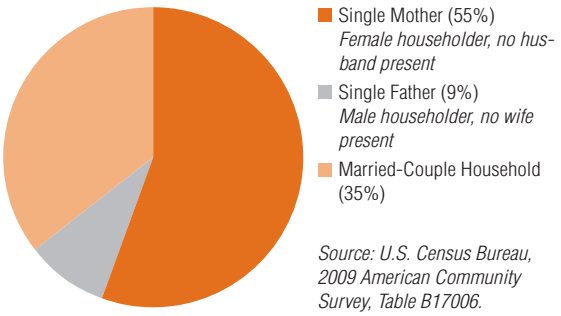
** Racial and ethnic groups are based on those used by the U.S. Census Bureau.*

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 children are provided the greatest opportunities to succeed.

Single-Parent Families

In 2009, 25.8% 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. Of the Nebraska families that were headed by a single parent in 2009, 25.3% lived in poverty, as compared to only 4.0% of families headed by married couples.[3] Single parents may struggle more than their married counterparts with the costs of child care, balancing work and home duties, and spending quality time with their children. A lack of essential resources and few supports have been linked with parental stress which can lead to a greater occurrence of child abuse or neglect.[4] Figure 4.1 illustrates all children in poverty by family type.

Figure 4.1: Nebraska Children in Poverty by Family Type (2009)



Source: U.S. Census Bureau, 2009 American Community Survey, Table B17006.

Temporary Assistance for Needy Families (TANF)

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

In Nebraska, children comprise 75% of total ADC enrollment, according to a snapshot of program recipients from June 2009. There was a monthly average of 17,163 children receiving ADC benefits in state fiscal year (SFY) 2009, a decrease from 17,609 in SFY 2008. ADC was provided to a monthly average of 8,597 Nebraska families in SFY 2009, a decrease from a monthly average of 8,994 families in SFY 2008. The total amount of monthly payments equaled $32,810,733, an average of $318.04 per family per month in 2009. This is a $7.82 decrease in average payments per family from 2008. Approximately 50% of the cost of ADC benefits was paid for by state general funds, and the remaining 50% was provided by federal TANF funds.

The maximum ADC payment amounts to 24% of the federal poverty level as prescribed by Nebraska law.[5] A family of four was considered to be living in poverty if its monthly income was under $1,837.50 in 2009. However, a family that size could receive a maximum of $435 a month in ADC assistance, an amount well below a poverty-level income. Nebraska ranks in the lower half of the country for its adequacy of benefit levels.[6] Figure 4.2 presents a historic view of ADC utilization since 1999. The average number of Nebraska families receiving ADC monthly has steadily decreased from a slight peak in 2004.

A June snapshot of ADC recipients, broken down into age groups, shows that the 0-5 age group is the largest recipient of ADC benefits (see Figure 4.3). Figure 4.4 presents a June snapshot of ADC recipients by race, indicating that

White Americans accounted for 40% of ADC benefits, followed by Black Americans who accounted for 29%.

With any decline in ADC enrollment, as is the case in Nebraska since 2004, we would hope to see an increase in employment as well as a decrease in the number of individuals, families, and children living in poverty. Unfortunately, the decline in enrollment has occurred as our state was experiencing a simultaneous decrease in employment throughout fiscal year 2009 and an increase in individual, family and child poverty.[7] If ADC is to fulfill its goal of helping families support themselves without public assistance, we must ensure that those leaving the program are able to meet their basic needs through high-quality employment.

Table 4.3: Federal Poverty Guidelines (2009)

Persons in family or household	100% Poverty (Poor)	130% Poverty*	185% Poverty	200% Poverty* (Low-Income)
1	$10,830	$14,079	$20,036	$21,660
2	$14,570	$18,941	$26,955	$29,140
3	$18,310	$23,803	$33,874	$36,620
4	$22,050	$28,665	$40,793	$44,100
5	$25,790	$33,527	$47,712	$51,580

Source: Federal Register, Vol. 74, No. 14, January 23, 2009, pp. 4199-4201, http://aspe.hhs.gov/poverty/09fedreg.pdf.

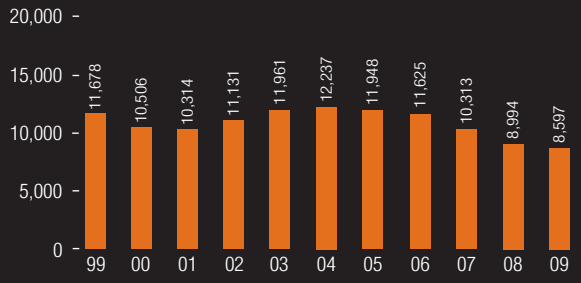
** Approximations are based on 100% of the federal poverty guidelines.*

Divorce and Child Support

In 2009, 12,027 couples were married and 6,084 marriages ended in divorce. The number of marriages in 2009 was lower than in 2008 (12,353 marriages) and the number of divorces was higher than in 2008 (5,885). In 2009, divorce affected 5,790 children, an increase from 2008 when 5,442 children were affected. Of the divorces granted in 2009, custody was awarded to mothers 1,982 times (1,958 times in 2008), to fathers 341 times (331 times in 2008) and joint custody was awarded 781 times (664 times in 2008).

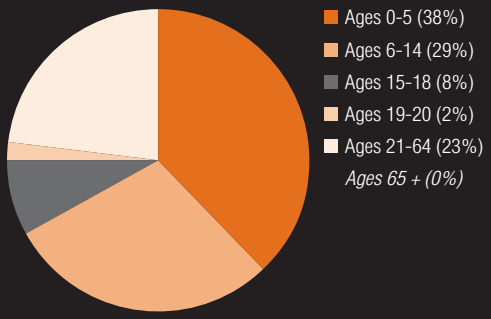
The court may award child support to the custodial parent. However, the custodial parent does not always re-

Figure 4.2: Average Number of Nebraska Families Receiving ADC Monthly (1999-2009)



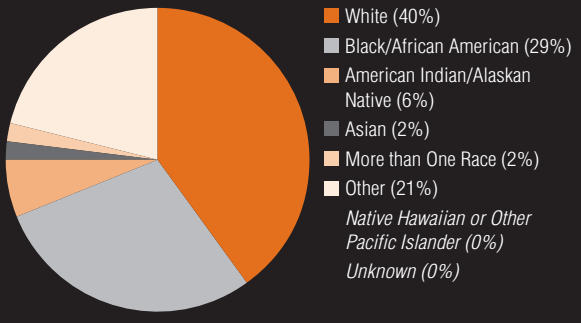
Source: Financial Services, Operations, Nebraska Department of Health and Human Services (DHHS).

Figure 4.3: ADC Recipients by Age (June 2009)



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

Figure 4.4: ADC Recipients by Race (June 2009)



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

ceive child support from the non-custodial parent. A parent can request DHHS assistance if they are not receiving the child support they are owed. The assistance will be provided by Child Support Enforcement (CSE), an agency that operates under DHHS. In FY 2009, CSE provided assistance to 105,942 cases. Families dependent on Aid to Dependent Children (ADC) filed 8,891 and non-ADC families filed 97,051 cases. In FY 2009, CSE collected a total of $197,928,605 in child support payments and disbursed a total of $200,079,877.

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 in retaining more of their earned income. In 2009, a total of $277,414,000 was claimed as the federal Earned Income Tax Credit on 134,630 Nebraska federal tax returns. In addition, 151,430 families claimed the federal Child Tax Credit, receiving $206,068,000 and 52,280 families claimed the federal Child and Dependent Care Credit, receiving $25,143,000.

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

IMPACT BOX

Asset Limits in Public Benefit Programs

By Aubrey Mancuso, Opportunity@Work

Times of economic uncertainty often lead to an increase in the number of families utilizing public benefit programs. The number of Nebraska families utilizing the Supplemental Nutrition Assistance Program (SNAP), more commonly known as food stamps, has increased by over 20% over the course of the past year. This program, and other public benefit programs, should be available as a means of temporary support during difficult economic times with the ultimate goal of moving families toward self-sufficiency.

Many public benefit programs use both income and assets to determine eligibility. This practice often limits eligibility to those with few to no financial resources by establishing asset limits on what families can save and own in order to receive assistance. Asset limits were initially intended as a safeguard against systemic abuses from individuals who may lack income but may otherwise have significant resources. Today, many believe that these limits are inadequate and often function as a barrier to economic self-sufficiency for some low-income families.

In the case where a household's resources exceed the limits, long-term savings and assets must be "spent down" before the family can receive short-term assistance. While homes and personal effects are exempt from these limits, many resources required for building long-term financial security – such as retirement accounts, and college, medical or emergency savings accounts – are not. The end result is that in or-

a refundable tax credit equaling 8% of the federal EITC for working families. In 2007, the state refundable EITC rose to 10%. In 2009, the Nebraska state EITC was claimed on 131,468 returns (an increase from 115,807 returns in 2008), and $27,455,000 was refunded. The Nebraska Child and Dependent Care Credit was claimed on 56,899 Nebraska state income tax returns, and the total amount received, including both the refundable and non-refundable credit, was $12,484,000 in 2008.

Nebraska also offers free tax assistance to families statewide through a collaboration of state and local agencies. To access free tax assistance, call 2-1-1 or visit www.canhelp.org/EITC.htm.

Homeless Assistance Programs

The Nebraska Homeless Assistance Program (NHAP) of the Nebraska Department of Health and Human Services (DHHS) funds emergency shelters, transitional housing and services for people who are homeless or at risk of becoming homeless. The objective of the 2009 Nebraska Homeless Assistance Program was to assist in the immediate alleviation of homelessness of Nebraska citizens using the Department of Housing and Urban Development's (HUD) Emergency Shelter Grant (ESG) funds and the Nebraska Homeless Shelter Assistance Trust Fund (HSATF).

The state strongly supports a collaborative approach to addressing the needs of people who are homeless through a Continuum of Care process. The process promotes a coordinated, strategic planning approach for programs that assists families and individuals who are homeless or near homeless. This approach is a community and regionally-based process that provides a coordinated housing and service delivery system. During the July 1, 2009-June 30, 2010 grant year, 66 programs of grantees statewide provided Continuum of Care services to people who were homeless or near homeless.

For the 2009-10 grant cycle, funded agencies collaborated to assist 18,599 individuals who were homeless and 41,263 individuals who were near homeless. Within specific Continuum of Care regions, the Panhandle, North Central, Southeast, Northeast, and Lincoln reported decreases in the number of individuals who were homeless (-9.1%, -7.9%, -15.9%, -2.7%, and -9.1%, respectively). The Southwest region reported an increase in the number of homeless individuals served (+5.9%). All regions funded by the Emergency

der to receive temporary assistance, families must sacrifice resources that are essential to their long-term financial security. In addition to the potential depletion of existing resources, these limits also discourage families already receiving assistance from developing savings. A family receiving food stamps in Nebraska is only allowed to save $2,000 before becoming ineligible for the program. The significant loss of benefits that results from relatively small increases in savings provides a disincentive for families to build resources that could ultimately move them toward greater economic security.

Ultimately, all families need to save in order to weather difficult economic times and prepare for the future. Families receiving public benefits should be no exception. Nebraska has taken some steps toward incentivizing asset-building, such as the exemption of Independent Development Accounts from savings limits, but there is still a great deal of room to improve eligibility guidelines in ways that encourage moving toward self-sufficiency.

Nebraska could further encourage financial independence for low-income families by exempting resources that generate income or are earmarked for future expenses, like individual retirement accounts and college savings plans. These exemptions would also ensure that families facing unexpected financial hardship as a result of a job loss or physical accident could receive temporary assistance without having to sacrifice long-term financial stability. Nebraska could also raise asset limits to more adequately reflect the amount that families need to be saving to move toward self-sufficiency. Families experiencing economic difficulties should not have to make the difficult choice between short-term emergency assistance and long-term financial security. Public benefit programs should encourage savings as a means of moving toward self-sufficiency

Shelter Grant (Panhandle, North Central, Southwest, Southeast, Northeast, and Lincoln) reported a 6.6% aggregate decrease in the number of near homeless individuals served. Similar data comparisons cannot be made for the Omaha area because it is only funded via the Homeless Shelter Assistance Trust Fund (meaning it does not receive Emergency Shelter Grant funding from the State of Nebraska). Some of the regional decreases for both homeless and near homeless individuals may be attributed to effective statewide service provision of the Homelessness Prevention and Rapid Re-Housing Program (HPRP), part of the American Recovery and Reinvestment Act of 2009 (ARRA).

According to Nebraska Management Information System (NMIS) data, the following 2009-2010 program year information is true for agencies that specifically reported via HMIS: 20% of individuals served were age 17 or younger; 19% of individuals served were in families; and 7% of children served were not associated with family or were unaccompanied youth. It must be noted that these data do not include individuals served by domestic violence agencies because domestic violence providers do not report via Homeless Management Information System (HMIS).

A major policy shift regarding homelessness prevention and service provision occurred when President Obama signed the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act on May 20, 2009 (the Act re-authorized HUD's Homeless Assistance programs). The bill modified HUD's definition of homelessness to include demographics also defined as homeless by other federal agencies. HUD's current definition of homelessness includes individuals living in places not meant for human habitation (ex: streets, abandoned buildings, etc), individuals living in an emergency shelter or transitional housing facility, and individuals facing an imminent loss of housing and with no other housing options or supports. The HEARTH Act added to this definition the following: an individual at imminent risk of homelessness or a family or unaccompanied youth living unstably.[8] The HEARTH Act homeless definition includes families with children and unaccompanied youth who: are defined as homeless under other federal programs (such as the Department of Education's Education for Homeless Children and Youth Program); have lived for a long period without living independently in permanent housing; have moved frequently; and will continue to experience instability because of disability, a history of domestic violence or abuse, or multiple barriers to employment. The HEARTH Act will ensure that HUD utilizes the same definition of homelessness as other agencies, and this will greatly assist service providers and state stakeholders receiving federal funding. Provisions of the HEARTH Act will not be implemented nationally until 2011 at the earliest.

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

2 U.S. Census Bureau, 2009 American Community Survey, Table B09005.

3 U.S. Census Bureau, 2009 American Community Survey, Table B17010.

4 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.

5 Calculations were based on a four-person household with a $22,050 annual income, considered the 2009 poverty level. Maximum monthly ADC payments in Nebraska for a four-person household was $435.

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

7 U.S. Department of Labor, Bureau of Labor Statistics (Unemployed Persons) for the months of fiscal year 2009 (July 2008 through June 2009).

8 Imminent risk means that a person is leaving his/her current housing within the next 14 days, and no other housing options exist and no resources exist to obtain housing.

Education

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

To the detriment of our children and their future, there remain significant disparities among groups of children in our education system, particularly for some children of color.[2] Due to high poverty rates among people of color that have resulted from historical conditions and structural inequities, children of color are disproportionately concentrated in low-income areas.[3] Low-income geographies have a smaller tax capacity and consequently are less able to support the high quality education experiences that may be available in higher income areas. This income disparity affects both urban and rural areas.[4]

High School Graduates

During the 2008-2009 school year, 21,615 Nebraska high school students were awarded diplomas. The 2008-2009 graduation rate was 89.9% compared to 89.8% in 2007-2008 and 89.3% for the 2006-2007 school year. In the 2008-2009 school year, graduation rates for White, Asian, and Female students were higher than the statewide rate; however, the rates for Black, Hispanic, Indian, and Male students were below the statewide rate. Table 5.1 presents graduation rates by race, ethnicity and gender.

Nebraska has used the definition for graduation rate developed by the National Center for Education Statistics (NCES) since 2002-2003, which is the definition used in this report. 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, during which the students moved through high school, and the high school diploma recipients.

Table 5.1: Graduation Rates by Race, Ethnicity and Gender (2008-2009 School Year)

Students*	Graduation Rate**
White	93.23%
Black	69.36%
Asian	93.79%
Hispanic	77.79%
Indian	68.59%
Female	91.48%
Male	88.33%
Nebraska Total	89.88%

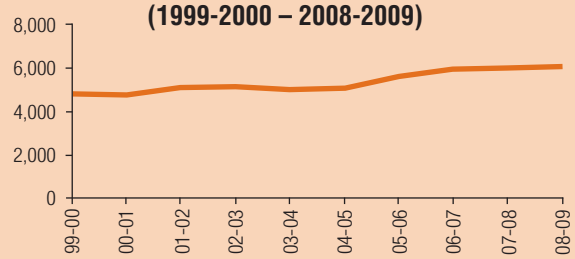
Source: Nebraska Department of Education.

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

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

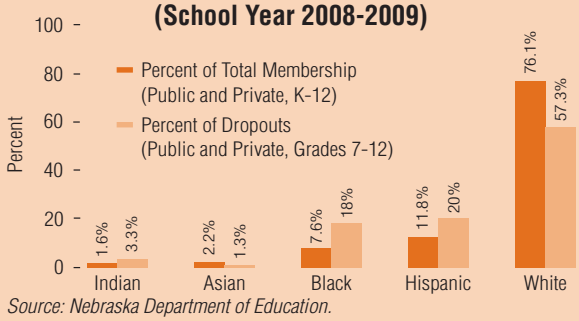
Beginning with the 2007-2008 school year, Nebraska began to accumulate data in the Nebraska Staff and Student Record System (NSSRS) to allow the state to calculate the new graduation rate as defined by the U.S. Department of Education. The new gradua-

Figure 5.1: Exempt or "Home School" Students (1999-2000 – 2008-2009)



Source: Nebraska Department of Education.

Figure 5.2: Percent of Dropouts Compared to Percent of Enrollment by Race and Ethnicity* (School Year 2008-2009)



Source: Nebraska Department of Education.

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

tion rate, the Cohort Four-Year Graduation Rate, follows a cohort or group of students that begins in grade nine in a particular school year and graduates with a high school diploma in four years or less. The new definition utilizes net transfers rather than dropouts to calculate the graduation rate. Nebraska will publish the Cohort Four-Year Graduation Rate, starting with the 2011 Graduation Cohort, at the end of the 2010-2011 school year.

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 2008-2009 school year, there were 6,134 exempt, or "home school," students in Nebraska, an increase from 6,062 students in 2007-2008. Figure 5.1 demonstrates the trends in the number of home schooled children since the 1999-2000 school year.

In addition, 1,383 students ages 16 through 18 took all or portions of the General Education Development (GED) test in 2009. Of these, 888 students (64.2%) successfully completed the tests and qualified for a GED credential.

POLICY BOX

School-Based Health Centers

By Mai Nguyen, Voices For Children in Nebraska

In the past few years there have been tremendous strides in terms of providing quality and affordable health care to all children. The Patient Protection and Affordable Care Act of 2010 as well as the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 will ensure that more children will have health insurance. Despite its successes however, our health care system continues to fail a large number of children, especially those coming from low-income backgrounds. Multiple barriers to access for basic health services persist that prevent children from receiving adequate care. School-based health centers (SBHCs) are vital in addressing these disparities in access to improve the health of children. SBHCs are clinics located on school premises that provide a range of primary and preventive care services.[1] Prior research has shown that SBHCs are successful in increasing access to preventive care for children and serving members of underserved populations.[2] Furthermore, it has been found that SBHCs help reduce inappropriate use of emergency rooms to cut Medicaid costs, decrease hospitalization rates for children with chronic diseases such as asthma or diabetes, and have a positive impact on mental health of students.[3] These benefits derived from SBHCs go on to impact academic success as healthier children perform better in school.

In Nebraska, there currently exists one school-based health center in Grand Island and multiple pilot centers in the Omaha area. The Student Wellness Center in Grand Island opened in 1997, and until this year was the only SBHC in Nebraska. The center provides services for students at Walnut Middle School grades 6-8 and Grand Island Senior High grades 9-12 who have a signed parental permission form. The Student Wellness Center is partnered with St. Francis Medical Center and offers a range of services including immunizations, acute care, care for chronic illness (i.e. asthma, diabetes, eating disorders), laboratory tests, medications such as antibiotics and inhalers, substance abuse services and mental health services.[4] Students must have a signed parental permission form to receive services and the Student Wellness Center provides a competitive fee schedule for services received. Over the past 12 years, the Student Wellness Cen-

School Dropouts

During the 2008-2009 school year, 2,290 Nebraska students dropped out of school, 1,366 male and 924 female.[5] This was a decrease of 87 dropouts from the previous school year. Research indicates that some groups of people of color have higher dropout rates than White students due to reasons such as poverty and level of segregation.[6] Figure 5.2 on page 40 compares percent of dropouts to percent of enrollment by race and ethnicity.

Expelled Students

During the 2008-2009 school year, 892 Nebraska students among all grades were offered alternative education in response to expulsion.[7] Table 5.2 presents the number of statewide expulsions starting with the 1999-2000 school year.

In general, public school students are provided with an alternative school, class or educational program upon expulsion. In Nebraska, a student can be expelled from a school but not from the school system, allowing for the student to continue his or her education in either a formal alternative program or at home. In some cases, the student and his or her parents may 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.

Table 5.2: Statewide Expulsions (1999-2000 – 2008-2009)

School Year	Number of Expulsions
1999-2000	824
2000-2001	770
2001-2002	816
2002-2003	857
2003-2004	858
2004-2005	924
2005-2006	928
2006-2007	959
2007-2008	1,000
2008-2009	892

Source: Nebraska Department of Education.

ter has been successful in providing affordable and accessible healthcare for the students of Grand Island public schools. In Omaha, plans to open up six pilot SBHCs throughout the metro-area have been led by Omaha Public Schools, Building Bright Futures, and the Children's Hospital and Medical Center. These six SBHCs are located within schools with high poverty rates and will provide many of the basic services that the Student Wellness Center of Grand Island offers.[5] Hopefully these SBHCs will be able to provide increased access to quality care for those families who need it most.

The most significant challenge facing SBHCs is sustainable funding. Especially during tough economic times, private and government grants are becoming more and more limited, meaning SBHCs will have to cut back on services or even shut down.[6] LB1106 is an important piece of legislation that will help promote the creation of new SBHCs as well as the maintenance of existing ones. LB1106, passed in March 2010, allows for SBHCs to become qualified service providers under the Nebraska Medicaid program. The passage of LB1106 will:

- allow for medical services provided by SBHCs to be reimbursed at the federally qualified health center reimbursement rate,
- establish School Health Advisory Councils to ensure the best interests of the community, school and health care providers are served,
- require the Department of Health and Human Services to seek federal matching funds for legal permanent resident children through CHIPRA, and
- provide an influx of federal dollars for services to legal permanent resident children at SBHCs.

LB116 is important in that it allows for a source of sustainable funding for SBHCs in Nebraska and increases access to health care for many low-income children. It is important that we work to make sure that all children have access to affordable and quality health care, and LB1106 is a step in a positive direction to providing that through SBHCs.

[1] Mina Silberberg and Joel C. Cantor, "Making the Case for School-Based Health: Where Do We Stand?" *Journal of Health Politics, Policy and Law*, 33, 1(February 2008).

[2] *Ibid.*

[3] "School-Based Health Center and Academic Performance: What is the Intersection?" *National Assembly on School-Based Health Care*, January 2005.

[4] Student Wellness Center information available at: http://www.gips.org/programs/health-services/student-wellness-center.

[5] "Talking Points for School-Based Health Centers," *Building Bright Futures*, July 2010, http://buildingbrightfutures.net/post/sections/5/Files/SBHC_Talking_Points.pdf.

[6] Silberberg and Cantor, 2008.

Special Education

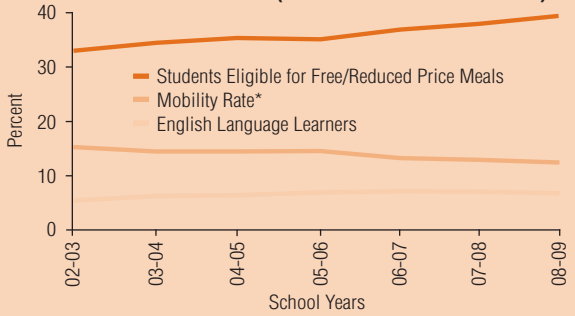
On October 1, 2009, 47,602 Nebraska students from birth to age 21 received special education services. It is important for a child's development and education that the need for special education be identified at an early age. There were 6,681 children, birth to age five, with a verified disability receiving special education services (this is a point-in-time count for October 1). School districts reported 40,921 students ages 6 to 21 with disabilities during the 2008-2009 school year.

Student Characteristics

Some student characteristics are linked with additional barriers to academic and personal success. Students face unique challenges when they frequently change schools, have difficulty speaking English, or live in poverty. Figure 5.3 highlights decreasing trends in mobility rate, increasing eligibility for free for free reduced meals, and increasing rates of English language learning in Nebraska public schools.

Mobility rate highlights students entering and leaving school during the school year. Research indicates that as students move more frequently, they face an increased risk of lower test scores and of dropping out. Further, schools with high student mobility are more likely to have higher rates of school crime and suspension, as well as lower rates of student participation in the classroom.[8]

Figure 5.3: Nebraska Public Schools Trends in Student Characteristics (2002-2003 – 2008-2009)



Source: Nebraska Department of Education, http://reportcard.education.ne.gov.

** Mobility Rate – Beginning in 2008-2009, the determination of mobility rates is made from individual state data. Prior to this data, mobility rate was determined through the following calculation: Any child who entered or left 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.*

Increasing rates of eligibility for free and reduced meals correlate with increasing poverty. Poverty influences which opportunities may be available to children.[9] However, free and reduced meals through the School Lunch Program help connect students with nutritious meals they may not otherwise access. Such meals help children with classroom attendance, behavior, and attention.[10]

English language learners (ELL) refer to students whose native language is not English and who have difficulties speaking, reading, writing, or understanding English.[11] Nationally, ELL students are more likely to be placed in remedial or low-level courses and taught basic skills. Consequently, they may have less access to courses that prepare them for college, thereby adding an additional barrier to future success.[12]

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

[2] Jaekung Lee and Kenneth K. Wong, "The Impact of Accountability on Racial and Socioeconomic Equity: Considering Both School Resources and Achievement Outcomes," American Educational Research Journal, 41, 4(2004) 797-832.

[3] Margery Austin Turner and Lynette Rawlings, "Promoting Neighborhood Diversity: Benefits, Barriers and Strategies," Urban Institute, August 2009.

[4] Margery Austin Turner and Alan Berube, "Vibrant Neighborhoods and Successful Schools: What the Federal Government Can Do to Foster Both," Urban Institute, July 2009.

[5] Dropout rates are calculated using grades 7-12.

[6] Orfield, G., Losen, D., Wald, J., & Swanson, C. *Losing Our Future: How Minority Youth are Being Left Behind by the Graduation Rate Crisis*, Cambridge, MA: The Civil RightsProject at Harvard University, 2004.

[7] The total of 892 is an unduplicated count of students expelled from each district, though students could have been counted twice if expelled from more than one district.

[8] Beesley, A., Moore, L., and Gopalani, S. (2010). *Student mobility in rural and nonrural districts in five Central Region states* (Issues & Answers Report, REL 2010–No. 089). Washington, DC: U.S. Department of Education, Institute of Education Sciences, National Center for Education Evaluation and Regional Assistance, Regional Educational Laboratory Central. Retrieved from http://ies.ed.gov/ncee/edlabs.

[9] Annemarie Bailey Fowler and Tiffany Seibert, *Kids Count in Nebraska 2008 Report*, Voices for Children in Nebraska.

[10] "Child Nutrition Fact Sheet: National School Lunch Program," Food Research & Action Center. Retrieved from http://frac.org/newsite/wp-content/uploads/2009/09/cnnslp.pdf.

[11] "2008-2009 State of the Schools Report: A Report on Nebraska Public Schools." Nebraska Department of Education. Retrieved from http://reportcard.education.ne.gov/Page/DemoMobility.aspx?Level=st.

[12] A Teacher's Guide to State English Language Learner Assessment and Accountability, National Council of La Raza, 2009. Retrieved from http://www.aecf.org/KnowledgeCenter/SearchResults.aspx?keywords=ELL&source=topsearchKC.

Health – Physical and Behavioral

Voices for Children in Nebraska believes that all children should have access to quality and affordable health care. Adequate levels of immunization, public health measures to prevent disease and disability, and support for maternal health and positive birth outcomes are examples of measures that help children now and later. Good health, both physical and behavioral, is an essential element of a productive life. It is no surprise that children who receive preventive health care throughout their lives become healthier adults.

Too many children in Nebraska face significant barriers to leading healthy and productive lives. Poor nutrition, a lack of access to preventive care, poor environmental conditions and delayed and inadequate diagnosis and treatment are all linked to inferior health outcomes, school attendance, and academic performance.[1] Low-income children and children of color experience less access to quality care due to a high

Justice

rate of uninsurance and the corresponding lack of preventive care and culturally competent services. The spatial segregation of many low-income neighborhoods translates into limited access to health resources such as medical facilities, pharmacies, and safe recreational areas.[2] Such neighborhoods are also often disproportionately exposed to air, water and soil pollutants and lead hazards.[3] Finally, troubling disparities have been revealed in the quality of care that children receive based on their race or ethnicity. Studies of a variety of medical treatments document that patients of color receive a lower quality and intensity of health care than White patients, which leads to poorer medical outcomes among people of color.[4]

Nebraska Births

There were a total of 26,992 live births to Nebraska residents in 2008. In breaking out births by the mother's age, 8.5% of births were to girls 19 and under; 25.5% were to women ages 20-24; 31.7% were to women 25-29; and 34.3% were to women 30 and over. By race, 77.6% of babies were White, 6.6% were Black, 2.3% were Asian, 1.7% were American Indian, and 11.7% were Other. Babies of Hispanic origin accounted for 15.8% of births.

Maternal Health, Preconception and Prenatal Care

Many of the factors that determine outcomes for pregnant 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 (such as folic acid); workplace hazards; and other factors can adversely affect fetal development and result in pregnancy complications and poor outcomes for both the mother and infant.[5]

Preconception care identifies risks and improves the health of women before pregnancy, positively impacting the future health of women, children and families. Prenatal care monitors pregnancy progress and identifies potential problems before they become serious for either mom or baby. Women who see a health care provider regularly during pregnancy have healthier babies and are less likely to deliver prematurely or to have other serious problems related to pregnancy. The Centers for Disease Control and Prevention (CDC) recommends starting prenatal care as early as possible, as well as seeking care prior to pregnancy. The state uses the Kotelchuck Index to determine adequacy of prenatal care.[6] In 2008, 3,845 (14.6%) births were recorded to mothers who reported inadequate prenatal care and 3,392 (12.9%) to those who reported intermediate prenatal care.[7] This is a 3.3% increase from 2007 in the number of mothers reporting inadequate prenatal care and a 2.6% decrease in the number reporting intermediate care. Mothers reporting adequate or 'adequate plus' prenatal care comprised 72.5% of all births in which the quality of prenatal care was measured in 2008. Table 6.1 presents data on the adequacy of prenatal care by race and ethnicity.

Uninsured women face greater barriers to prenatal care than insured women, even in the presence of strong institutions that are well known in their communities for providing care to the uninsured.[8] Other commonly cited barriers to adequate prenatal care among low-income women are a lack of transportation, no knowledge of where to find care, not liking the way they were treated at the clinic, language barriers, ig-

Table 6.1: Adequacy of Prenatal Care by Race or Ethnicity (2008)

Race or Ethnicity*	Inadequate	Intermediate	Adequate or Adequate Plus
American Indian	13.3%	15.6%	53.1%
Asian	17.8%	13.8%	68.4%
Black	25.2%	12.8%	62.0%
White	11.6%	12.6%	75.8%
Other	26.5%	14.1%	59.4%
Hispanic	25.4%	13.4%	61.1%

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

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

Note: Adequacy of prenatal care is determined using the Kotelchuck Index.

norance as to the importance of prenatal care (particularly for subsequent pregnancies), and uncertainty about whether they wanted the baby or ambivalence about pregnancy.[9] Figures 6.1, 6.2 and 6.3 present data on prenatal care.

Infant Mortality

Infant mortality rates are frequently used as an indicator of the standard of well-being in a community. In 2008, the Nebraska infant mortality rate (deaths per 1,000 births) was 5.4, which represents a decrease from the 2007 rate of 6.8 and is tied with the 2003 infant mortality rate as the lowest ever recorded in Nebraska. A total of 146 infant deaths occurred in Nebraska in 2008.

Table 6.2: Infant Mortality Rates* by Race and Ethnicity (2007 and 2008)

	2007	2008
White	6.80	5.25
Black	15.29	16.31
American Indian	14.20	4.33
Asian	4.72	1.59
Hispanic	5.17	5.86
Overall	6.80	5.41

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

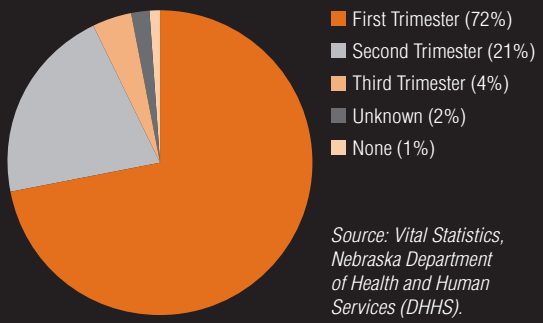
** Infant Mortality Rate is calculated as the number of infant deaths per 1,000 births.*

Birth defects, accounting for 39 infant deaths (21.3%) in 2007 and 34 deaths (23.3%) in 2008, were the leading causes of infant death during 2007 and 2008. Sudden Infant Death Syndrome (SIDS), accounted for 18 deaths (9.8%) and 15 (10.3%) deaths in 2007 and 2008, respectively. Premature births were the cause of 16 infant deaths (8.7%) in 2007 and 20 (13.7%) in 2008. From 1999-2008, 1,624 babies under age 1 died in Nebraska.

Low Birth Weight

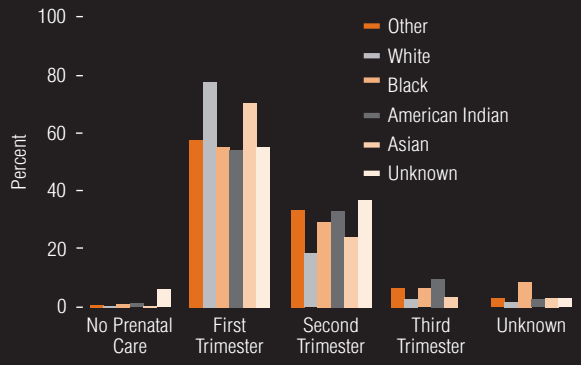
The highest predictor of death and disability among infants in the United States is low birth weight. A newborn weighing less than 2,500 grams, or 5.5 pounds, is considered of low birth weight and a newborn weighing less than 1,500 grams, or 3.3 pounds, is considered of very low birth weight. In 2008 in Nebraska, 1,583 newborns were born with a low weight (5.9%

Figure 6.1: Trimester Prenatal Care Began, All Births (2008)



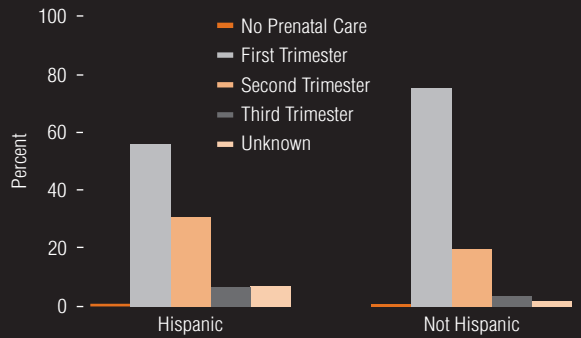
Source: Vital Statistics, Nebraska Department of Health and Human Services (DHHS).

Figure 6.2: Trimester Prenatal Care Began by Race, All Births (2008)



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

Figure 6.3: Trimester Prenatal Care Began by Ethnicity, All Births (2008)



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

of all births) and 326 (1.2%) were born with a very low weight.

Smoking is an attributable cause of low weight births. Pregnant women who smoke cigarettes are nearly twice as likely to have a low birth weight baby as women who do not smoke.[10] The percentage of women in Nebraska who reported smoking during pregnancy was 14.0% in 2009.[11] 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.[12]

Teen Birth Rate

Although it has been falling, the United States still has the highest teenage pregnancy rate among comparable countries.[13] While teen 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.[14] Research shows having children as a teenager can limit a young woman's educational and career opportunities and increase the likelihood that she will need public assistance. In addition, 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.[15] 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 live in poverty.[16] The children of teen parents are also more likely to become teen parents themselves, thus perpetuating the cycle of teen pregnancy and generational poverty.[17]

In 2008, girls ages 17 and under gave birth to 694 babies. This marks a small decrease in births among this age group, from 711 births in 2007. However, when including teens ages 18 and 19, the teen birth rate increased slightly from 2007 to 2008. In 2008, 2,311 babies were born to girls ages 19 and under. This represents 8.6% of all babies born in Nebraska in 2008 and a small increase from the 2,303 babies born to girls ages 19 and under in 2007.

Across a 10-year span since 1999, 7,319 babies were born to mothers ages 17 and under. The number of births to teens ages 10-17 steadily declined from 1998 to 2005 but rose again in 2005 and 2007. In 2008, 9.1% of births to mothers ages 10-17 were not the mother's first birth. Of the 694 babies born to teen mothers ages 10-17 in 2008, 354 (51.0%) had White mothers, 96 (13.8%) were born to Black mothers, 37 (5.3%) had American Indian mothers, 5 (.7%) were born to Asian mothers and 1 had a mother categorized as Other. In addition, 201 (29.0%) births were attributed to teen mothers identified as Other. Teen girls ages 10-17 of Hispanic ethnicity gave birth to 264 (38.0%) babies. Figure 6.4 and Figure 6.5 present data on teen births by age and teen birth trends.

One-Parent and Two-Parent Household Births

The risk of having children with adverse birth outcomes, such as low birth weight and infant mortality, are greater for unmarried mothers than for married mothers. The number of unwed parents grew again in 2008 (the most recent year for which data were available), with 9,140 (33.9%) babies born to single mothers. Nebraska children living with single parents were more likely to live in poverty (25.3% poverty rate) than children living in married-couple households (4.0% poverty rate) in 2009.[18] The likelihood that a mother will be married upon the birth of the child increases with the age of the mother.

Immunizations

The national goal set by the CDC is that 90% of all children receive the primary immunization series, described below, by the age of 2. The 2009 U.S. national average was 70.5%. According to the National Immunization Survey (NIS) for 2009, 65.4% of Nebraska two-year-olds (19-35 months of age) had received four DTaP (diphtheria-tetanus-pertussis) shots, four pneumococcal disease shots, three polio shots, one MMR (Measles-Mumps-Rubella) shot, three Hepatitis B immunizations, and one Varicella (chicken pox) shot. The survey did not include information about HiB (H. influenza type B) im-

munizations. The percentage of children who had received the primary immunization series in 2009 is a decrease from 2008, when 71.5% of Nebraska two-year-olds had received the series. One possible reason for the drop is a lower rate of children receiving the fourth DTaP dose. Because this dose occurs outside the normal timeframe of other routine doctor visits and vaccines, it is more likely to be missed or deferred. Another possible reason is that, while the fourth dose of pneumococcal disease is included in CDC goals, its necessity is dependent on the age at which children receive the first shot. In other words, unvaccinated children 7-months-old and over don't need all four doses, even though all four doses are required to meet the goal.

There were 140 cases of pertussis (whooping cough) and no deaths due to pertussis reported in Nebraska in 2009. This is a decrease from 2008, which had 276 cases. During the last two years, there was an outbreak of pertussis that affected most states. Prior to that outbreak, Nebraska rarely had more than 15 cases of pertussis each year. Most cases have been in the teen and young adult population. However, pertussis can easily be spread and is a potentially deadly disease for young children. The outbreak has highlighted a need for a booster for pertussis. In response to that need, the CDC, along with the American Academy of Pediatrics and the American Academy of Family Physicians, recommended in 2005 that one dose of the newly licensed tetanus, diphtheria and acellular pertussis booster dose (Tdap) be given at the 7th grade visit. A Nebraska law went into effect on July 1, 2010, requiring all 7th graders to provide proof of a booster dose of Tdap for school.

Child Deaths

In 2008, there were 147 child deaths, ages 1-19 in Nebraska. This is a decrease from 156 in 2007. The leading cause of child death in Nebraska is motor vehicle accidents. In 2008, 38 children ages 1-19 were killed in motor vehicle accidents (25.9% of all child deaths ages 1-19), a decrease from 58 deaths (37.2%) in 2007. Child deaths due to non-motor vehicle

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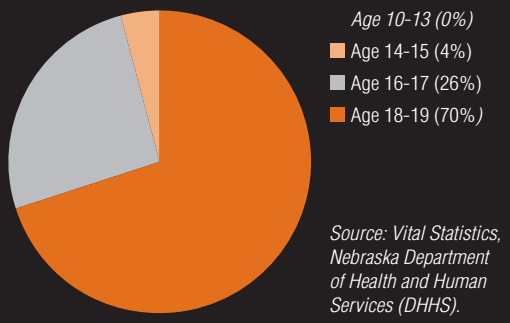
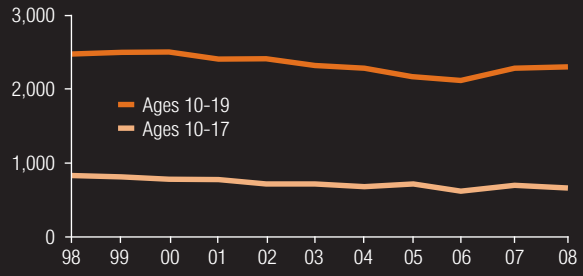
Figure 6.4: Teen Births by Age (2008)



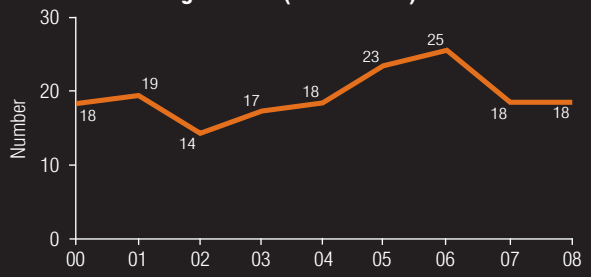
Source: Vital Statistics, Nebraska Department of Health and Human Services (DHHS).

Figure 6.5: Teen Birth Trends (1998-2008)



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

Figure 6.6: Child Deaths by Suicide Ages 1-19 (2000-2008)



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

Table 6.3: Selected Causes of Death Among Children Ages 1-19 (1998-2007 and 1999-2008)

	Frequency	
Causes	**1998-2007**	**1999-2008**
Motor Vehicle Accidents	601	578
Non-Motor Vehicle Accidents	219	219
Suicide	187	188
Homicide	119	117
Cancer	127	129
Birth Defects	59	60
Heart	51	47
Cerebral Palsy	31	26
Asthma	20	24
Pneumonia	16	13
HIV/AIDS	1	1
All Other Causes	263	268
Total	1,694	1,670

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

accidents accounted for 17 and 26 child deaths in 2007 and 2008, respectively. Ten child deaths were attributed to cancer in 2007 and 14 in 2008. Nebraska saw a steady increase in child suicide from 2004 to 2006. Although 2007 and 2008 numbers show a decline, suicide was the second leading cause of death among children ages 1-19 in Nebraska in 2007 at 18 deaths and the third leading cause in 2008 at 18 deaths. Thirteen children ages 1-19 were lost to homicide in 2007 and 14 in 2008. Homicide and cancer tied as the fourth-leading causes of death among children ages 1-19 in 2008. Figure 6.6 and Table 6.3 present historical data on selected causes of child death. For additional information on deaths due to child abuse and neglect, please see the section "Child Abuse and Neglect/Domestic Violence" beginning on Page 20.

Access to Health Care

Uninsured children tend to live in employed families that do not have access to insurance. Most often in these cases the employer does not offer insurance, the insurance offered is too expensive or the insurance does not cover the necessary medical needs of the family. In 2009, there were 31,000 uninsured children, ages 17 and under, in Nebraska.[19]

According to the U.S. Census Bureau, there were 21,000 uninsured Nebraska children, 18 and under, who were considered low-income in 2009.[20] In 2008, the number of uninsured low-income children, 18 and under, was 32,000. Figure 6.7 presents historical data on health coverage of Nebraska children.

Many of these uninsured low-income children are eligible for Kids Connection. This program was expanded in 2009 to provide low-cost health care coverage for children living in families at or below 200% of the federal poverty level, up from 185%. Kids Connection refers to the Children's Health Insurance Program (CHIP) which provided health coverage for a monthly average of 26,256 children ages 18 and under in state fiscal year (SFY) 2009. Medicaid provided health coverage for a monthly average of 114,023

children in SFY 2009. Figures 6.8 and 6.9 provide data on Nebraska Medicaid and CHIP expenditures and average monthly eligibility.

Blood Lead Levels

Blood lead testing is recommended for all children at 12 to 24 months of age, as well as for any child 6-years-old and younger who has been exposed to lead hazards. Elevated blood lead levels (EBLL) can cause increased behavioral problems, malnutrition, and significant physical and cognitive development problems. Lead poisoning can be fatal.

In 2009, there were 23,347 Nebraska children 0-6 years old tested for blood lead levels. Of those, 314 children (1.34%) had EBLL. However, it is difficult to obtain the number of children poisoned as some parents do not bring children back into clinics for confirmatory tests, and not all children are tested.

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

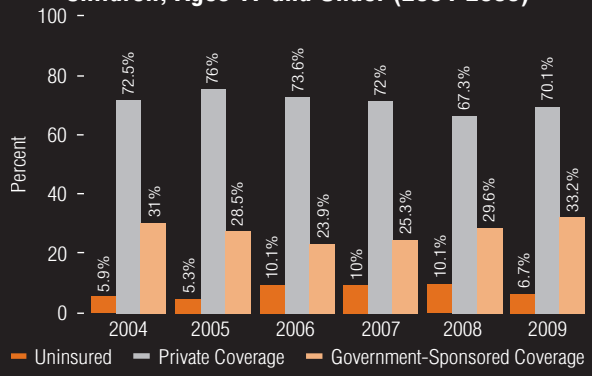
Behavioral Health

DHHS funds behavioral 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. In general, 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 behavioral health services in the state.

Community-Based Services and Residential Treatment

Mental health and substance abuse services are provided to youth in an array of prevention and treatment services. These

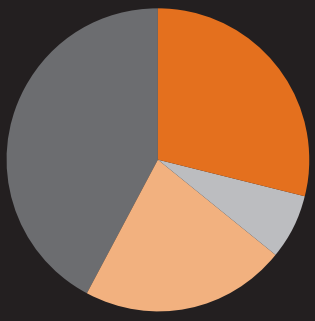
Figure 6.7: Health Coverage for Nebraska's Children, Ages 17 and Under (2004-2009)



Source: U.S. Census Bureau, Current Population Survey, Table HIA-5: Health Insurance Coverage Status and Type of Coverage by State – Children Under 18: 1999 to 2009.

Note: The percentages of children with private and government-sponsored insurance coverage may not add up to 100% because some children may have had more than one type of coverage.

Figure 6.8: Nebraska Medicaid Expenditures by Category (State Fiscal Year 2009)

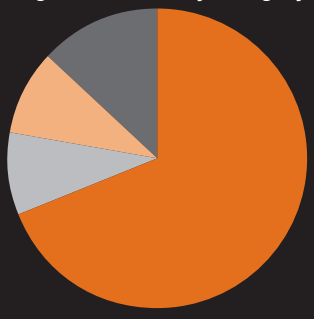


Total: $1,538,377,038

- 29% Children *$444,376,668*
- 7% ADC Adults *$108,670,527*
- 22% Aged *$345,556,480*
- 42% Blind and Disabled *$639,773,363*

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

Figure 6.9: Nebraska Medicaid Average Monthly Eligible Persons by Category (State Fiscal Year 2009)



Total: 204,008

- 69% Children* *(140,279)*
- 9% ADC Adults** *(18,815)*
- 9% Aged *(17,598)*
- 13% Blind and Disabled *(27,316)*

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

** Children's category combines Medicaid and CHIP coverage.*

*** ADC Adults are those receiving Aid to Dependent Children, or temporary cash assistance through the state of Nebraska.*

services may be provided by the following divisions within DHHS: the Division of Behavioral Health, the Division of Children and Family Services and the Division of Medicaid and Long-Term Care.

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

Of the community-based programs funded by the Division of Behavioral Health, services were provided to an unduplicated count of 2,930 children ages 18 and under in SFY 2009. Among children ages 18 and under, 2,281 received mental health services only, 619 received substance abuse services only, and 30 received both community based mental health and substance abuse services.[21]

POLICY BOX

Reversal in Nebraska's Prenatal Care Policy Puts Babies at Risk

By Naomi Thyden, Voices for Children in Nebraska

In March 2010 a total of 1,619 pregnant women in Nebraska lost access to prenatal care through Medicaid. Of these pregnant women, 752 were U.S. Citizen or Legal Permanent Resident women, and 867 were undocumented women.[1] Before March 2010, unborn children in Nebraska could qualify for prenatal care through Medicaid even if their mothers did not meet eligibility requirements. This provided unborn children of undocumented women access to prenatal care.

The policy change occurred because, in November 2009, federal Medicaid officials informed the Nebraska Department of Health and Human Services that Nebraska's policy was not in compliance with federal Medicaid policy. Federal Medicaid policy does not allow an unborn child to be eligible for assistance unless its mother is eligible. However, Nebraska could have continued to cover the same population of unborn children by taking up the unborn child option in our State Children's Health Insurance Program (SCHIP). SCHIP is funded by a federal matching system much like Medicaid's, and SCHIP's federal match rate in Nebraska is slightly higher than Medicaid's.[2] In a nutshell, Nebraska could have continued to cover unborn children without additional cost by making a simple administrative change.

The decision by lawmakers to not restore prenatal care to expecting mothers will likely result in negative health consequences for babies born in Nebraska as well as negative financial consequences for public funds. Whether the mother is eligible for healthcare, any baby born to a low-income mother will be eligible for state-funded healthcare through Kids Connection.[3]

In an effort to track the consequences of this policy reversal, Sen. Kathy Campbell introduced LR 501, which called for a study to examine costs to the state and birth outcomes associated with decreased access to prenatal care. A committee was convened and continues to monitor this issue.

Research indicates that babies who did not receive prenatal care fared worse than those who did. Additionally, the financial costs are likely to be greater for babies who did not receive this care. For example, a recent study in California compared the birth outcomes and the costs associated with births to undocumented women with and without prenatal care.[4]

- Undocumented women without prenatal care were nearly 4 times more likely to deliver infants of low birth weight and were more than 7 times as likely to deliver prematurely when compared to undocumented women with prenatal care;

Regional Centers

Throughout calendar year 2009, inpatient and residential mental health and substance abuse services were provided to adolescents at the Lincoln and Hastings Regional Centers. The adolescent program at the Lincoln Regional Center (LRC) consisted of a 16-bed residential program (two 8-bed units) and an eight-bed treatment group home, all located on the Whitehall campus. The Hastings Regional Center (HRC) operated a 40-bed Chemical Dependency Program for youth from the Youth Rehabilitation and Treatment Center (YRTC) in Kearney.

During calendar year 2009, a total of 171 youth ages 18 and under, all male, received services from a regional center – 145 from the HRC and 26 from the LRC adolescent programs. By race, 127 of the 171 youth were White (74.3%), 28 were Black or African American (16.4%), 7 were American Indian (4.1%), 7 were multiracial (4.1%), and 2 listed their race as "other" (1.2%).

Youth Risk Behaviors

Youth risk behaviors include activities such as alcohol, tobacco and drug use, inadequate nutrition, lack of physical activity and sexual activity. To monitor and measure the prevalence of these behaviors, the CDC developed several

- Babies admitted to the NICU having never received prenatal care **stayed twice as long** and **cost twice as much** as NICU babies who had prenatal care;
- The cost of postnatal care for an infant without prenatal care was $2,341 more initially and $3,247 more when incremental long-term morbidity cost was added than that for an infant with prenatal care.

Healthcare in the months before birth helps make sure a baby is not just born healthy, but also has a better chance of a healthy life for years to come. Prenatal care beginning in the first trimester leads to improved life chances for infants, compared to babies whose mothers started prenatal care late or not at all.[5] A lack of prenatal care is associated with a baby's increased chances of illness, disability, and death. By investing in prenatal care, we are investing in the life of the child and eliminating high costs of poor birth outcomes, often borne by the state.

Prenatal care focuses on three areas: identifying any risks to the mother or baby during pregnancy, treating medical problems, and education.[6] For example, for women at risk of hypertensive disorders, or high blood pressure, something as simple as calcium supplements may be given to prevent low birth weight or early birth.[7] Nationally, infant mortality rates are six times higher among babies who received prenatal care late or not at all, compared with those whose care started in the first trimester.[8]

Recommendations:

- Restore prenatal care to unborn babies in Nebraska regard less of the documentation status of their mothers.
- Expand prenatal services to cover unborn babies in all low-income families, up to 200% Federal Poverty Level. The current policy provides Medicaid coverage for prenatal services to women at or below 185% of the Federal Poverty Level.

This reversal of Nebraska's long-standing policy to prioritize the health of unborn children will have long-term effects as we see more children born with preventable health conditions that will persist throughout their lifetimes. Babies in our state will be paying the price of this leadership decision for years to come.

To share information about the impact of decreased access to prenatal care, please contact Sen. Kathy Campbell's office at 402-471-2731.

[1] Letter from Kerry Winterer, CEO, NE DHHS to Senator Jeremy Nordquist, March 26, 2010.

[2] "Nebraska: Medicaid & CHIP," The Henry J. Kaiser Family Foundation, http://www.statehealthfacts.org/profileind.jsp?cat=4&rgn=29.

[3] Low-income is defined as at or below 200% Federal Poverty Level, or $44,100 for a family of four in 2009.

[4] Lu, Lin, Prietto, and Garite, "Elimination of Public Funding of Prenatal Care for Undocumented Immigrants in California: A Cost/Benefit Analysis." *American Journal of Obstetrics and Gynecology* 182 (January 2000): 233-9.

[5] Rima Shore and Barbara Shore, *Reducing Infant Mortality*, Annie E. Casey Foundation. (July 2009): 5.

[6] Nebraska Department of Health and Human Services, *Nebraska Pregnancy Risk Assessment Monitoring System (PRAMS) 2000-2003 Monitoring Report*, (February 2009): 14.

[7] Shore and Shore, 3.

[8] U.S. Department of Health and Human Services, health Resources and Services Administration, Maternal and Child Health Bureau, *Evidence of Trends, Risk Factors, and Intervention Strategies*, (2006): 17.

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surveys such as the Youth Risk Behavior Survey (YRBS) and Youth Tobacco Survey (YTS). In addition, DHHS administers the Nebraska Risk and Protective Student Survey. In recent years, participation in these surveys has been poor. The participation rates have been so low that data remains unweighted and the results cannot be used to draw statewide conclusions about youth risk behaviors. To make this process easier, the Nebraska Department of Health and Human Services has packaged all three under one name, Nebraska Student Health and Risk Prevention Survey (SHARP), to simplify the process for schools. The SHARP survey will be administered during the fall of each even calendar year, starting in 2010.

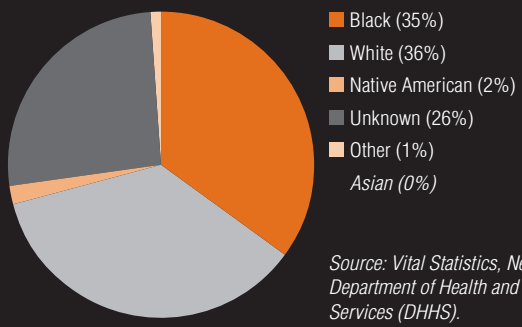
Youth Risk Behavior Survey

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

Tobacco

According to information provided by the Campaign for Tobacco-Free Kids, 22.3% of high school students smoked in 2007 in Nebraska. Moreover, Campaign for Tobacco-Free Kids estimates that 5.4 million packs of cigarettes are illegally bought or smoked by youth each year in Nebraska, and 1,900 youth under age 18 become new daily smokers each year in Nebraska.[22]

Figure 6.10: Reported STD Cases By Race, 19 and Under (2009)



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

Motor Vehicle Crashes

The leading cause of deaths among Nebraska children is automobile crashes.

According to the Nebraska Department of Roads, 28 children ages 17 and younger died in motor vehicle traffic accidents in CY 2009. That is an increase from 24 deaths in 2008. Moreover, 278 children suffered disabling injuries due to accidents, an increase from 215 in 2008. In the period of 1999-2009, 393 Nebraska children age 17 and younger have died due to vehicle accidents.

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

There were 2,316 cases of sexually transmitted diseases reported by children ages 19 and under in Nebraska in 2009. This is a decrease from 2,633 cases in 2008. Figure 6.10 presents reported cases of STD by race.

According to the CDC, young people, especially youth of color, are at persistent risk for HIV infection. HIV infection often slowly progresses to AIDS among infected young people. In Nebraska, there were 16 children living with HIV ages 0-11 and 37 children ages 12-19, a total of 53 child HIV cases as of 2009. Twelve people under age 19 at the time of AIDS diagnosis have died from the disease between 1983 and 2009.

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

[1] "Unequal Opportunities for Health and Wellness," *Race Matters Tool Kit,* Annie E. Casey Foundation, 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] Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report*, April 21, 2006, Vol. 55, No. RR-6.

[6] According to the Nebraska Vital Statistics Report 2008, the Kotelchuck Index determines adequacy of prenatal care using information from the birth certificate about when prenatal care begins and how many visits occur prior to delivery.

[7] Out of the 26,992 births that occurred in Nebraska in 2008, 26,297 had known Kotelchuck Index scores.

[8] 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.

[9] *Ibid.*

[10] *U.S. Department of Health and Human Services*, "The Health Consequences of Smoking: A Report of the Surgeon General C2004," Centers for Disease Control and Prevention, Office on Smoking and Health, Atlanta, GA, May 2004.

[11] Pregnancy Risk Assessment Monitoring System (PRAMS), Nebraska Department of Health and Human Services.

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

[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, "Why Teens Have Sex: Issues and Trends," *KIDS COUNT Special Report*, 1998.

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

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

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

[18] U.S. Census Bureau, 2009 American Community Survey, Table B17010.

[19] U.S. Census Bureau, Current Population Survey, 2009 Annual Social and Economic Supplement, Table HI05.

[20] U.S. Census Bureau, Current Population Survey, 2009 Annual Social and Economic Supplement, Table HI10. "Low-income" families were those who were living below 200% of the federal poverty level, which was about $44,100 for a family of four in 2009.

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

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

Juvenile Justice

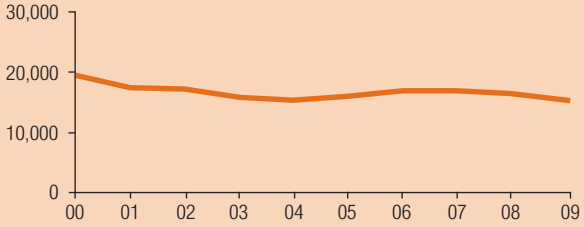
Voices for Children in Nebraska believes that all children have a right to due process and equal protection under the law, access to judicial systems that provide appropriate, fair and lawful determination, and rehabilitative social services where needed. Children can find themselves involved in the juvenile justice system for a variety of reasons, ranging from truancy to homicide. Family problems including child abuse, domestic violence, poverty, mental health issues and self-esteem can all be factors that influence a juvenile's behavior. We must create systems of support which reduce the number of children entering the juvenile system and develop policies and programs to ensure that once a youth has entered the system, he or she has quality resources available, such as adequate mental health treatment and educational experiences that will greatly improve the odds of success for that 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. These include 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. Where racial disparities are found to exist, they tend to accumulate as youth are processed deeper into the system.[1]

Juvenile Arrests

In calendar year (CY) 2009, 15,109 Nebraska juveniles were arrested. Figure 7.1 presents a historical view of juvenile arrests, demonstrating a 19% decrease from 18,750 arrests in 2000 to 15,109 arrests in 2009.

Figure 7.1: Juvenile Arrests, 17 and Under (2000-2009)



Source: Nebraska Commission on Law Enforcement and Criminal Justice.

Females comprised 33.4% (5,040) of all juvenile arrests in 2009, and males made up the remaining 66.6% (10,069). These averages are consistent with the percentages of female and male juvenile offenders over the last several years. Violent crime arrests comprised only 1.8% of all juvenile arrests in 2009. Table 7.1 presents juvenile arrests by offence and gender.

While we can track juvenile arrest by race, unfortu-

Riley

Table 7.1: Selected Nebraska Juvenile Arrests by Offense and Gender (2009)*

Offense	Males	Females	Total
Violent Offenses	232	41	273
Felony Assault	112	34	146
Robbery	97	6	103
Forcible Rape	19	1	20
Murder and Manslaughter	4	0	4
Non-Violent Offenses	9,683	4,926	14,609
Larceny Theft (Except Motor Vehicle)	1,788	1,478	3,266
All Other Offenses (Except Traffic)	1,559	681	2,240
Misdemeanor Assault	1,428	651	2,079
Liquor Laws	1,145	877	2,022
Drug Abuse Violations	899	253	1,152
Vandalism-Destruction of Property	1,030	184	1,214
Disorderly Conduct – Disturbing the Peace	543	269	812
Runaways	234	232	466
Curfews and Loitering Law Violations	206	122	328
Burglary-Breaking or Entering	288	17	305
Driving Under the Influence	148	82	230
Weapons: Carrying, Possessing, etc.	123	10	133
Sex Offense (Except Forcible Rape and Prostitution)	95	15	110
Stolen Property: Buy, Receive, Possess, Conceal	125	24	149
Offenses Against Family and Children	13	20	33
Arson	51	8	59
Forgery & Counterfeiting	7	2	9
Prostitution and Commercialized Vice	1	1	2

Source: Nebraska Commission on Law Enforcement and Criminal Justice.

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

nately, we are unable to report juvenile arrests by ethnicity on the state level since the Omaha Police Department and the Douglas County Sheriff do not track the ethnicity of juveniles arrested. For this reason, we have no way of knowing whether Hispanic juveniles are overrepresented in juvenile arrests in the largest and most diverse city and county in the state. Figures 7.2 and 7.3 present juvenile arrests in 2009 by age and race.

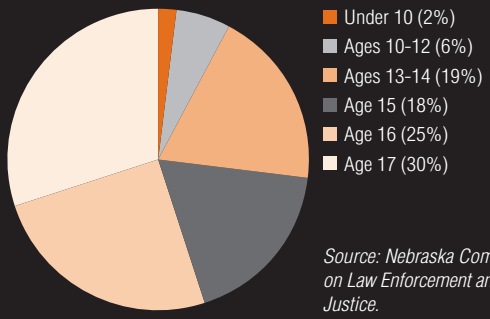
Juvenile Detention

For 2009, Voices for Children is unable to report an accurate statewide total of juvenile detention due to difficulties in data collection. At the time this report went to print, 2009 data from the Scotts Bluff County Detention Center were unavailable from the Nebraska Commission on Law Enforcement and Criminal Justice. In September 2007, the Scotts Bluff County Detention Center consolidated facilities, which has resulted in data collection challenges for the state. Consequently, 2009 detention data for juveniles ages 17 and under, presented in Table 7.2, do not provide a complete reflection of youth detention in Nebraska.

In our data collection process, Voices for Children in Nebraska did contact each of the four detention centers to request 2009 data. Each facility was able to provide 2009 data for youth ages 17 and under. A snapshot of these data is provided in Table 7.3. The data provided by individual detention centers differ slightly from the statewide data totals provided by the Nebraska Commission on Law Enforcement and Criminal Justice.

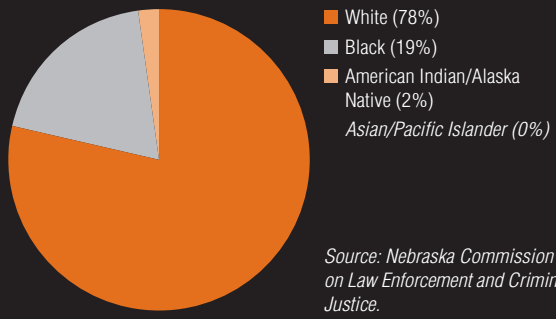
There were 183 juveniles under age 18 held in adult detention facilities in 2009. Juveniles detained in adult facilities must be separated by "sight and sound" from adult detainees, according to the federal Juvenile Justice and Delinquency Prevention Act (JJDPA). Females spent fewer days in adult detention facilities, averaging 2 days, while males averaged 25 days. Hispanic juveniles experienced the longest periods of detention in adult jails and lockups, averaging 41 days. Native American juveniles averaged 29 days of detention in

Figure 7.2: Juvenile Arrests by Age (2009)



Source: Nebraska Commission on Law Enforcement and Criminal Justice.

Figure 7.3: Juvenile Arrests by Race (2009)



Source: Nebraska Commission on Law Enforcement and Criminal Justice.

Table 7.2: Juveniles Held in Juvenile Detention Facilities By Race (2009)

Agency	American Indian/ Alaskan Native	Asian/Pacific Islander	Black	White	Unknown	Count
Lancaster County Detention Center (Lancaster County)	2.73%	2.34%	27.27%	66.36%	1.30%	770
North East Nebraska Juvenile Services (Madison County)	10.95%	0.86%	8.93%	77.52%	3.35%	568
Scotts Bluff County Detention Center (Scotts Bluff County)	*	*	*	*	*	0
Douglas County Youth Center (Douglas County)	1.35%	0.32%	51.99%	46.08%	0.26%	1,558
Statewide Total	3.73%	1.00%	36.64%	57.49%	1.14%	2,896

Source: Nebraska Commission on Law Enforcement and Criminal Justice.

** Due to issues related to the consolidation of facilities, Nebraska Commission on Law Enforcement and Criminal Justice has not received data from Scotts Bluff County Detention since September 2007. This issue is under investigation.*

Table 7.3: Juveniles Held in Juvenile Detention Facilities by Ethnicity (2009)

Agency	Hispanic	Not Hispanic	Unknown	Count
Lancaster County Detention Center (Lancaster County)	13.90%	86.10%	0.00%	770
North East Nebraska Juvenile Services (Madison County)	30.99%	68.84%	0.18%	568
Scotts Bluff County Detention Center (Scotts Bluff County)	*	*	*	0
Douglas County Youth Center (Douglas County)**	0.00%	0.00%	100%	1,558
Statewide Total	9.77%	36.40%	53.83%	2,896

Source: Nebraska Commission on Law Enforcement and Criminal Justice.

** * Due to issues related to the consolidation of facilities, Nebraska Commission on Law Enforcement and Criminal Justice has not received data from Scotts Bluff County Detention since September 2007. This issue is under investigation.*

**Douglas County Youth Center reported "Unknown" ethnicity for all juveniles.*

Table 7.4: Juveniles Held in Juvenile Detention Facilities as Reported by Individual Facilities (2009)

Agency	Female	Male	White	Black	American Indian/ Alaskan Native	Asian/ Pacific Islander	Hispanic	Other	Unknown	Total Juveniles
Lancaster County Detention Center (Lancaster County)	26.9%	73.1%	51.6%	28.0%	2.8%	2.0%	14.2%	1.3%	0.0%	788
North East Nebraska Juvenile Services (Madison County)	25.6%	74.4%	55.4%	8.0%	9.9%	1.6%	24.8%	0.3%	0.0%	677
Scotts Bluff County Detention Center (Scotts Bluff County)*	23.5%	76.5%	78.4%	2.9%	18.6%	0.0%	*	0.0%	0.0%	102
Douglas County Youth Center (Douglas County)	24.7%	75.3%	36.2%	52.1%	1.7%	0.5%	9.3%	0.3%	0.0%	1,502

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

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

Note: Data reported are for youth ages 17 and under.

adult jails and lockups, while Black and White juveniles were detained in adult jails for an average of 23 days.

Probation

In 2009, there were 5,698 juveniles supervised on probation, a slight decrease from the 5,802 juveniles in 2008. Of those juveniles placed on probation in 2009, 65% were White, 15% were Black, 2% were Native American, 1% were Asian, and 17% were of a race classified as "Other." Moreover, 18% of juveniles placed on probation were Hispanic. During 2009, 2,221 juveniles were successfully released from probation. Of those juveniles successfully released from probation, 68% were White, 12% were Black, 2% were Native American, 1% were Asian, and 17% were classified as "Other." Of those juveniles successfully released from probation, 19% were Hispanic.

The number of juveniles placed on probation for both misdemeanor felony offenses decreased slightly from 2008 levels. There were 2,514 juveniles placed on probation for misdemeanors and 255 placed on probation for felonies.

Youth Rehabilitation and Treatment Centers (YRTC)

The two Youth Rehabilitation and Treatment Centers in Nebraska are located in Kearney and Geneva.

Established for males in 1879, the YRTC Kearney's mission is: *To help youth live better lives through effective services affording youth the opportunity to become law abiding and productive citizens.*

Established for females in 1892, the YRTC 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 state fiscal year (SFY) 2008-2009, 489 males were admitted for treatment to Kearney and 114 females to Geneva. In all, a total of 603 youth were committed to YRTC care from July 2008-June 2009. This was a decrease of 16 YRTC commitments from the previous fiscal year.

YRTC Kearney had an average daily population of 169 in SFY 2008-2009. This number does not include the

POLICY BOX

LB800 Includes Juvenile Justice Reforms

By Grant Custer, Voices for Children in Nebraska

Recent efforts at reforming the juvenile justice system in Nebraska culminated in the passage of LB800, which incorporated several bills, in 2010. In its final version, LB 800:

- Authorizes metropolitan areas to undertake a juvenile offender civil citation pilot program. The program would allow a peace officer to issue a civil citation as an alternative to taking into temporary custody a youth who has committed a misdemeanor. The citation would require the youth to appear at a juvenile assessment center where he or she would be assigned to do community service or participate in other available programs. A civil citation would not result in a criminal record for the youth.
- Gives adjudicated youth the right to petition the court to seal their record after successfully completing their diversion, mediation, probation or sentence. For a record to be sealed means that it shall not be available to the public except upon the order of a court when good cause has been shown.
- Gives probation officers the power to impose administrative sanctions for youth on probation. Administrative sanctions are additional probation requirements, such as increased supervision contact requirements or substance abuse testing, assigned to hold youth accountable for substance abuse and noncriminal violations of their probation. They offer an alternative to beginning formal probation revocation proceedings.
- Prioritizes ensuring that any temporary placement of a youth be made in the least restrictive environment consistent with the youth's best interests and public safety.
- Requires that any preadjucation youth ordered to receive a psychological evaluation – and possibly temporarily placed within a facility

122 youth who were paroled from YRTC Kearney to the Hastings Juvenile Chemical Dependency Program, which provides intensive residential chemical dependency services. Males at Kearney remained an average of 167 days and had an average age of 16 at admission. Of all young men committed to Kearney, 49% were White, 23% were Hispanic, 22% were African American, 5% were American Indian and 1% were Asian. The major offenses committing males to YRTC Kearney were assault (21.3%), theft (17.4%), criminal mischief (11.0%), burglary (10.4%), and possession of drugs (10.2%). Thirty-three students earned their General Educational Development (GED) credentials while at Kearney. The average per diem cost for 2008-2009 at Kearney was $165.82 per youth. In 2008-2009, YRTC Kearney paroled 122 youth to Hastings Juvenile Chemical Dependency Program.

Geneva provided services for an average of 73 females per day in SFY 2008-2009. The average female committed to Geneva was 16 years old at admission and remained there 231 days. The top offenses were assault (29.0%), shoplifting (18.4%) and theft (9.7%). This excludes 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. Thirteen students received their high school diplomas in 2008-2009. Of the young women placed at YRTC Geneva, 47% were White, 19% were Black, 18% were Hispanic, 9% were American Indian, 3% were Asian/Pacific Islander and 4% were Other. The per diem cost of Geneva for 2008-2009 was $254.19 per youth.

Juveniles Treated As Adults

There are fundamental differences between the culpability of juveniles and adults who have committed crimes. 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 age18."[2] Research consistently indicates that treating children as adults in the justice system neither works as a

or institution for the period surrounding the evaluation – be provided a hearing before the court within ten days of the completion of the evaluation.

- Funds provided through the County Juvenile Services Aid Program shall prioritize programs and services targeted towards reducing the juvenile detention population.
- Allows for videoconferencing to be used to conduct hearings in juvenile cases.
- Provides judges the ability to impound the driver's license or permit of a youth convicted of a drug offense.
- Expands the ability of a peace officer to take a youth into temporary custody. Previously a peace officer was required to be present at the youth's violation of a law or municipal ordinance. The statute now allows for a youth to be taken into temporary custody provided the officer has reasonable grounds to believe the youth committed a violation.
- Allows peace officers to take into temporary custody a youth who they believe to be truant and deliver the youth to their enrolled school.
- Authorizes the juvenile court to issue a fine or assign community service to the parents or guardians of a youth who has been found to be excessively absent from school.
- Requires that all school districts develop a policy on excessive absenteeism in collaboration with their local County Attorney. If a youth is absent more than twenty days per year the school must file a report with the County Attorney. The County Attorney may then file a complaint or petition.
- Requires that schools report monthly statistics on excessive absenteeism to the Commissioner of Education.
- Creates a Truancy Intervention Task Force, made up of representatives from the Commissioner of Education, probation, and the Department of Health and Human Services, to review collected statistics and develop recommendations to reduce excessive absenteeism.

deterrent, nor does it prevent or reduce violence. In fact, the Centers for Disease Control and Prevention has found that the "transfer of youth to the adult criminal justice system typically results in greater subsequent crime, including violent crime, among transferred youth."[3] Nebraska has no minimum age at which a juvenile can be tried as an adult. Though a 2010 U.S. Supreme Court ruling declared unconstitutional the sentencing of life without the possibility of parole for youth convicted of non-homicide offenses, Nebraska legislature has yet to prohibit the sentencing of youth to life without possibility of parole.[4] While young people must accept responsibility and the consequences of their actions, our justice systems must acknowledge the fundamental differences between juveniles and adults to effectively pursue the goals of promoting public safety, while improving the odds of success for troubled youth.

In 2009, the cases of 6,213 Nebraska juveniles were filed in adult court; of these, 1,220 cases were transferred to juvenile court. Filings in adult court represented 33% of juvenile arrests in 2009. Figure 7.5 presents cases of juveniles who filed in adult courts by race in 2009.

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 2009, 87 Nebraska youth, ages 18 and under, were processed through the adult system and housed in a Nebraska Correctional Youth Facility. This is an increase from 68 youth in 2008. Of these 87 youth, 15 were incarcerated for robbery, 18 for assault and 1 for homicide. Additionally, 12.6% of the youth incarcerated in adult prisons in Nebraska were 16 and under. Of all youth 18 and under incarcerated in adult prisons, 66.7% were youth of color (classified as Black, Hispanic or

Table 7.5: Juvenile Interaction with the Justice System by Race (2009)

	Teen Population[i]	Arrests	Youth in Detention Facilities[ii]	Placed on Probation[iii]	YRTC Commitments[iv]	Juveniles Tried in Adult Court[v]	Juveniles Incarcerated in Adult Prison[vi]
White	77%	78%	46%	65%	49%	59%	32%
Black	6%	19%	35%	15%	21%	18%	39%
Native American	1%	2%	4%	2%	6%	3%	3%
Asian	2%	0%	1%	1%	1%	2%	0%
Other	14%	0%	15%	17%	23%	12%	25%
Unknown	0%	0%	0%	0%	0%	6%	0%
Total	100%	100%	100%	100%	100%	100%	100%

Note: Percentages are rounded to the nearest whole number.

[i] The "Teen Population" in this figure comprises youth in Nebraska ages 10 through 17 in 2009. "Other" includes 2% of "Two or more races, Not Hispanic" and "12% Hispanic" categories.

[ii] Data were provided by individual detention facilities. "Other" primarily represents Hispanic youth, who made up 14% of this category. Ethnicity data were not provided by Scotts Bluff County Detention Center.

[iii] Out of the total of 5,698 juveniles on probation, 1,026 or 18% were Hispanic. Since ethnicity data are captured separately, they are not included in the table.

[iv] This is the total of YRTC commitments at both Geneva and Kearney for FY2009. 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. For Kearney, "Other" represents Hispanics only. For Geneva, "Other" represents primarily Hispanic youth and a small number from an "Other" category.

[v] Juveniles Tried in Adult Court is broken down by race and ethnicity, so the "Other" percentage encompasses 12% Hispanic."Total juveniles tried in adult court is out of 4,993 juvenile cases filed in adult court and not transferred to juvenile court.

[vi] Juveniles in Adult Prison is broken down by race and ethnicity, so the "Other" percentage encompasses 24% Hispanic and 1% Other.

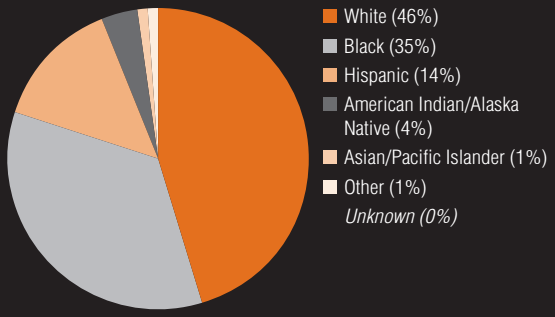
Native American), 32.2% were White and 1.2% were classified as "Other."

As of October 2010, there were 26 persons serving sentences of life without the possibility of parole who were sentenced for crimes committed before age 18.[7] Twelve (46.2%) of these persons sentenced to life without parole as juveniles are Black. One person is Native American, and the remaining are White. Sixteen (61.5%) of these persons were sentenced in Douglas County.

Racial Disparities in the Juvenile Justice System

Nationally, the problem of the overrepresentation of youth of color in our juvenile justice system is pervasive and troubling. It is critical that data are collected and analyzed at every phase of the juvenile justice process to identify at what point of interaction with the system the disparate outcomes are taking place. Table 7.5 presents data on juvenile interaction with the justice system by race.

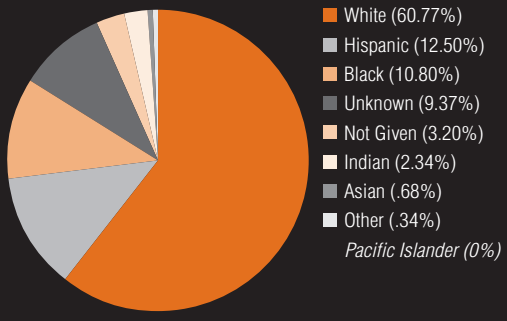
Figure 7.4: Juveniles Held in Juvenile Detention by Race and Ethnicity (2009)



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

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

Figure 7.5: Number of Juveniles Whose Cases Were Filed in Adult Courts (2009)



Source: Nebraska Administrative Office of the Courts.

Note: Out of 4,993 cases initially filed in adult court, 1,220 were later transferred to the juvenile court.

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

[2] "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.

[3] *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.

[4] *Graham v. Florida.* 2009. http://www.supremecourt.govopinions/09pdf/08-7412.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, Inmate Database, http://dcs-inmatesearch.ne.gov/Corrections/COR_download.htm, Accessed 9.21.09.

Nutrition

Voices for Children in Nebraska believes that all children should have access to adequate nutrition. Nutrition serves as the foundation for children's health, academic achievement and overall development. Being undernourished can inhibit a child's ability to focus, absorb information and exhibit appropriate behavior at home and school. Good nutrition can prevent illnesses and encourage proper physical growth and mental development.[1] Supplemental food programs that include access to nutritious foods and offer education can assist families in providing healthy food for their children.

USDA Nutrition Programs

Supplemental Nutrition Assistance Program (SNAP)

The Supplemental Nutrition Assistance Program (SNAP), formerly called food stamps, is a highly successful program created to reduce food insecurity among low-income and impoverished people in the United States. The federal government pays for 100% of SNAP benefits, while administrative costs are covered by state governments. SNAP 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% 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 program. SNAP is a critically important part of Nebraska's low-income safety net, and DHHS must be commended for its effective administration of benefits.

In state fiscal year (SFY) 2009, the use of food stamps continued to rise over previous years. DHHS distributed food stamps to an average of 127,889 persons or 55,178 households each month in SFY 2009. The average payment was $244.83 per household or $105.63 per person, totaling $162,110,219 (99.68% of the funding was provided by the federal government). There were 71,038 children, ages 18 and under, who received food stamps in Nebraska in June 2009. This is an increase from 62,518 children in June 2008. Figures 8.1 and 8.2 demonstrate food stamp participation by age and race, respectively.

School Lunch and Breakfast

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 reduced price meals (see the Economic Well-Being section, page 35, for FPL). Through this program, the USDA subsidizes all lunches served in schools. During the 2008-2009 school year, 429 districts participated with 1,038 sites. There were 115,673 children found to be income eligible for free and reduced meals on the last Friday in September 2009. The County Data section provides an indicator on the

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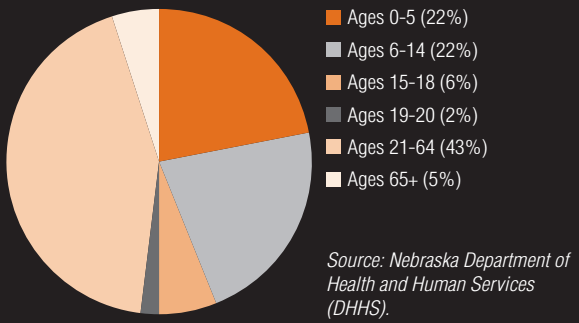
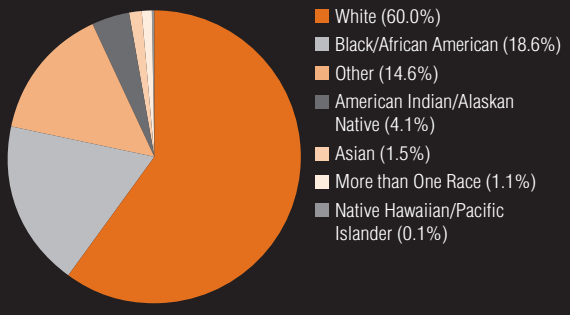
Figure 8.1: SNAP Participants by Age (June 2009)



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

Figure 8.2: SNAP Participants by Race (June 2009)



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

percent of children eligible for free and reduced meals in each county.

The USDA also provides reimbursements to schools for breakfast as they do for lunch. Unfortunately, fewer schools choose to participate in the breakfast program. During the 2008-2009 school year, 731 schools in 237 districts participated in the school breakfast program.

In the 2008-2009 school year, the USDA reimbursed a total of $46,497,462 for all free/reduced breakfast and lunches in Nebraska. The state government match for free/reduced lunch and breakfast was $415,805.

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 46,012 meals was served daily to Nebraska children through the SFSP in 2009. In 2009, 29 of the 93 Nebraska counties offered the SFSP.

POLICY BOX

Farmers' Markets and SNAP

By Mai Nguyen, Voices for Children in Nebraska

Voices for Children in Nebraska believes that all children and families should have access to a variety of quality and affordable foods. The Supplemental Nutrition Assistance Program (SNAP), formerly known as the food stamp program, promotes this ideal in its attempts to reduce hunger, improve food security and provide access to a healthful diet and nutritional education. However, health disparities persist between impoverished communities and more affluent neighborhoods. Recent studies show that SNAP recipients are more prone to health problems, specifically those involving obesity or diet-related diseases.[1] This in part is due to lack of access to affordable, nutritious foods in what is referred to as "food deserts" – areas where there is little to no access to healthy fresh foods as compared to fast food restaurants or convenience stores.[2]

Lack of access to healthy foods is a fundamental public health issue, and there have been many efforts to combat the presence of these "food deserts" to increase availability of nutritious and affordable foods in urban or rural areas. One such effort that many states across the nation are implementing is to allow SNAP benefits to be accepted at local farmers' markets. Allowing SNAP benefits at farmers' markets increases access to nutritious foods in areas that are underserved by retail grocers.[3]

LB986

Programs to allow SNAP benefits at farmers' markets have been implemented in over 24 states and Nebraska is on its way to becoming one as well. On April 9, 2010, the Nebraska State Legislature passed LB986, a bill that would expand the Agricultural Opportunities and Value-Added Partnership Act to allow grants for the purchase of electronic scanners and point-of-sale devices. The bill was introduced by Senator Danielle Conrad of Lincoln and would enable Nebraskans utilizing SNAP benefits, accessed through Electronic Benefit Transfer (EBT) technology, to purchase food at farmers' markets. Senator Conrad states that approximately one in four Nebraska families with children are using federally subsidized food programs or will in the near future; allowing SNAP benefits would provide many of these families access to nutritious foods that they would not otherwise have.[4] Currently only a few farmers' markets are accepting SNAP benefits, one of which includes Lincoln's Community CROPS Pentzer Park Farmers' Market, whose Executive Director Ingrid Kirst testified in favor of the bill. Allowing grants for electronic scanners and point-of-sale devices, LB986 will provide more farmers' markets the opportunity to purchase the technology needed to accept federally subsidized food and nutrition benefits. Furthermore, accepting SNAP benefits will allow farmers and farmers' markets to tap into a larger customer base and benefit the local economy.[5]

Challenges

There exist many challenges to implementing programs that allow SNAP benefits at farmers' markets. The first includes issues with policy or procedures associated with accepting federally subsidized food and nutrition benefits. In order for markets or vendors to operate an EBT machine and accept SNAP benefits, they must first obtain a license through the United States Department of Agriculture Food and Nutrition Services. Once a li-

Commodity Distribution Program

The USDA purchases surplus commodities through price support programs and designates them for distribution to low-income families and individuals through food banks, soup kitchens and pantries. In FY 2008, a total of 140,748 Nebraska households were served with Pantry Baskets through the Commodity Distribution Program. Updated statistics for FY 2009 were not available, however, as the state no longer tracks these data.

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 (CSFP). The program provides surplus commodity foods such as non-fat dry milk, cheese, canned vegetables and fruits, bottled juices, pasta, rice, dry beans, peanut butter, infant formula and cereal. For federal fiscal year (FY) 2009, a monthly average of 952 women, infants

cense is obtained, farmers' markets must then develop a scrip program – a system that turns benefits into an alternate form of currency that may be used at individual market stands.[6] Many administrative details must be taken into account when considering these programs, so in June 2010 the USDA released a how-to handbook on SNAP at farmers' markets that guides farmers' markets and vendors in implementing successful programs to accept SNAP benefits (this handbook can be found at www.fns.usda.gov).

Another challenge that arises is the cost of implementing and maintaining SNAP benefits programs at farmers' markets. Wireless terminals for point-of-sale devices or scanners that process EBT technology can cost nearly $1,000 to install and program and operation costs can be around $30 a month.[7] LB986 is important in helping to overcome costs associated with program implementation in that it would open up approximately $850,000 to $1 million of unallocated funds under the Agricultural Opportunities and Value-Added Partnership Act to be used for grants.[8] Furthermore, there are numerous federal grants that markets may apply for to offset costs including the Community Food Projects Competitive Grants or Farmers' Market Promotion Program which provide funds for agricultural cooperatives and nonprofits.[9]

The final challenge to SNAP at farmers' markets programs is actually connecting SNAP recipients to farmers' markets. Although the number of farmers' markets accepting SNAP benefits has increased in the past few years it has been found that about 0.008% of total SNAP transactions took place at farmers' markets.[10] This means that although the option is there, very few SNAP recipients are using their benefits at farmers markets. The reason for this is that many barriers still exist for SNAP recipients to shop at farmers' markets including transportation problems, inconvenient hours, market prices and the fact that many SNAP recipients are simply unaware of the existence of farmers' markets.[11] To increase SNAP transactions at farmers' markets, many states have implemented incentive or bonus programs that match SNAP benefits and allow SNAP participants to stretch their limited funds further. These incentive programs are shown to be widely successful in attracting more SNAP recipients to farmers' markets and increasing awareness about farmers' markets.[12]

Although there are many challenges to implementing SNAP at farmers' markets programs, these programs are vital in addressing a fundamental public health issue. Increasing access to fresh, nutritious foods is important in providing low-income families with healthy diets and combating the health disparities that exists between impoverished communities and affluent areas. Specifically in Nebraska, grants to purchase EBT technology at farmers' markets will allow SNAP recipients more options and further the goal of providing all children and families access to a variety of quality and affordable foods.

[1] United States Department of Agriculture, "Access to Affordable and Nutritious Food: Measuring and Understanding Food Deserts and Their Consequences," *Report to Congress*, June 2009.

[2] Ibid.

[3] Suzanne Briggs, Andy Fisher, Megan Lott, Stacy Miller and Nell Tessman, "Real Food, Real Choice: Connecting SNAP Recipients with Farmers Markets," *Community Food Security Coalition and Farmers Market Coalition*, June 2010.

[4] Nebraska State Legislature, Unicameral Update, Vol. 33 No. 7, February 16-19, 2010.

[5] *Ibid.*

[6] United States Department of Agriculture, *Supplemental Nutrition Assistance Program (SNAP) at Farmers Markets: a How-To Handbook*, June 2010.

[7] Nebraska State Legislature, Unicameral Update.

[8] *Ibid.*

[9] *Supplemental Nutrition Assistance Program (SNAP) at Farmers Markets: a How-To Handbook.*

[10] Briggs et. al.

[11] *Ibid.*

[12] *Ibid.*

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and children were served by CSFP with 11,424 food packages. This is a 1.8% increase in the number served from FY 2008. CSFP serves all 93 counties through 8 local non-profit agencies and 19 warehouses across the state. Each year the number of individuals served and funds allocated are determined by USDA.

Women, Infants and Children (WIC)

The special Supplemental Nutrition Program for Women, Infants and Children (WIC) is a short-term intervention program designed to influence lifetime nutrition and healthy behaviors in a targeted, high-risk population. WIC provides nutrition and health information, breastfeeding support and monthly vouchers or coupons for specific healthy foods to Nebraska's pregnant, post-partum and breastfeeding mothers, as well as to infants and children up to age 5. Examples of such foods are fresh fruits and vegetables, 100% whole wheat bread, whole wheat and corn tortillas, brown rice, milk, juice, cheese, eggs, beans, peanut butter and cereal. Eligible participants must meet the income guidelines of 185% of FPL and have

a nutritional risk. Parents, guardians and foster parents are encouraged to apply for benefits. Program participation helps ensure children's normal growth, reduce levels of anemia, increase immunization rates, improve access to regular health care and improve diets. In October 2009, Nebraska revamped its WIC nutrition program to reflect the latest science on healthy diets and address obesity. These changes provide better access to food with less fat and more fiber and help families consume fewer overall calories, eat more vegetables and fruits, and drink fewer sweetened beverages.

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 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 new-born, longer pregnancies, fewer premature births, lower incidence of moderately low and very low birth weight infants and a greater likelihood of receiving prenatal care.[2] Children participating in WIC also demonstrate better cognitive performance. In FY 2009, Nebraska WIC served a monthly average of 44,941 participants (10,588 women, 10,825 infants and 23,528 children) through 109 clinics. Participation in the WIC program has steadily increased. While 2009 Nebraska birth data were not available at the time this report was published, 58% of the 26,992 babies born in 2008 were enrolled in the WIC program. The 2009 average cost for food benefits and nutrition services for a pregnant woman participating in the Nebraska WIC Program was approximately $661 per year (fiscal year). Tables 8.1 and 8.2 demonstrate WIC participation by category and the average number of participants since 2000 respectively.

[1] Mark Nord, "Food Insecurity in Households with Children: Prevalence, Severity and Household Characteristics," *USDA*, September 2009.

[2] 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.

Table 8.1: WIC Participation by Category (Federal Fiscal Year 2009)*

Breastfeeding Women	2,828
Postpartum Women	3,219
Pregnant Women	4,541
Infants	10,825
Children	23,528
Total	44,941

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

** These data reflect average participation per month during that fiscal year.*

Table 8.2: Average Monthly WIC Participants (2000-2009)

Year	Participants
2000	32,194
2001	33,797
2002	36.454
2003	37,731
2004	39,087
2005	40,252
2006	40,733
2007	41,482
2008	43,855
2009	44,941

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

Out-of-Home Care and Adoption

Voices for Children in Nebraska believes that all children should have protection from physical, emotional and sexual abuse, neglect, and exploitation. Nebraska children may be placed in out-of-home care as a result of abusive or neglectful behavior by their parent/guardian or due to their own uncontrollable behavior. The 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. 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. There are a small number of children placed in private residential facilities who are not considered wards of the state.

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

A total of 8,677 Nebraska children were in out-of-home care at some point in 2009. This was a decrease of 558 children from 2008. During the calendar year 2009, 3,970 entered care while 4,468 children exited. Both the number of children who entered and those who exited care decreased from 2008.Of the 3,970 children who entered care in 2009, 2,452 (61.8%) were placed in out-of-home care for the first time and 1,518 (38.2%) for the second time or more. A total of 4,448 children were in care on December 31, 2009 – 172 fewer children in care than the previous year. Of the 4,448 children in care on December 31, 2009, all were DHHS wards. Figure 9.1 presents a historical view of the number of children in out-of-home care since 2000.

Children of color represent 25.0% of Nebraska's child population (ages 19 and under).[1] However, children of color made up 31.1% of children in out-of-home care on December 31, 2009.[2] These data are presented in Table 9.1 on page 69.

Research continues to show that parents of color are no more likely than White parents to abuse or neglect their children.[3] Despite this fact, children of color continue to be overrepresented in the Nebraska out-of-home care system. National research has shown that race is one of the primary determinants in child protective services' decisions during reporting, investigation, substantiation, placement, and exit from care.[4]

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 review requirements. About 270 trained citizen volunteers serve on local FCRBs to engage in this important review process. Completed reviews are shared with all parties legally involved with the case. The FCRB also has an independent tracking system for all Nebraska children in out-of-home

care and regularly disseminates information on the status of those children. For this section, the FCRB provided data in the subsection "Out-of-Home Care Placements," on number of adoptions, and in the figures and tables as indicated. DHHS provided data on licensed and approved foster homes, for multiple placements by race and ethnicity, about Safe Haven placements, and in the figures and tables as indicated.

Out-Of-Home Care Placements

Children may enter foster care for a variety of reasons. Neglect is the most frequently recorded cause for removal of children from the home of their parent(s) or guardian(s). Neglect has several forms that range from outright abandonment to inadequate parenting skills which affect child well-being. Parental drug abuse is the second most prevalent cause of placement followed by parental alcohol abuse and substandard or unsafe housing. Table 9.2 presents a summary of reasons children entered foster care in 2009.

Once in out-of-home care, there is a variety of placement possibilities for children. Of the 4,448 children in care on December 31, 2009, there were 1,931 (43.4%) in foster homes; 1,000 (22.5%) placed with relatives; 775 (17.4%) in group homes, residential treatment centers or centers for the developmentally disabled; 340 (7.6%) in detention or youth development centers; 227 in emergency shelters; 106 were runaways or had unknown whereabouts; and 35 were living independently or semi-independently, as they were near adulthood. The remaining 34 children were placed in psychiatric, assisted living or medical facilities; special school; or other placements.

Of the 4,468 children who left foster care during 2009, a total of 3,154 (70.6%) were returned to their parents and 487 (10.9%) children were adopted. The number of completed adoptions in 2009 decreased compared to the 572 completed adoptions in 2008. In 2009, 319 (7.1%) children reached the age of majority and became independent. Sixty-six (1.5%) children were released from detention or youth residential

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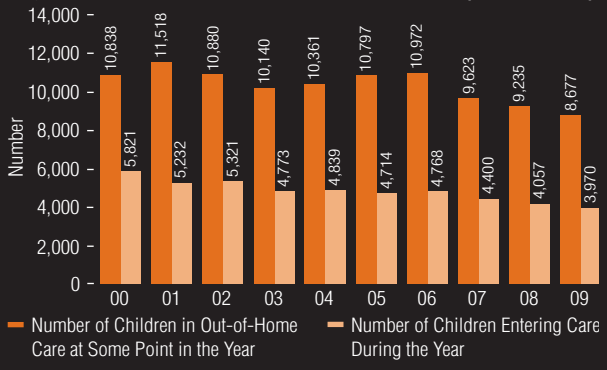
Figure 9.1: Children in Out-of-Home Care (2000-2009)



Source: State Foster Care Review Board.

Table 9.1: Out-of-Home Care Children by Race and Ethnicity (December 31, 2009)

Race/Ethnicity	Number	Percent
White	2,567	57.7%
Black	971	21.8%
American Indian	232	5.2%
Asian	36	0.8%
Multiple Races	145	3.3%
Other or Not Reported	497	11.2%
Total	4,448	100.0%

Source: State Foster Care Review Board.

Table 9.2: Summary of Reasons Children Entered Foster Care (Reviewed 2009)[i]

Category	All Children Reviewed		By Number of Removals: Children who were in foster care for the first time		By Number of Removals: Children who were in foster care at least once previously	
Neglect[ii]	1,999	58.3%	1,218	57.1%	781	60.3%
Parental Drug Abuse	1,209	35.2%	794	37.2%	415	32.0%
Parental Meth Abuse[iii]	543	15.8%	385	18.0%	158	12.2%
Parental Alcohol Abuse	403	11.7%	232	10.9%	171	13.2%
Housing Substandard/Unsafe	796	23.2%	456	21.4%	340	26.2%
Physical Abuse	424	12.4%	387	18.1%	37	2.9%
Parental Incarceration	349	10.2%	211	9.9%	138	10.6%
Abandonment	274	8.0%	166	7.8%	108	8.3%
Parental Illness/Disability	325	9.5%	191	9.0%	134	10.3%
Sexual Abuse[iv]	279	8.1%	175	8.2%	104	8.0%
Death of Parent(s)	46	1.3%	24	1.1%	22	1.7%
Relinquishment	24	0.7%	3	0.1%	21	1.6%
Domestic Violence	21	0.6%	11	0.5%	10	0.8%
Child's Behaviors	784	22.9%	326	15.3%	458	35.3%
Child's Mental Health	113	3.3%	36	1.7%	77	5.9%
Child's Disabilities	71	2.1%	29	1.4%	42	3.2%
Child's Drug Abuse	88	2.6%	41	1.9%	47	3.6%
Child's Meth Abuse	0	0.0%	0	0.0%	0	0.0%
Child's Alcohol Abuse	32	0.9%	14	0.7%	18	1.4%
Child's Illness	40	1.2%	25	1.2%	15	1.2%
Child's Suicide Attempt	10	0.3%	2	0.1%	8	0.6%
Parental Mental Health*	18	0.5%	11	0.5%	7	0.5%
Abuse of Sibling*	4	0.1%	3	0.1%	1	0.1%
Parent also in Foster Care*	1	0.0%	1	0.0%	0	0.0%
Born Affected (Drugs/Alcohol)*	1	0.0%	1	0.0%	0	0.0%

[i] Up to 10 reasons for entering foster care could be identified for each child reviewed. Multiple reasons may be selected for each child. This chart contains all the reasons identified at the time of removal.

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

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

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

* Indicates new reson for entry into foster care tracked in 2009. Because these indicators were new, data are not for the whole year.

Note: The percentages are based on 3,430 individual children reviewed. Of those children 2,134 were in foster care for the first time, while 1,296 had been in care at least once previously.

Source: State Foster Care Review Board.

treatment centers and returned to their parents. Three children considered medically fragile died while in foster care in 2009. This was a decrease from 8 deaths among children in foster care in 2008.

Licensed and Approved Foster Homes

In December 2009, there were 2,008 licensed foster homes. In becoming a licensed or approved foster home provider, candidates must go through local, state and national criminal background checks, as well as through child and adult abuse registry and sex offender registry checks. 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 2009, there were 2,016 approved foster homes, an increase of 131 approved foster homes from 2008. However, licensed foster homes decreased by 255 in 2009, to 2,008. In general, some of the loss in licensed homes may occur due to a decrease in the number of youth in foster care or because the licensed homes adopt the children whom they were fostering and then decided against fostering more children. Also, as approved homes can only be used for children who are relatives or close friends of the child, these homes are closed to further placements as soon as the specific child leaves the home.

Lack of Foster Care Homes

According to DHHS, a total of 4,024 approved or licensed homes were available in Nebraska in December 2009. This is a decrease of 124 possible placements from December 2008. Nebraska faces an ongoing need for foster placements. Foster care providers are always needed, particularly for children who are teenagers, who have special needs (i.e., lower functioning and/or significant acting-out behaviors) and sibling groups of three or more. Foster homes provide the least restrictive, most family-like out-of-home placement for children who cannot remain at home.

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

Multiple Placements

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. Unfortunately, it is not unusual for a child to be moved repeatedly while in out-of-home care.

Numbers for multiple placements vary between the FCRB and DHHS based on differing definitions of the term 'multiple placements.' DHHS uses the federal definition in order to meet federal standards and to be able to compare placement rates across states. The FCRB closely matches the federal definition for placement setting changes, with modifications based on statute and best practice. The FCRB modifications typically result in a calculation presenting a higher number of placements. Though this report has previously used data collected by FCRB for multiple placements, these data were not available this year. Instead, statistics using data from DHHS are reported.

Of children in care on December 31, 2009, 31.3% had experienced four or more placements. Generally, Black and American Indian youth experienced the most placements, compared to other youth in foster care. For example, on December 31, 2009, 8.3% of American Indian youth and 9.0% of Black youth in care had experienced 10 or more placements compared to 6.8% of White youth. Table 9.3 provides data on the number of placements in foster care by race and ethnicity.

Adoption Services

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

In calendar year 2009, there were 487 adoptions of state wards finalized in Nebraska. This is a decrease from 2008 when 572 adoptions were finalized. Figure 9.2 presents historical data on adoption since 1999.

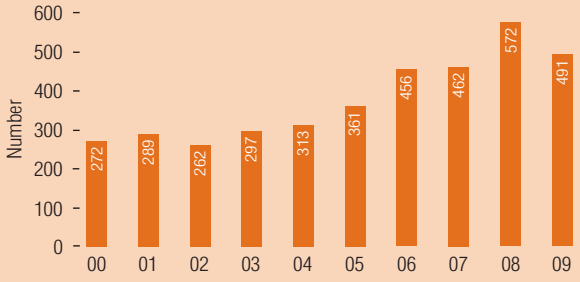
Table 9.3: Number of Placements by Race and Ethnicity (December 31, 2009)

	Placements			
Race/Ethnicity	**1 to 3**	**4 to 6**	**7 to 9**	**10+**
Asian	90.3%	6.5%	3.3%	0.0%
Black	61.9%	20.5%	8.6%	9.0%
Hispanic	73.3%	17.0%	6.0%	3.7%
Multi-Racial	76.7%	13.8%	5.3%	4.2%
Native American	60.7%	20.9%	10.2%	8.2%
Other Race	70.6%	22.0%	4.6%	2.8%
Race Not Entered	100.0%	0.0%	0.0%	0.0%
White (Not Hispanic)	69.8%	17.2%	6.2%	6.8%

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

Note: Caution should be used if comparing these data to the same from previous Kids Count reports, as a different source is used this year. The sources use different methodology in calculating number of placements.

Figure 9.2: Number of State Ward Adoptions in Nebraska (CY 2000-2009)



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

Nebraska Safe Haven Law

Safe Haven laws have been enacted in all 50 states to address infant abandonment and infanticide, in response to an increase in the abandonment of infants. The first Safe Haven

law passed in Texas in 1999 to allow "mothers in crisis to safely relinquish their babies to designated locations where the babies are protected and provided with medical care until a permanent home can be found."[5] Safe Haven laws are intended to allow a parent of an infant, or an agent of the parent, to remain anonymous and to be shielded from prosecution for abandonment or neglect in exchange for surrendering the baby safely.

In 2007, two bills were introduced with the intention of creating a Safe Haven law in Nebraska, LB 6 and LB 157, though neither bill passed in its original form. The Safe Haven bill (LB 157) that eventually went into effect on July 18, 2008,

POLICY BOX

Kinship Care Presents Benefits and Challenges

By Naomi Thyden, Voices for Children in Nebraska

When parents can no longer care for their children, it is often relatives who first step up to take over responsibility. These relatives are known as kinship caregivers. Some kinship caregivers are foster parents for a child in the state's care. In 2009, 14.9% of children in the care of the Nebraska Department of Health and Human Services lived with a relative foster parent, and 32.5% lived with a non-relative.[1] Living with a related foster parent rather than a nonrelated foster parent can be very beneficial for a child.

Children in kinship foster care:

- Report feeling loved at a higher rate.[2]
- Are less likely to run away.[3]
- Feel less stigmatized.[4]
- Experience greater stability and fewer placement changes.[5]
- Are more likely to be reunited with their parents.[6]

Because of the advantages of kinship foster care for children, it is the federal and state policy to give preference to relatives when placing children in out-of-home care. A few examples of policies and practices that address the unique advantages and challenges of kinship care are waivers of foster care training requirements, Pre-hearing Conferences and subsidized guardianship.

Waiver of training requirements

Kinship caregivers can be granted a waiver for non-safety foster care licensing standards on a case-by-case basis. Foster licensing standards were not put in place with kinship caregivers in mind, and these waivers allow more children to be more quickly placed with relatives. However, it can also leave caregivers without knowledge they need. Caregivers who do not go through training do not receive as much information about the foster care system.[7]

Pre-Hearing Conferences

Pre-hearing conferences are a form of dispute resolution which allow a child's parents and other stakeholders to work together outside the courtroom to figure out what is best for the child. One benefit of pre-hearing conferences is that they can help identify relatives who are potential caregivers. Unlike training waivers and subsidized guardianship, pre-hearing conferences are not yet supported by legislation, and are used inconsistently throughout the state.

Subsidized Guardianship

Subsidized guardianship is an option for kinship caregivers who are willing to care for a child permanently and need continued financial support from the government, but do not feel comfortable with adoption.

Although kinship care is advantageous for children, it also has unique challenges.

Challenges of kinship foster care include:

- Children are twice as likely to live in a low-income household.[8]
- Children are more than twice as likely to live with a single caregiver.[9]
- Children tend to remain in foster care longer.[10]
- Grandparents who are kinship caregivers are more likely to have mental and physical health problems.[11]
- Existing familial ties between biological parents and foster parents complicate the need to maintain appropriate boundaries between the children and their parents.[12]

As of December 31, 2009, 932 youths in state custody were in a

did not include any age limit. Shortly thereafter, a total of 36 children, ranging in age from 1 to 17 years old, were relinquished under the Safe Haven law. Teenagers ages 13-17 composed 61% (22 children) of all children who were relinquished under Safe Haven. Out of the 36 children, 23 were males and 13 were females. Of these children, 34 had received prior mental health treatment, 12 of whom had received treatment at a level higher than outpatient. Moreover, 20 of the children had previously been state wards, 14 had been adopted or were in guardianships or relative placements. Of the 36 children who came into the state's custody under Safe Haven, 23 were White, 11 were Black, 1 was Native

relative foster home. Estimates which include youths living with relatives outside of the state's care are much higher. In 2000 there were 8,321 children in Nebraska living in the home of a relative without a parent present.[13] Without a legal relationship, it is difficult for relative caregivers to enroll children in school, obtain medical insurance, and complete other necessary tasks.[14]

Due to the unique challenges of kinship care, kinship caregivers often require the same – if not more – support and services. Unfortunately, kinship caregivers in Nebraska routinely express that they feel like they are on their own, they do not understand the system and do not get the support they need for intra-familial issues.[15] In addition, sometimes relative placement is not deemed appropriate by all professionals, or would only be appropriate with additional support, but children are placed with a relative anyway and don't receive support.[16]

To address the unique challenges for kinship caregivers, child welfare agencies can:

- Provide special training to kinship caregivers on intra-familial issues.[17]
- Develop a clear statement of the financial support that is available to children in kinship foster homes and informal kinship care (TANF, Medicaid, SSI, CHIP, child support, etc.).[18]
- Develop and implement procedures to ensure that children in kinship care receive benefits and provide assistance to kinship caregivers in applying for benefits.[19]
- Assess the caregivers on their ability to maintain appropriate boundaries with birth parents, their interest in working toward reunification, and their interest in permanency options. Make sure they are not in competition with birth parents for the child's affection and have no history of abusing or allowing abuse to occur.[20]
- Develop specialized kinship staff.[21]
- Provide at least the same level of financial support and benefits to kinship foster parents as non-related foster parents.[22]

The Nebraska Foster and Adoptive Parents Association (NFAPA) provides a Kin-nect Support Line (1-888-848-4546). It is toll-free and offers 24 hour support statewide for related caregivers. It provides information and referrals for training and support groups.

[1] Nebraska DHHS Division of Children and Family Services: *2009 Data at a Glance*, http://www.hhs.state.ne.us/jus/2009DAG.pdf. In addition to living with relative foster parents and with non-relative foster parents, state wards also were placed with their own parents, in group homes, institutions, in unknown whereabouts, in independent living situations and in pre-adoptive homes.

[2] Gleeson, James P. Kinship Care Research and Literature: Lessons Learned and Directions for Future Research. *Kinship Reporter* Vol. 1, No. 2 (Summer 2007).

[3] *Ibid.*

[4] *Ibid.*

[5] Conway, Tiffany, and Rutledge Q. Hutson. Is Kinship Care Good for Kids? *Families First* (June-July 2007).

[6] Nebraska Foster Care Review Board. *2008 Annual Report.*

[7] *Ibid.*

[8] Ehrle-Macomber, Jennifer, Rob Geen and Regan Main. 2003. Kinship Foster Care: Custody, Hardships, and Services. *Snapshots of America's Families III*, No. 14. (November 20), http://www.urban.org/publications/310893.html.

[9] *Ibid.*

[10] Nebraska Foster Care Review Board.

[11] Gleeson, 2007.

[12] *Ibid.*

[13] Children's Defense Fund. *The State of America's Children 2010 Report*, May 28, 2010.

[14] Beltran, Ana, interview by Kojo Nnamdi, *Kinship Care: Prevalence, Benefits, Challenges*, WAMU, April 26, 2001. http://www.urban.org/url.cfm?ID=900350 .

[15] Nebraska Foster Care Review Board.

[16] *Ibid.*

[17] *Ibid.*

[18] Child Welfare League of America. Kinship Care: Best Practices. http://www.cwla.org/programs/kinship/bestpractice.htm (accessed June 28, 2010).

[19] *Ibid.*

[20] Miller, Jennifer. Quality kinship care: an evolving practice. *Common Ground.* Volume XXV, Number 1. February 2010.

[21] *Ibid.*

[22] Child Welfare League of America, 2010.

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

As of September 2009, approximately 14 months after the Safe Haven law had gone into effect, 20 of the children who came into the state's custody under Safe Haven were in foster care and 16 of those cases have closed. Eight of the closed resulted in a guardianship or adoption, 6 youth were returned to their home state, 1 was returned home and 1 was transferred to the adult court system. More up-to-date information is not available, as DHHS no longer specifically tracks these children.

[1] U.S. Census Bureau, 2009 Population Estimates Program – Age, Sex, and Race/Ethnicity Estimates for Counties.

[2] Percentage of children of color was calculated by subtracting the number of White and Other or Not Reported children from the total, and then dividing by the total.

[3] 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.

[4] *Ibid*.

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

2010 County Data Notes

1. TOTAL COUNTY POPULATION IN 2009

Source: U.S. Census Bureau, 2009 Population Estimates Program – Age, Sex, and Race/Ethnicity Estimates for Counties.

2. CHILDREN 19 AND UNDER IN 2009

Source: U.S. Census Bureau, 2009 Population Estimates Program – Age, Sex, and Race/Ethnicity Estimates for Counties.

3. CHILDREN UNDER 5 IN 2009

Source: U.S. Census Bureau, 2009 Population Estimates Program – Age, Sex, and Race/Ethnicity Estimates for Counties.

4. MINORITY CHILDREN 19 AND UNDER IN 2009

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, 2009 Population Estimates Program – Age, Sex, and Race/Ethnicity Estimates for Counties.

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

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

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

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

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

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

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

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

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

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

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

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

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

11. AVERAGE MONTHLY NUMBER OF FAMILIES ON ADC IN 2009

Fractional figures have been rounded to display whole numbers. The state total does not include a monthly average of 10 families on ADC in 2009 that were labeled 'out-of-state' and are not attributed to any county.

Source: Financial and Program Services, DHHS.

12. AVERAGE MONTHLY NUMBER OF CHILDREN ELIGIBLE FOR MEDICAID AND SCHIP SERVICES IN 2009

In this context, "eligible" means that a child has been determined eligible and is participating in the program. These are average monthly eligible figures. Fractional figures have been rounded to display whole numbers. This total includes 1,521 out-of-state children who were eligible in 2009.

Source: Financial and Program Services, DHHS.

13. NUMBER OF CHILDREN AGES 18 AND UNDER RECEIVING FOOD STAMP BENEFITS IN JUNE 2009

There were 175 children labeled "out-of-state" that are included in the Nebraska total but not attributed to any county.

Source: Financial and Program Services, DHHS.

2010 County Data Notes continued

14. NUMBER OF WOMEN, INFANTS AND CHILDREN PARTICIPATING IN WIC SERVICES IN SEPTEMBER 2009

    Source: DHHS.

15. AVERAGE NUMBER OF FREE/REDUCED LUNCHES SERVED DAILY IN OCTOBER 2009

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

    Source: Nebraska Department of Education.

16. PERCENTAGE OF STUDENTS ELIGIBLE FOR FREE AND REDUCED PRICE MEALS (LAST FRIDAY IN SEPTEMBER 2009)

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

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

17. AVERAGE DAILY NUMBER OF MEALS SERVED BY THE SUMMER FOOD PROGRAM IN 2009

    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 2008

    Source: Vital Statistics, DHHS.

19. PERCENTAGE OF BIRTHS TO MOTHERS AGES 17 AND YOUNGER OUT OF TOTAL BIRTHS WITHIN A COUNTY IN 2008

    Source: Vital Statistics, DHHS.

20. NUMBER OF BIRTHS TO TEENS AGES 10- TO 17-YEARS-OLD FROM 1999 to 2009

    Source: Vital Statistics, DHHS.

21. NUMBER OF OUT-OF-WEDLOCK BIRTHS FROM 1999 TO 2008

    Source: Vital Statistics, DHHS.

22. NUMBER OF INFANT DEATHS FROM 1999 to 2008

    Source: Vital Statistics, DHHS.

23. CHILD DEATHS (AGES 1 TO 19) FROM 1999 to 2008

    Source: Vital Statistics, DHHS.

24. NUMBER OF INFANTS BORN AT LOW BIRTH WEIGHTS IN 2008

    Source: Vital Statistics, DHHS.

25. HIGH SCHOOL GRADUATES IN SCHOOL YEAR 2008-2009

    *******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) IN SCHOOL YEAR 2008-2009

    *******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.

Elijah

27. NUMBER OF CHILDREN WITH VERIFIED DISABILITY RECEIVING SPECIAL EDUCATION ON OCTOBER 1, 2009

The state total of 48,017 is a duplicated count, mening some students were counted in more that one district. The total number of unduplicated, or individual, students was 47,666, as indicated in the Education section.

Source: Nebraska Department of Education.

28. COST PER PUPIL BY AVERAGE DAILY MEMBERSHIP IN SCHOOL YEAR 2008-2009

Source: Nebraska Department of Education.

29. HEAD START and EARLY HEAD START ENROLLMENT FOR NOVEMBER 17, 2009

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

30. CHILDREN IN FOSTER CARE TOTAL ON DECEMBER 31, 2009.

Data are provided by county of commitment. Statewide total includes 1 commitment for which county was not indicated.

Source: Nebraska Foster Care Review Board.

31. REPORTED NUMBER OF YOUTH 19 AND YOUNGER WITH STD'S IN YEARS 2000-2009

Source: DHHS.

32. JUVENILE ARRESTS 2009

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

Source: Nebraska Commission on Law Enforcement and Criminal Justice.

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

2010 County Data

	1. Total Population (2009)	2. Children 19 & Under (2009)	3. Children Under 5 (2009)	4. Minority Children 19 & Under (2009)	5. % of Children 17 & Under in Poverty (2000)	6. % of Children Under 5 in Poverty (2000)	7. % of Minority Children 17 & Under in Poverty (2000)	8. % of Children 17 & Under in Poverty in Single Parent House hold (2000)	9. % of Children 17 & Under in Poverty in Married-Couple Family (2000)	10. % of Mothers in Labor Force With Children Under 6 (2000)	11. Families on ADC (2009)	12. Medicaid and SCHIP Eligible Children (2009)	13. Food Stamp Participation Children 18 & Under (June 2009)	14. WIC Participation (September 2009)	15. Free/Reduced School Lunch (October 2009)	16. % of Students Eligible for Free/ & Reduced Price Meals (Last Friday in September 2009)	17. Average Daily Number of Meals Served by the Summer Food Program (2009)
	33,324	9,257	2,205	1,762	10%	12%	17%	68%	32%	73%	186	2,648	1,237	817	2,127	38%	625
Adams	6,652	1,696	406	85	17%	19%	39%	41%	59%	87%	13	497	170	131	549	44%	0
Antelope	339	82	17	5	15%	20%	50%	38%	62%	100%	1	22	6	0	0	0%	0
Arthur	647	158	30	22	19%	8%	69%	31%	69%	59%	0	48	14	11	77	44%	0
Banner	458	103	18	3	22%	32%	0%	3%	97%	70%	0	57	13	16	68	57%	0
Blaine	5,427	1,442	309	60	12%	15%	18%	28%	72%	81%	10	275	106	98	335	34%	0
Boone	10,891	3,102	767	823	14%	18%	37%	68%	32%	73%	47	910	511	324	807	39%	93
Box Butte	2,063	448	92	11	20%	16%	0%	21%	79%	76%	4	133	24	61	157	44%	0
Boyd	3,062	704	140	19	15%	22%	46%	45%	55%	83%	3	227	76	69	201	40%	0
Brown	45,814	13,406	3,377	1,750	11%	14%	24%	71%	29%	79%	157	3,520	1,701	1,060	2,778	35%	854
Buffalo	6,922	1,728	387	154	12%	9%	13%	56%	44%	80%	18	415	200	119	427	33%	0
Burt	8,400	2,333	466	177	10%	14%	33%	29%	71%	77%	13	432	202	127	541	34%	0
Butler	25,485	7,082	1,602	525	7%	12%	5%	68%	32%	76%	53	1,431	613	351	1,062	27%	0
Cass	8,362	2,371	574	71	11%	8%	0%	23%	77%	85%	5	423	202	107	576	34%	0
Cedar	3,625	901	253	132	11%	16%	15%	41%	59%	69%	12	264	107	119	284	37%	0
Chase	5,474	1,384	299	198	13%	17%	22%	44%	56%	72%	13	509	156	130	294	35%	0
Cherry	9,720	2,589	680	356	12%	15%	31%	57%	43%	74%	29	581	301	146	548	33%	766
Cheyenne	6,205	1,681	386	221	13%	16%	26%	40%	60%	75%	21	465	211	159	316	35%	160
Clay	10,332	3,668	1,093	2,265	14%	16%	21%	26%	74%	73%	49	1,042	344	584	1,224	30%	0
Colfax	9,132	2,557	586	487	10%	14%	24%	34%	66%	74%	16	477	187	207	719	36%	0
Cuming	10,784	2,846	661	134	16%	20%	26%	36%	64%	79%	22	866	285	313	709	39%	0
Custer	20,651	7,104	2,016	4,062	15%	17%	23%	67%	33%	70%	102	2,462	1,236	1,251	2,297	53%	878
Dakota	8,735	2,454	483	386	14%	31%	32%	47%	53%	77%	30	696	330	178	559	42%	276
Dawes	25,076	8,324	2,175	4,325	14%	16%	21%	48%	52%	72%	129	2,603	1,131	1,172	3,093	58%	1,437
Dawson	1,839	411	100	27	12%	13%	29%	42%	58%	94%	8	141	92	44	173	42%	0
Deuel	6,289	1,662	396	327	12%	17%	12%	46%	54%	85%	8	312	136	147	397	35%	0
Dixon	35,640	9,543	2,525	1,752	10%	14%	22%	53%	47%	73%	171	3,051	1,666	1,222	2,620	40%	457
Dodge	510,199	147,246	42,647	54,223	13%	14%	31%	77%	23%	72%	4,145	46,967	25,718	14,154	37,545	36%	22,469
Douglas	1,957	468	90	66	16%	16%	31%	24%	76%	91%	3	142	41	56	181	45%	0
Dundy	5,962	1,563	323	144	8%	11%	21%	56%	44%	72%	10	431	129	112	362	32%	0
Fillmore	3,089	704	163	15	17%	15%	43%	41%	59%	77%	4	221	95	51	157	45%	213
Franklin	2,516	643	138	21	10%	10%	10%	30%	70%	74%	5	177	77	56	204	37%	0
Frontier	4,556	1,133	240	73	15%	17%	44%	45%	55%	69%	16	375	178	109	529	46%	0
Furnas	22,653	5,529	1,391	371	10%	13%	26%	53%	47%	84%	57	1,550	822	479	1,105	32%	0
Gage	1,739	321	78	20	22%	22%	52%	26%	74%	92%	3	150	57	38	178	64%	110
Garden	1,709	380	90	15	12%	11%	0%	8%	92%	85%	2	181	53	47	136	35%	0
Garfield	1,844	451	90	30	11%	6%	0%	22%	78%	89%	2	100	40	40	62	24%	0
Gosper	560	131	29	0	17%	21%	0%	50%	50%	33%	1	50	11	23	47	33%	0
Grant	2,251	585	142	39	22%	23%	0%	46%	54%	73%	3	213	48	100	340	61%	0
Greeley	57,487	17,695	5,048	7,035	16%	20%	29%	59%	41%	71%	375	6,382	3,183	2,524	5,892	49%	2,955
Hall	9,280	2,655	528	113	10%	10%	37%	51%	49%	80%	14	489	185	173	438	25%	0
Hamilton	3,234	759	163	30	14%	20%	4%	17%	83%	77%	10	219	89	40	132	42%	0

County Indicator	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.	15.	16.	17.
Hayes	959	240	45	18	26%	26%	46%	3%	97%	54%	0	46	10	7	73	50%	0
Hitchcock	2,806	647	159	36	23%	26%	37%	33%	67%	64%	3	252	104	85	129	46%	0
Holt	10,011	2,657	647	164	15%	13%	22%	14%	86%	80%	21	802	261	307	770	42%	413
Hooker	723	137	35	4	5%	6%	0%	30%	70%	71%	1	35	14	9	90	46%	0
Howard	6,443	1,746	398	92	14%	13%	24%	35%	65%	79%	14	426	145	125	451	36%	0
Jefferson	7,238	1,722	389	106	10%	15%	8%	51%	49%	72%	21	508	239	134	654	42%	68
Johnson	5,077	1,046	256	258	11%	11%	11%	40%	60%	79%	14	259	142	91	272	36%	163
Kearney	6,460	1,697	403	132	10%	10%	2%	56%	44%	78%	15	417	155	121	344	26%	0
Keith	7,760	1,867	444	190	13%	20%	25%	40%	60%	69%	25	515	261	144	450	34%	0
Keya Paha	802	202	39	20	34%	46%	0%	12%	88%	48%	2	49	4	14	50	51%	0
Kimball	3,576	868	204	99	12%	13%	22%	29%	71%	82%	7	318	122	80	194	34%	0
Knox	8,378	2,193	520	468	20%	23%	36%	27%	73%	72%	20	746	364	133	713	43%	132
Lancaster	281,531	76,945	20,616	15,794	10%	12%	24%	67%	33%	77%	1,097	18,814	10,557	6,098	14,725	31%	5,778
Lincoln	35,670	9,811	2,541	1,435	12%	16%	21%	64%	36%	74%	169	2,790	1,609	977	2,024	32%	1,263
Logan	732	174	53	5	13%	18%	11%	32%	68%	100%	3	52	27	20	44	25%	0
Loup	661	163	26	9	23%	23%	9%	5%	95%	56%	0	36		11	71	67%	0
Madison	34,505	9,641	2,678	2,445	13%	17%	32%	55%	45%	76%	180	3,042	1,572	1,026	2,379	34%	231
McPherson	488	131	35	6	22%	11%	100%	19%	81%	70%	2	39	14	6	0	0%	0
Merrick	7,666	2,086	464	180	10%	10%	25%	61%	39%	76%	14	550	190	174	443	36%	0
Morrill	4,911	1,305	317	280	20%	24%	36%	27%	73%	69%	17	501	275	130	511	55%	78
Nance	3,460	920	211	39	17%	24%	23%	30%	70%	76%	4	203	99	65	300	36%	0
Nemaha	6,856	1,812	429	145	13%	20%	0%	35%	65%	70%	31	496	275	111	414	28%	0
Nuckolls	4,334	990	221	57	17%	17%	39%	33%	67%	83%	7	272	115	69	460	41%	0
Otoe	15,214	4,112	1,017	527	9%	14%	28%	53%	47%	81%	49	958	505	296	885	31%	0
Pawnee	2,614	611	128	24	14%	14%	0%	37%	63%	75%	3	154	75	46	264	54%	270
Perkins	2,769	724	177	62	20%	25%	17%	24%	76%	63%	5	165	65	41	118	30%	0
Phelps	9,032	2,452	573	218	12%	12%	34%	43%	57%	75%	29	596	255	191	498	30%	0
Pierce	7,184	2,037	445	94	14%	18%	28%	30%	70%	84%	10	380	142	128	393	26%	0
Platte	32,515	9,457	2,440	2,301	9%	11%	20%	43%	57%	75%	95	1,994	882	833	2,016	30%	451
Polk	5,079	1,354	303	98	7%	11%	48%	42%	58%	77%	5	270	116	72	409	32%	0
Red Willow	10,651	2,812	697	288	11%	14%	17%	65%	35%	85%	27	810	417	288	681	33%	0
Richardson	8,125	1,964	426	223	11%	15%	29%	60%	40%	75%	21	689	372	172	690	41%	50
Rock	1,509	310	71	6	36%	36%	63%	22%	78%	65%	2	124	21	30	75	39%	0
Saline	13,872	4,095	1,050	1,366	9%	7%	21%	51%	49%	71%	29	987	375	523	1,011	34%	339
Sarpy	153,504	46,793	12,979	8,823	5%	6%	8%	60%	40%	74%	357	6,970	3,287	2,208	4,801	19%	2,517
Saunders	20,057	5,556	1,314	337	7%	10%	8%	46%	54%	75%	27	941	447	288	907	26%	0
Scotts Bluff	36,865	10,205	2,760	3,652	22%	26%	42%	58%	42%	73%	189	3,991	2,204	1,198	3,164	48%	1,631
Seward	16,481	4,855	977	332	6%	8%	9%	43%	57%	78%	12	622	288	186	616	21%	0
Sheridan	5,264	1,371	308	391	20%	27%	42%	48%	51%	72%	15	537	208	109	456	49%	251
Sherman	2,881	725	164	29	19%	33%	0%	27%	73%	59%	6	233	62	68	258	53%	0
Sioux	1,281	265	56	19	24%	12%	0%	26%	74%	58%	1	43	8	9	29	30%	0
Stanton	6,311	1,761	411	164	7%	5%	25%	68%	32%	82%	10	275	130	55	178	38%	0
Thayer	5,003	1,209	295	61	15%	16%	51%	55%	45%	77%	8	279	136	79	284	32%	0
Thomas	565	115	23	4	21%	10%	0%	14%	86%	76%	1	32	7	15	35	36%	0
Thurston	7,306	2,825	802	2,182	33%	34%	41%	61%	39%	69%	195	1,654	1,116	46	1,190	71%	755
Valley	4,108	1,003	235	71	16%	17%	58%	47%	53%	74%	6	286	103	89	221	30%	0
Washington	19,718	5,482	1,135	426	8%	12%	13%	46%	54%	79%	27	774	406	202	612	17%	0
Wayne	9,249	2,583	484	271	11%	16%	40%	48%	52%	80%	25	434	179	138	489	31%	0
Webster	3,431	840	178	48	14%	12%	27%	30%	70%	65%	11	260	130	78	253	38%	0
Wheeler	763	193	36	3	28%	32%	100%	19%	81%	56%	1	52	16	12	53	46%	0
York	13,837	3,723	900	529	10%	13%	56%	41%	59%	79%	17	928	374	294	678	32%	0
State Total	1,796,619	507,731	134,717	126,865	12%	14%	27%	60%	40%	74%	8,621	140,278	71,038	44,596	115,673	38%	41,198

2010 County Data

	18. Total Births (2008)	19. % of Births to Mothers Ages 17 and Under (2008)	20. Number of Births to Mothers Ages 10-17 (1999-2008)	21. Number of Out-of-Wedlock Births (1999-2008)	22. Infant Deaths (1999-2008)	23. Child Deaths Ages 1-19 (1999-2008)	24. Low Birth Weight (2008)	25. Graduates (2008-2009)	26. Dropouts (2008-2009)	27. Special Education (October 1, 2009)	28. Cost Per Pupil by ADM (2008-2009)	29. Head Start (November 2009)	30. Foster Care (December 31, 2009)	31. STDs 19 & Under (2000-2009)	32. Juvenile Arrests (2009)
Adams	421	4.28%	143	1,325	26	23	31	397	23	1,076	$10,136.65	162	92	304	289
Antelope	82	2.44%	9	161	7	8	4	127	0	185	$13,060.98	34	6	15	5
Arthur	3	0.00%	0	5	0	1	0	*	0	14	$18,954.97	0	1	1	2
Banner	3	0.00%	0	8	1	0	0	19	*	18	$15,232.63	0	0		2
Blaine	6	0.00%	0	2	1	0	0	13	0	23	$16,895.12	0	0	1	0
Boone	63	0.00%	11	131	2	7	0	93	*	127	$12,727.09	17	3	13	1
Box Butte	165	4.24%	50	489	5	12	19	136	*	327	$10,398.04	0	4	46	140
Boyd	18	0.00%	3	30	1	3	2	22	*	73	$16,079.98	0	3	4	3
Brown	20	5.00%	11	75	0	6	0	46	*	64	$11,715.75	26	3	16	0
Buffalo	693	1.73%	115	1,637	40	38	39	500	40	1,265	$9,592.03	116	79	441	612
Burt	58	3.45%	21	209	2	8	2	103	*	223	$10,437.17	34	4	27	16
Butler	97	1.03%	12	213	1	10	5	128	*	210	$11,389.67	0	24	15	15
Cass	303	1.32%	65	764	21	29	25	264	11	598	$10,450.73	140	32	138	29
Cedar	126	0.00%	10	148	4	15	5	154	*	202	$12,827.94	17	0	8	2
Chase	54	9.26%	17	110	2	6	2	55	*	82	$13,179.66	10	5	3	15
Cherry	55	1.82%	20	208	3	7	1	62	*	110	$14,715.61	0	2	2	15
Cheyenne	157	0.64%	32	389	13	15	6	109	10	252	$11,223.74	18	13	18	37
Clay	74	0.00%	12	177	1	9	3	66	*	152	$11,746.61	36	8	17	3
Colfax	228	2.19%	95	785	17	15	9	189	11	227	$10,168.66	75	11	30	2
Cuming	102	0.98%	26	281	6	8	6	159	*	269	$10,835.08	38	17	20	30
Custer	113	0.00%	27	275	11	10	9	178	*	332	$11,866.58	27	12	20	56
Dakota	399	4.26%	158	1,607	25	21	26	265	12	586	$9,686.14	140	19	188	336
Dawes	83	1.20%	20	286	3	2	7	143	100	159	$11,426.40	0	1	141	51
Dawson	401	5.99%	189	1,585	32	45	25	349	38	805	$10,325.63	61	56	128	370
Deuel	14	7.14%	9	61	0	6	0	33	*	64	$16,115.36	10	1	2	6
Dixon	76	3.95%	25	206	3	5	5	87	*	191	$10,223.31	0	4	18	6
Dodge	520	3.27%	143	1,607	32	41	29	440	83	1,172	$9,508.52	125	87	315	280
Douglas	8,533	2.89%	2,721	28,097	564	435	657	5,871	987	14,116	$9,541.31	1,088	1,829	14,409	4296
Dundy	20	0.00%	4	43	1	4	2	18	0	71	$15,545.77	10	2	2	0
Fillmore	70	7.14%	23	150	5	12	5	92	*	235	$12,836.57	17	11	86	3
Franklin	36	2.78%	6	67	0	1	3	26	*	55	$10,815.49	32	2	1	6
Frontier	28	0.00%	5	54	1	3	1	66	*	98	$13,359.29	10	6	10	6
Furnas	47	2.13%	14	99	2	5	5	96	*	220	$12,598.39	20	14	11	4
Gage	275	1.45%	64	784	16	30	21	192	19	702	$10,010.91	87	29	84	156
Garden	15	0.00%	1	35	1	3	1	25	*	34	$15,624.83	10	1	8	0
Garfield	20	5.00%	4	25	2	2	0	29	0	53	$11,673.29	17	3	1	0
Gosper	13	0.00%	7	48	3	2	1	20	0	59	$11,658.18	10	2	4	2
Grant	8	0.00%	0	6	0	2	0	15	*	13	$19,828.59	0	0	3	0
Greeley	34	0.00%	5	50	4	3	0	39	0	98	$13,907.21	25	6	3	0
Hall	999	4.10%	400	3,688	65	56	67	669	90	1,388	$9,438.32	185	197	461	817
Hamilton	116	0.00%	20	199	6	8	6	137	*	288	$10,536.47	18	10	17	3
Harlan	32	3.13%	5	61	2	3	2	19	*	59	$11,492.83	10	4	5	26

County Indicator	18.	19.	20.	21.	22.	23.	24.	25.	26.	27.	28.	29.	30.	31.	32.
Hayes	9	0.00%	2	13	0	3	0	16	0	15	$17,134.70	0	0	1	0
Hitchcock	32	0.00%	2	57	3	2	3	15	0	42	$15,058.88	10	2	1	3
Holt	130	0.77%	21	258	7	14	12	170	0	300	$14,247.69	46	18	19	34
Hooker	8	0.00%	1	10	0	0	0	12	0	22	$14,749.36	0	1		0
Howard	69	2.90%	13	170	1	1	5	105	*	168	$10,122.71	20	7	18	3
Jefferson	82	2.44%	28	213	5	6	4	128	*	395	$11,511.88	0	10	30	15
Johnson	48	0.00%	15	128	1	7	3	74	*	124	$11,496.31	0	6	27	1
Kearney	89	0.00%	16	161	7	9	9	107	*	301	$11,414.89	17	13	16	26
Keith	73	2.74%	32	275	11	7	10	97	*	172	$10,929.52	17	12	20	83
Keya Paha	8	0.00%	3	9	0	0	0	*	0	*	$18,442.47	0	0		8
Kimball	41	2.44%	9	145	2	4	3	38	*	57	$12,826.74	17	8	14	3
Knox	108	4.63%	30	298	7	22	8	129	*	266	$12,481.01	18	1	22	8
Lancaster	4,226	2.18%	916	10,746	244	175	298	2,670	394	6,602	$9,115.11	600	879	4,109	3248
Lincoln	517	2.51%	126	1,575	31	38	50	425	63	984	$9,613.42	70	136	221	366
Logan	6	0.00%	2	13	1	2	0	15	*	34	$14,451.21	0	2	3	0
Loup	4	0.00%	0	5	0	1	0	13	0	26	$12,836.70	0	0		0
Madison	537	2.42%	183	1,922	34	31	37	499	28	978	$10,413.98	118	83	308	482
McPherson	6	0.00%	1	10	0	0	0	*	*	16	$22,025.73	0	0	1	0
Merrick	96	2.08%	13	202	5	11	7	93	0	156	$10,272.78	16	10	17	2
Morrill	72	1.39%	23	184	6	8	5	60	11	112	$11,755.56	20	4	29	37
Nance	43	0.00%	10	101	3	10	2	71	*	109	$10,413.58	16	6	8	14
Nemaha	96	2.08%	22	208	2	8	8	78	*	189	$10,174.04	0	8	31	31
Nuckolls	43	2.33%	16	106	3	6	2	80	*	256	$12,908.95	35	4	19	3
Otoe	200	2.00%	51	570	17	19	18	235	13	442	$9,921.34	0	38	75	90
Pawnee	36	0.00%	2	46	1	2	7	41	*	81	$13,179.77	0	1	6	6
Perkins	36	2.78%	4	58	1	2	4	28	*	73	$15,918.56	10	2	2	7
Phelps	126	1.59%	20	279	5	8	14	123	10	312	$9,761.35	17	19	13	28
Pierce	99	1.01%	15	168	4	8	4	134	*	219	$11,196.56	29	4	21	20
Platte	484	3.51%	142	1,347	35	35	33	454	33	818	$9,127.81	189	42	180	440
Polk	54	0.00%	7	114	2	9	3	97	*	189	$11,780.32	0	4	15	11
Red Willow	146	0.68%	27	372	7	10	6	148	13	346	$10,790.64	18	18	58	107
Richardson	86	1.16%	29	267	3	11	6	121	10	259	$12,039.94	0	9	49	81
Rock	15	0.00%	3	17	0	0	0	17	*	29	$16,836.61	0	0	1	2
Saline	211	6.16%	67	633	7	12	10	201	14	407	$9,823.56	52	16	82	101
Sarpy	2,605	1.46%	358	4,520	115	99	168	1,782	51	3,412	$8,926.03	185	237	1,197	1365
Saunders	246	0.81%	37	465	14	24	17	248	*	447	$10,290.28	44	22	58	55
Scotts Bluff	568	4.40%	277	2,156	34	46	49	405	38	764	$9,885.61	334	103	392	343
Seward	190	1.05%	22	319	8	13	13	202	13	367	$10,289.39	17	28	44	49
Sheridan	48	4.17%	21	237	5	5	2	62	*	144	$12,964.76	0	7	29	58
Sherman	38	0.00%	6	73	4	4	1	28	*	85	$12,865.21	18	5	6	0
Sioux	12	8.33%	2	12	0	0	0	*	0	*	$23,627.49	0	0	1	0
Stanton	80	1.25%	16	150	1	7	6	33	0	84	$11,070.94	17	5	16	37
Thayer	49	2.04%	8	98	2	11	5	77	*	172	$14,839.80	17	1	10	22
Thomas	6	0.00%	3	8	1	3	0	*	0	15	$21,706.35	0	1	2	1
Thurston	149	6.71%	125	1,150	16	17	9	81	12	340	$14,192.87	209	7	317	0
Valley	38	2.63%	8	89	3	4	1	50	0	98	$13,704.87	26	5	11	0
Washington	218	0.92%	24	457	12	17	11	286	13	522	$9,302.04	18	14	104	95
Wayne	97	1.03%	12	251	9	9	4	122	*	203	$10,115.06	18	12	54	11
Webster	47	2.13%	7	88	4	5	6	49	0	121	$10,701.60	37	1	8	4
Wheeler	6	0.00%	0	16	2	1	0	11	0	14	$18,797.03		0		0
York	179	3.35%	40	511	8	5	15	192	*	421	$11,737.19	51	33	39	167
State Total	26,992	2.57%	7,319	77,460	1,624	1,670	1,909	21,615	2,290	48,017	$10,023.20	4,951	4,448	24,740	15109

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 – The report utilizes data from the U.S. Census Bureau 2000 Census of Population and Housing, the U.S. Census Bureau 2009 Population Estimates Program, and the U.S. Census Bureau 2009 American Community Survey.

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

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

Selected Indicators for the 2010 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."
- ***Safety Assessment:*** A focused information gathering, decision-making and documentation process conducted in response to a child abuse/neglect or dependency report in which possible threats to child safety are identified, analyzed and understood. Through the collection and analysis of discrete information sets, the safety assessment guides decisions about the presence or absence of present danger or impending danger to a vulnerable child, resulting in a decision as to whether a child is safe or unsafe. Safety assessment is continuous and is used to guide key decisions throughout the involvement with the family.
- ***Court Involved case:*** A case in which the child or children in the family are determined to be unsafe during the safety assessment process, and for whom ongoing services are necessary to address identified safety threats, and the involvement of the court is required to assure the necessary oversight of the family's progress and the child's safety.
- ***Non-court Involved case:*** A case in which the child or children in the family are determined to be unsafe during the safety assessment process, and for whom ongoing services are necessary to address identified safety threats and the family can and is willing to work with DHHS without the involvement of the court.
- ***Safe:*** Children are considered safe when there is no present or impending danger or the caregivers' protective capacities control existing threats.
- ***Unsafe:*** Children are considered unsafe when they are vulnerable to presence of impending danger, and caregivers are unable or unwilling to provide protection.

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

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

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

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

Early Childhood Care and Education

Data sources: The number of children under five in Nebraska was determined by the U.S. Census Bureau 2009 Population Estimates Program. The number of children with parents in the workforce was obtained from the U.S. Census Bureau's 2009 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. Families who had not received ADC were eligible only if their income was at or below 120% of the federal poverty level. Subsidies are paid directly to a child care provide.

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. A state license is required.

Early Child Data Coalition Indicators – 1) Percent of licensed child care providers receiving child care subsidy; 2) Number of licensed child care slots per 1,000 Nebraska children (0-8); 3) Number of Nebraska children (1-8 years) who die of an unintentional injury, per 100,000; 4) Rate of substantiated child protective services cases per 1,000 Nebraska children (0-8); 5) Percentage of Nebraska children 0-8 with family incomes less than 100% of the federal poverty thresh-

old; 6) Percent of Nebraska children (0-8) who do not have health insurance coverage; 7) Percent of children 19-35 months who have received the 4:3:1:3:3 immunization series; 8) Prevalence of new mothers who experienced maternal depression related to their most recent pregnancy; 9) Percent of mothers who participated in parenting classes during their most recent pregnancy; 10) Percent of at risk children enrolled in quality early childhood programs; 11) Percent of mothers who report ever breastfeeding their infants; percent of mothers who report breastfeeding at 6 months; 12) Percent of children born at a low birth weight (less than 2,500 grams); 13) Infant mortality rate (per 1,000 live births); 14) Number of children 0-8 in out of home placement; 15)Teen Birth Rate (per 1,000 females age 15-19).

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. A state license is required.

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

Economic Well-Being

Data Sources: Data on poverty levels and single parent families in Nebraska were obtained from the 2009 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, child support collections and homelessness 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 – Nebraska has used the definition for graduation rate developed by the National Center for Educational Statistics (NCES) since 2002-2003, and this definition is used in this report. 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 students 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 in the Nebraska Staff and Student Record System (NSSRS) to allow the state to calculate the new graduation rate as defined by the U.S. Department of Education. The new graduation rate, the Cohort Four-Year Graduation Rate, follows a cohort or group of students that begins in grade nine in a particular school year and graduates with a high school diploma in four years or less. The new definition utilizes net transfers rather than dropouts to calculate the graduation rate. Nebraska will publish the Cohort Four-Year Graduation Rate, starting with the 2011 Graduation Cohort, at the end of the 2010-2011 school year.

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 were provided by DHHS. Data on maternal smoking were provided through the Pregnancy Risk Assessment Monitoring System (PRAMS) program at DHHS. 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 Current Population Survey, Annual Social and Economic Supplements 2003-2009. Data related to pertussis, immunizations, STDs, HIV/AIDS and blood lead levels were provided by DHHS. Data related to adolescent risk behaviors, sexual behaviors and use of alcohol, tobacco, and other drugs were taken from the 2005 Youth Risk Behavior Survey. Additional data on youth smoking were provided by the Campaign for Tobacco-Free Kids. 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 Kotelchuck 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 were provided by DHHS, Office of Juvenile Services. Data on youth committed to YRTC programs were taken from the programs' annual reports. Data on youth arrested/convicted of serious crimes were provided by the Crime Commission. Data concerning juveniles on probation were provided by the Administrative Office of the Courts and Probation.

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

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

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

Nutrition

Data Sources: Data on households receiving SNAP 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, adoptions and number of placements were provided by DHHS. All other data were provided by the Nebraska State Foster Care Review Board.

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

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

Multiple Placements –

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

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

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

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

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

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

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

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

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

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

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WELLS FARGO

MISSION STATEMENT

Voices for Children in Nebraska educates and motivates Nebraskans to take action to better the lives of Nebraska's vulnerable children in the areas of health, education, safety and economic stability.

VISION STATEMENT

Widely recognized across the State and revered a the trusted expert and advocate for key children's issues in Nebraska.