Approved _____
Date

MINUTES OF THE HOUSE COMMITTEE ON FEDERAL & STATE AFFAIRS.

The meeting was called to order by REPRESENTATIVE ROBERT H. MILLER at
Chairperson

1:30 a.m./p.m. on March 3, 1988 in room 526S of the Capitol.

All members were present except:
Representative Sifers

Committee staff present:
Mary Torrence, Revisor's Office
Mary Galligan, Research Department
Lynda Hutfles, Secretary

Conferees appearing before the committee:
Representative Marvin Barkes
Sister Anna Totta, Leavenworth
Christi Shelton, Leavenworth
Dr. Art Cherry, Topeka
Nola Turner, Shawnee County Health Department
Father Richard Etzel, Topeka Family Shelter
James McHenry, Ks. Commission for the Prevention of Child Abuse
Bruno Finnochari
Barbara Buehler, United Community Services
Nancy J. Perry, United Way of Topeka
Cindy Robinson, Kansas Action for Children
Jan Allen, SRS
John Pierpont, Children & Youth Advisory Committee
Kathy Johnson, Families Together, Inc.
Dr. Ed Flentje, Secretary of Administration
Melissa Ness, Kansas Children's Service League
Mary Jane Apel, Kansas Coordinator for Child Care
Elizabeth Taylor, Kansas Association of Local Health Departments
Judy Culley, The Shelter, Inc.
Judge Mitchel, Shawnee County Juvenile Court Judge
Rosemary Menninger, Alternative Education Program
Dr. Ben Rubin, American Pediatrics, KCK
Kathy Gibson, Catholic Social Services
Carla Daniels
Sister Theresa Bangert
Bob Heckler, Catholic Social Services
Eleanor Lowe
Katie Mallon, Kansas Action for Children
Nick Morks, Big Brother, Big Sister, Sedgwick County
Mike Brown
Bob Kitts
Sylvia Evans, KNI

Afternoon Session - Child Care Hearings

The afternoon meeting was called to order by Chairman Miller. An agenda was provided to the committee with a list of conferees for the afternoon and their phone numbers. The chairman said he tried to organize the meeting so that the testimony will flow in an orderly and understandable fashion. Instead of having questions from the committee members, the chairman asked that they contact the individuals and if they think a particular conferree has more to share with the committee to contact the chairman and he will be glad to schedule additional time at a later date for the conferee to come in.

Representative Barkes expressed his support of the committee hearings focussing on the needs of Kansas children. Although the state must shoulder some of the responsibilities for the failure to meet our children's needs, Representative Barkes said he believes the problem represents a failure of society as a whole and is a challenge for all parents and all institutions in both the public and private sectors. See attachment A.

Sister Anna Totta, St. Vincent's Clinic in Leavenworth, told the committee that St Vincent's opened two years ago to provide medical services to the medically poor. They found that although their income guidlines allow persons at 150% of the proverty level or below to use their services, 75% of the patients lived at or below poverty level. 67% of the patients came from families whose incomes are minimum wage or less, still 71% of the patients show someone in the household is employed. So often the poor are labeled undeserving. The medically poor are struggling families who are working. Their patients work at jobs which pay them minimum wage - fast food, nursing home, child care, gas station attendants, etc. The main reason they do not have health insurance is beacuse their employers do not offer health insurance as a benefit or offer little help in the way of insurance benefits. Data from the Department of Health & Environment suggests that ¼ of all Kansans are poor and uninsured or under insured -481,000 persons - only 38% of those below proverty level will receive medicaid -240,000 children.

Sister Totta said she thought the Leavenworth Community is not much different from the rest of the medically poor in the state. 42% of their patients are children. St. Vincent's Clinic has very limited services. There are only 8 charity clinics in Kansas and four of them are in Wichita. None of these provide care to the pregnant woman or neonatal care. None of them have the funds to pay the malpractice costs.

Health care at the primary level should help prevent very expensive care for babies born with health problems, low birth weights, or prematurely. Kansas ranks 14th in the nation for infant mortality. Over ½ of the states have opted for the medicaid option. If Kansas does not, they will probably rank even lower. Beyond the medical option, one solution would be to increase eligibility on the federal and state levels for other poor families up to 100% of the poverty level. Another solution would be to adopt laws which require more businesses to cover employees with insurance.

Sister Totta introduced Christi Shelton and her children who use the clinic at Leavenworth.

Christi Shelton explained that her husband works a 40 hour week and makes approximately $14,000 per year. The company he works for provides health care, but they have to pay $192.00 a month. The cannot financially do this, thus they have no insurance. They have three children.

Dr. Art Cherry, Topeka Pediatrician, told the committee that 25% of his practice is medicaid. Children who are in the medicaid system are getting pretty good care - a lot better than when they went to the Shawnee County Health Clinic and sat on the bench on Friday afternoons. They never saw the same doctor twice. More children and more mothers are needing care. Kansas needs to avail upon itself to give more care. Dr. Cherry said he spends ½ of his time preventing illness. He explained a program, EPSDT (Early Periodic Screening Diagnosis and Treatment).
In order for services to be paid for by medicaid under this program, children must select a primary physician. Under this program he detects needs, keeps immunizations up to date, checks hearing, sight, etc. He can also talk to the parents about the growth and develpment of their child; can pick up problems before they become serious problems. Currently, it costs $250 per day to be in the hospital in Topeka. He can provide immunizations for less than that. This is just room and board and does not include medications etc. Hospitalization for a premature baby at Stormont Vail Hospital runs from $800-$1,000 a day for medical care. If we can prevent one premature baby, we can save a considerable amount of money.

Nola Turner, Program Director at the Shawnee County Health Department, told the committee she is in charge of implementing the WIC program. Women and children in Kansas do not have adequate medical care. Too often federal and state monies are spent trying to solve problems created by the unavailability of health services. Expansion of medicaid guidelines to 100% of the poverty level is necessary.

Early, adequate prenatal care is a must. Kansas Children are tommorrow's leaders. They do not have a choice as to the environment in which they live and they cannot be their own advocate. It is the responsibility of the state to ensure that they have the opportunity to achieve their greatest health potential.

Father Richard Etzel explained the Topeka Family Shelter which has been in operation since April, 1987. In that period of time they have served ten families. A family stays with them for a 90 day period, develops a savings account immediately so the family will have enough on hand after 3 months to rent its own space, and receives individual tutoring on jobs, budgeting, homemaking, and community relations.

Father Etzel spoke to the shortage of housing. Many homeless children are in families that have an income or are among those who have meager family resources. The availability of housing stock for the poor and the near poor in most communities is decreasing. No programs exist to meet the needs of this economic group. Many homes that could be used by the indigent, are left unused and abandoned in our communities because landlords cannot afford to keep them open for use. The lives of children who are homeless are terribly affected. These children may never have the chance to develop their potential unless their lives can be stabilized. They do not eat nutritious foods and their health is suffering. Father Etzel suggested that a way must be found to save and rehabilitate the houses being torn down, so that these units can become homes for the poor. A task force should be created to do a good survey on homeless children in families, develop a plan of action, with guidlines for implementation, and call on all segments of society to cooperate in the efforts of the task force. See attachment B.

James McHenry, Kansas Commission for the Prevention of Child Abuse, presented some practical alternatives. Mr. McHenry told the committee that we have in Kansas two programs available - Healthy Start Program and Parents as Teachers. These programs will significantly effect a whole stream of social problems including teenage pregnancy, people who are dependant on the welfare system and more specifically child abuse and neglect. Parent education programs show a significant reduction both in instances of abuse and neglect.

Bruno Finnochari spoke to the committee on day care. High quality early childhood programs provide many benefits to Kansas children, families and comminities. Research findings have noted that children who attend high quality early childhood programs are more apt to achieve success in school, social and emotional competence and improved opportunities for health. The communities benefit from these programs in cost savings between $3 and $7 for every $1 spent on a year of early childhood education. There is a lowered reliance on social and welfare services; reduced unemployment and enhanced lifetime earnings potential; a lower crime rate and less delinquent behavior during the teen years; increased earning powers of mothers due to their expanded opportunities; fewer pregnancies and births through age 19 and improved access for community residents to educational, health, and social service systems. See attachment C.

Barbar Buehler, Chairman United Community Services of Johnson County, focused her remarks specifically on child care. Because of the dramatic increase in the number of single-parent and working-couple households, the non-family paid child care system - primarily family child care homes and child care centers - has become an essential component of our economic infrastructure. The provision of child care outside the home is essential, particularly when we consider that the fastest growing segment of the work force is women with young children. Establishment of a child care commission will give added weight to child care issues, and will develop a critically needed master plan for Kansas children. The legislature must make a genuine commitment to the issue of child care by investing dollars, time and leadership to ensure that affordable, accessible, available and high quality child care is placed in the first-priority category it deserves. See attachment D.

Nancy J. Perry, President and Chief Professional Officer of the United Way of Greater Topeka, strongly supported the need for quality child care in the community and throughout the state. Many states across the nation are developing innovative approaches to the issue and are attempting to establish funds for the training of child care providers. The Kansas Commission on Child Care would allow a qualified group of individuals to report back to the governor and legislature with a master plan for the continuim of care for Kansas children. The commission will be able to provide the necessary background information concerning where we've been and will recommend a master plan for the future. We must be aware of the growing need for child care and take the appropriate measures to ensure that child care needs are met. See attachment E.

Cindy Robinson, Attorney for Kansas Action for Children, spoke on juvenile justice issues. The two main issues on the juvenile justice system in Kansas right now are the treatment of juvenile runaways and the use of jails to detain youth. Kansas will receive no new federal funds in the area of corrections after October 1989 unless they release over 1,000 youths from jail by the end of this year or unless the federal law is changed. There were good reasons for establishment of the Juvenile Justice Act and the legislature needs to keep the following in mind when considering bills. There is a danger in putting impressionable youths in adult facilities; there is a danger of escalating children into justice system when they have not broken any criminal law; there is a danger of disproportionately locking up of runaway girls who were incarcerated at a much higher rate than boys and there is a danger in mixing offenders with non-offenders. There are no easy solutions to the problems. Kansas needs the cooperation of the Advisory Commission on the Juvenile Defense Program, the state Advisory Commission to the Juvenile Justice Act, SRS, Judges and all juvenile justice practicioners. There is a need for better training and support for front line practitioners to deal with the most difficlut children. There is a need for a more realistic funding mechanism for private practioners and a better monitoring and evaluation of pilot projects. There is also a need for more flexible licensing regulations to allow for experiments, and there is a need for unequivicable commitment from all parties, including the legislature to continue progress and not to backtrack. Otherwise, we will see more suicide in jails, expensive and extensive litigation and a whole generation of runaways discarded by the justice system.

Melissa Ness, Kansas Children's Service League, explained that the League is a statewide non-profit organization focussing their efforts on protecting, enhancing and promoting the welfare of Kansas children. They provide a variety of services dependent on local need. KCSL is a member of the Children's Coalition. Children cannot vote or lobby for policies and investment they need to grow up healthy and secure.

In order for children to have the best choice for survival they must have adequate food and nutrition, adequate shelter, access to medical services and adequate community intervention and support services for families in crisis. There are no single, quick or cheap fixes. The Children's Coalition has chosen an increase in AFDC cash grants, an increase in the number of available day care slots, an increase in foster care provider rates and an increase in the number of slots for child protective service workers, as their legislative priorities. Early and significant investment in basic survival needs of Kansas children is a good investment. See attachnent F.

Mary Jane Apel, Kansas Coordinator for Child Care, supports the establishment of a Child Care Commission. One important step toward good child care is quality training for child care providers so that they can build on their knowledge and skills and improve their ability to care for children. Many of the children are in child care for most of their waking hours, so we must be sure the children are cared for properly and in the kind of environment they need. Child care is the fastest growing business in the nation. There are about 20,000 providers in the state of Kansas.

There are many opportunities and courses available. Behavior and guidance, child development, working with infants and todlers, working with 3-6 year olds are just a few of the course available to the providers.

Ms. Apel told the committee that their organization would like to offer their experience and effective training in the planning and the establishment of the commission.

Elizabeth Taylor, Kansas Association of Local Health Departments, explained their three priorities for the 1988 session of the Legislature. The #1 priority this year is the state support of local health departments. Public health in Kansas is an area that has been neglected and allowed to struggle with limited resources. The public health care system has suffered from benign neglect and far too few dollars. Priority #2 is Aids prevention and control. The public health aspects of AIDS should be handled as other communicable diseases in that possitive blood tests should be reported to health departments and contact follow-ups should take place. The #3 priority deals with child care program enhancement. Local health departments are asked by the Kansas Department of Health & Environment to inspect child care facilities in their respective counties. Funding for this is based on the number and type of facilities, not the amount of local effort required to perform these functions for KDHE. Additional funding is needed for reimbursement for complaint investigations and for the processing of applications for registered facilities in addition to the existing licensure evaluations. The local health associations support recommendations for the Child Care Commission and would like to see the local health departments allowed some imput in the formation of this commission. See attachment G.

Kathy Johnson, Families Together, Inc., is a parent of a six year old child with cerebal palsy. She works with parents across the state of Kansas. Families Together is a non-profit organization which provides services for the parents of children with disabilities. Ms. Johnson supports HB2849 and also supports HB2053 which concerns school district equalization act effecting the definition of pre-school age exceptional children. Families with a disabled child have the same needs as other families with children except these needs are compounded. See attachment H.

Dr. Ed Flentje, Secretary of Administration, spoke on behalf of the Governor. The purpose of the Commission is to elevate the issues effecting children and families in Kansas and to help build an agenda for children and families. The issues cut across agencies, jurisdictions, a variety of institutions - public and private, state and local. A number of cabinet agencies are involved in responding to the needs of children and families. Services include an array of services - health & education, living assistance, medical care, custody, special education, employment, etc. There are a variety of needs. The Governor asked the Director of Budget to provide an estimate of what the state is now doing in the area of children and the Budget Director compiled an array of programs and services. $1.8 billion is budgeted for these services. That is roughly ½ of the entire budget. The Governor made a number of recommendations to augment those programs that respond to children and families, but at the same time there are a number of needs that are not fully met. There are issues that are not yet resolved and problems not yet to be fully identified and addressed. We have not fully worked out how this commission on children and families will be constituted but welcome suggestions on how it should be constituted and defined. The commission should identify choices available to Kansans, identify issues and to solicit public input and report back to the Governor and the legislature. They should provide the Governor and the legislature with an agenda for children and families and it is their intent that the Commission does not last more than one year.
The commission needs to prioritize the various demands in this area and provide guidance to the Governor and to the legislature in a very critical area of public concern.

Jan Allen, SRS, Commissioner of Adult Services, discussed briefly the needs of Kansas families for quality care that is accessible and affordable. There is an increasing demand for quality child care. It is estimated that by 1990, 60% of all children will be cared for outisde the home. Without child care at a reasonable cost, low income families cannot work and become self-sufficient. See attachment for summary of annual expenditures and children served and testimony - See attachment I.

John Pierpont, Children & Youth Advisory Committee, spoke to the health needs of young children and about the Healthy Start/Home Visitor program. Healthy Start/Home Visitor programs promote newborn and child health by providing information, referrals, support and transportation to parents with or expecting a newborn. They learn about WIC and EPSDT Services and have contact with a supportive person who is knowledgeable about parenting and child care. Healthy Start/Home Visitor programs, when properly executed have been shown to reduce the incidence of chld abuse to infants; the incidence of preventable childhood diseases; and the number of serious childhood injuries in the families served. Both pre and post natal care programs are vital to our children's health. See attachment J.

Wint Winter spoke to child abuse, family abuse, child death, low birth weight. There are many children's deaths due to child abuse. Why are these deaths on the rise. Reports of child neglect have esculated 210%. It is wrong for us to know about child abuse and child neglect and not tell the people of Kansas about it. The formation of the Child Care Commission is a step in the right direction. We have a lot of Kansas children at risk and we need to do something about it. 24% of the children are living in families that are at a level of income that is below 50% of the median income and there is no other industrialized nation where this occurs. We have too many children living in families with too little income. It is your responsibility, as legislators, to make people aware of the conditions in the State of Kansas. When this condition is made known, the people of Kansas will come to you for additional support for children in Kansas.

The meeting was recessed until 7:00 p.m.

Evening Session - Child Care - March 3, 1988 - 7-9p.m.

The meeting was called to order by Chairman Miller. He told the committee that unlike the afternoon meeting, questions would be allowed. An agenda of names and phone numbers was made available to committee members.

Judy Culley, Administrator, The Shelter, Inc., told the committee that the state is involved directly and inderictly in the lives of many children through its medical programs, its educational programs, its recreational programs, etc. As the administrator of an emergency shelter in Lawrence, Ms. Culley said she is familiar with the needs of children in the state's custody. Their facility serves as emergency/temporary placement for those children removed from their homes by SRS or law enforcement. Ms. Culley explained a simplified diagram of the process whereby a child goes from being identified as in need of services to the point that custody is revoked. In order for their needs to be met, all of the services that are listed must be made available to them. Until all of these services are adequately funded the state will not be sufficiently addressing the needs of the children whose lives have been entrusted to the shelter. See attachment K.

When asked about the number of children served at one time, Ms. Culley said they can serve 10 children at a time. Last year they served 156 Children. Ms. Culley said they can serve children up to 90 days. The age of the children served in the facility are 12-17. They have had children who have had as many as 20 placements.

Judge Mitchell, Juvenile Court Judge in the 3rd Judicial District in Shawnee County, told the committee he has been on the bench since October, 1985 and was asked to come to appear before the committee to address some children's issues. There are many of these issues that need to be addressed. We have a responsibility to provide for the best interests of these children who come before us. We are sorely in need of additional resources. SRS needs additional funds and additional workers. We need the tools with which to work and assist these children.

One of Judge Mitchell's major concerns is the modification in the law concerning children who are runaways. These young people (14-16) who run away and the systems inability to effectively deal with them are of great concern. Under current law we cannot maintain these children in a secure facility. We have in effect a revolving door situation with the ultimate result that these children are being placed in group home settings, shelters or foster care setting and simply going in the front door and out the back door. We cannot identify or address the problem that causes the children to run if we cannot maintin them for a resonable period of time to evaluate their needs and to develop appropriate therapy or counseling.

Judge Mitchell suggested that the courts should be allowed to place the runaway in a secure facility for a period not to exceed 90 days. A secure facility has controlled ingress and egress. There should be a safeguard placed in the legislation that a child being placed in such a facility for the purpose of evaluation can only be placed there once in a 12 month period so that the facility does not turn into a warehouse. We have to identify the problem before we can help with it. We are dealing with the future of Kansans. We cannot ignore or delay; we must address the needs of the children of Kansas. We are having a problem with prison overcrowding. This problem will only get worse if we don't do something now.

There was discussion of the 300 juvenile cases that were referred to that the district attorney's office, (these were not all child care cases) that the district attorney's office did not have the time to get through the process. This is 300 cases over and above the 2,010 cases there were filed in 1987. There are three assistant district attorneys that deal in the area of juvenile law. There is one judge, Judge Mitchell. He spends 40% of his time (2 full days a week) calling dockets trying to keep track of the cases and trying to keep a handle on the cases so that they know what is happening. There were 1500 cases in 1986 and 940 in 1982. This caseload will continue to increase until affirmative action is taken to address the needs and issues of children. If the problems are addressed at an early age, we will be far ahead.

Shelly, Laurie, Valerie, Leslie, & Linn with their alternative education program teacher, Rosemary Menninger, gave a presentation on teenage pregnancy. The young ladies discussed the need for state funding for day care in the #501 district program. There are more teenage pregnancies than ever before and there is a need for low cost day care in the school so these young girls can afford to leave their children and finish their education.

They discussed what kind of cooperation and support they each received from their respective family and the father of their child. They all felt there should be someplace for the fathers to go for advise and counseling.

They all agreed there was not enough sex education taught in the schools and that young girls needed to be better prepared for sex and its consequences at a much earlier age than high school, preferably junior high or even sixth grade. They also felt there should be more information on the choices they have when they do become pregnant - abortion, adoption, and keeping the child. In discussing the adoption alternative, it appeared that the main reason for choosing the adoption alternative might be the financial aspect. All the girls agreed that they could not have given their child up for adoption because of things they had heard about abuse and they did not feel they could go through life not knowing where their child was or what kind of life he was living.

The main goal of these girls was to finish school, go to work and care for their child.

Dr. Ben Rubin, Kansas Chapter of the American Pediatrics of Kansas City, Kansas, encouraged the legislature to fund the program that would give a medicaid card to pregnant women and children. Dr. Rubin has practiced in KCK for 24 years

out of two offices (inter city and surburban). He sees women who come in and have had no prenatal care and seriously ill children. He discussed the EPSDT program which he feels is very successful and provides a medical home for children and has seen to it that pregnant women have received medical care. Many of these women work, but just don't make enough money to pay their medical bills.

Kathy Gibson, representing ASSIST a service of Catholic Social Services, told the committee they help single young mothers age 14-21 by providing support and an appreciation for thr necessity of setting goals. Ms. Gibson introduced Carla Daniels, who participates in their program.

Carla Daniels shared with the committee what it is like being on ADC (Aide to dependent children). She said her family had been on ADC and welfare for as long as she could remember. She grew up on welfare and that is the only thing she knew. She realized as she got older that there were people who were not and that became her goal - get off welfare. Carla has three children and is going to Platt school studying to be a secretary. She wants to get a job so she can take care of herself and her children. She feels she will need to make at least $5.00 per hour to make her payment and make a living for her family Carla has no family in Topeka and depends on Assist for support. Each month she decides which bills need to be paid and which one she will let go. She gets further in debt each month; sooner or later this will catch up with her. Her last class was to be the next day and then she would go out and look for a job. She told the committee she has paid child care until March 25, so she is hoping to find a job in that time so she does not loose her day care slot.

There was discussion of the father of her children and the problems she has had with him paying child support. Also discussed were the questions asked by SRS while trying to get them to help her with child support. These questions were very personal. The grants and loans she received to attend Platt College were also discussed.

Carla told the committee that she is going to get off welfare, get a job, and try to instill in her children that there is more to life than being on welfare.

Sister Theresa Bangert, Catholic Chaplain at the Topeka State Hospital, read a poem she had written about a child she worked with for three years at the hospital. See attachment I.

Bob Heckler, Chatholic Social Services, is head of Therapeutice Foster Care and explained how their organization works. They are targeted toward kids age 10-18 with severe emotional problems who have little or no chance of being with their parents and could spend many years in a state institution if there isn't a way to get out. One goal is to keep the kids as long as they can so that they can settle long enough to develop trust and work through their anger and grief due to the trauma and caos they have experienced for most of their lives. They also help them establish meaningful relationships and connections with some of their family members and help them to learn to think for themselves so that they can achieve optimum independence rather than be dependent.

Mr. Heckler said they expect their kids to learn job skills and to attend school. Some are in special education classes and some have been mainstreamed into regular classes. They have had 27 kids and only a few of them have had to return to the hospital. They currently have two staff members. There are 11 kids currently in the program with 9 families to provide foster care and two practicing students who give extra manpower. They have no secretarial staff. The services monitors foster homes, provides education, jobs, medical needs, individual and group counciling for relatives. They recruit and train families to provide care, assist and provide recreationsl activities for the kids and are available to help in a crisis situation.

Eleanor Lowe told the committee she is a volunteer citizen advocate and past president of Kansas Action for Children. For the past few years one of the

goals for Ks. Action for Children has been to promote family-centered, home-based services to troubled families. She explained how this has evolved into the Family Preservation Project in Kansas. She also highlighted some of the activities of Kansas Action for Children, specifically, their work in promoting public awareness, understanding and wider community involvement in this project which is being implemented by SRS. See attachment M.

Katie Mallon, President, Kansas Action for Children, Inc., explained to the committee that her organization is a private, not-for-profit, organization of Kansas citizens. Their mission is to ensure that the needs and rights of children in Kansas are identified and met. Rather than helping children on a case by casse basis through direct service, our members are volunteers who are committed to advocating for needed changes in public policies and systems serving children. See attachment N.

Ms. Mallon asked the committee how anyone could expect a return of the windfall to the people if we expect to provide the needs of children being discussed at the hearing. This money should be used for children. The Harris poll says 3 out of 4 people would rather see their tax increase if these programs can go to children's services. It is how you spend the money! You can go back to your constituents and say "no we are not going to give you the windfall back - You know why? - Cause this is what we are going to spend it on". When you tell them of the worthy programs and the good that it can do for the children in Kansas, your opposition will fade quickly.

Nick Morks, Big Brother,Big Sister Program in Sedgwick County, spoke to single parent families. Economic and social pressures have significantly altered family life for all kids. Especially those in one-parent families. There is a significant proportion of our school age population that is at high risk for drug and alcohol abuse, teenage pregnancy, physical and sexual abuse and dropping out of school. He said that when he started teaching in 1970, 1 out of 15 children were one-parent families. In 1987 the number is 1 out of 3 in the Wichita Public Schools who come from one-parent families and he said he believes this is a statewide figure. This says that we have a serious problem. 49% of all pre-school students in public schools are from single parent families. Single parent kids are more likely to cause trouble in the classroom as a group. Most of the kids spend too much time in from of the TV with role models that are not very positive. Mr. Morks said that as you consider the future, you must consider the needs facing single parent families. Deficiencies in the lives of these children lead to many of the social problems facing us today - Drug and alcohol abuse, teen pregnancy, etc.

Mike Brown, registered nurse specializing in maternal-child health, asked the committee to consider stimulating more state-wide public and private efforts to help Kansas children prevent serious health complications from sexual activity, such as preteen and teen pregnancies. See attachment O.

Bob Kitts expressed his views as a parent who has nine children and three grand-children. He is a disabled veteran on social security disability. He told the committee of problems he has had with his 12 year old son and that he allowed SRS to take custody of his son. He said this was the most tragic mistake he has ever made. He related problems he has had since his son has been with SRS. He said if he had treated his son the way SRS has, he feels he would have been in jail for child neglect and abuse. There is no cooperation by SRS and the court. He has had to inform his probation office as to what is going on. His best friend at this point is the district attorney who is supposed to be prosecuting his son and his son's probation officer.

He told the committee that it is a tragic mistake to handcuff 12 year old boys and drag them publicly into court which is done on a daily basis in Shawnee County. All we are doing is fostering criminals. These young people need a place where they can be screened and find out what their problems are. He related to the committee that when he was in court the day before and his wife had to

go to Stormont Vail Hospital to sign a medical release to sew his son's mouth up. The people at SCYC are not loving people, they take points away from kids if they say, "dam". He has been locked in his room ever since he has been out there. There is nothing he can do about it. If I made enough money he wouldn't be there to start with. He said he has never felt such frustration, anger and contempt for what is going on with his son. He has contempt for himself because he was so stupid as to be trusting in somebody that really doesn't care. He said he cannot even get in touch with his son's social worker. His counselor told him he would be getting out this week, and I am the one that has to tell him that he is not. I'm also the one who has to pay the $1,000 restitution because he was shot at and run off the road in Oklahoma.

Mr. Kitt said that he has worked as a policeman and a detective, has coached and tried to help and do things for kids and now that he needs help, where is it. The people getting paid to care of his son are not doing it. He advised the committee to be very careful where funds go and to see if maybe some of these funds should be cut entirely.

Sylvia Evans, Registered Nurse at KNI Community Service Unit, explained that they evaluate children who are referred from SRS, the courts and private citizens. Most of these children are either mentally or developmentally handicapped. The evaluation takes about two weeks. There is a waiting list of approximately 35 children. She said she was not asking for funds to start a new program. She would like the legislatuare to consider expansion of their existing program and possibly a satalite program where they can send skilled people into the home to show the parent hands on experience in dealing with the child so that the kids don't end up in an institution. Respit care in the home also needs expanded.
The costs of instutionalizing these children (cost and selfworth) is astronomical, whereas training children so they can stay at home is a much less.

Hearings were concluded.

A

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HOUSE OF
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Testimony, by Rep. Marvin Barkis
To the House Federal and State Affairs Committee
Special Hearing on Children's Issues
March 3, 1988

I want to thank the Chairman and the members of the committee for the opportunity to testify today. I also want to thank the Speaker for his part in setting this day as a day for all of us to focus on the needs of Kansas children.

I am the father of three children, Anne (14), Will (8), and John (5). I love my children and I love being a father. As a father, I want the best for my children. I have also come to feel very strongly that my love and my responsibilities should not end with my own children but should extend to and include all children.

This last year in my law practice I had several cases involving unusually painful children's situations. It really hit me that things were not going well for many children in my county. The more I focus on this area, the more my sense of crisis is reinforced. I believe that we have not and are not adequately meeting the needs of our children -- that we are faced with a silent crisis, a crisis that is shared by the rest of the nation.

Although the state must shoulder some of the responsibility for the failure to meet our children's needs, I believe the problem represents a failure of the society as a whole and is a challenge for all parents and all institutions in both the public and private sectors.

The conferees you will hear from today will profile the nature of the crisis and I hope they will also propose some solutions. It will then be up to you and me.

There are many good reasons for us to act.

First, it is our duty to do our best work where it is most needed. Second, it is a wise investment for our taxpayers who will then avoid paying the price tomorrow for the neglect of today's children. Third, it is a wise investment for our state's economic future, since it is the children of today who will be tomorrow's workers and tomorrow's consumers. Finally, and most importantly, it is our moral duty.

Attach A

Too often our democracy seems to respond to problems only when they reach crisis levels or when they are on the agenda of a powerful interest group. Unfortunately, children's issues have not been on the agenda of the powerful and have not been perceived of as having reached the critical stage. It is time we realize that our failure to address these issues will produce a crisis tomorrow in dimensions we cannot fully comprehend.

But this much we know...

Those children whose mothers do not receive good prenatal care and nutrition will be the medical problems of tomorrow.

Those children who are not sheltered from violence will likely become violent themselves and many of them will be the child abusers and convicts of tomorrow.

Those children who lose hope will be the welfare problem of tomorrow.

And those troubled children who see us turn our backs on them will turn their backs on us tomorrow.

We can't let that happen.

The challenge we must take to every community in this state is that we can all do more, and we can all make a difference. It is within our power to substantially improve the lives of thousands of Kansas children.

On this issue, unlike so many of the issues that we deal with each day, the good that we do for each Kansas child will literally last a lifetime.

Father Elgel B.

TOPEKA FAMILY SHEL[illegible] INC.
507 S.W. FILLMORE
TOPEKA, KANSAS 66606
(913) 232-1650

HOMELESS CHILDREN

Introduction and Outline.
To conserve time and save your eyes, my remarks about homeless children will be restricted to those children who are still part of a family, are not abandoned, nor wards of the state, because our target population at Topeka Family Shelter is families with dependent children. Like most of us Americans who suddenly find ourselves trying to cope with a social problem we had not realized before, we have only limited answers and suggestions.

The Topeka Family Shelter experience is the basis for the data we present to you today. We have been operating the Shelter, at 507 Fillmore, here in Topeka, since April of 1987. In that period of time we have served 10 families. A family

1) stays with us for a 90 day period,
2) develops a savings account immediately so the family will have enough on hand after 3 months to rent its own space.
3) receives individual tutoring on jobs, budgeting, homemaking, and community relations.

Just for your information, the 10 families have left the shelter with an average of $600 each in hand.
Since we began the operation, we have been receiving from 5-8 calls a week from families seeking shelter.

I offer a three part testimony here;

1) Numbers of Homeless Children is increasing because of a housing shortage and declining incomes.
2) Problems Homeless Children
3) Possible solutions

1) <u>Shortage of housing; Declining incomes:</u>

Many homeless children are in families that have no income or are among those who have meager family resources. These families may have non-employed parents with no work-related income, or may have under-employed parents who do not earn enough to maintain their own home. What these families can offer for rents and shelter payments is relatively small. If they fall behind on payments, whether caused by jobs that are not producing enough income, or caused by jobs they have lost, they become victims of eviction. Thus they live in their cars, abandoned buildings, or double and triple up with friends and relatives in usually already crowded conditions.

b) the availability of housing stock for the poor and the near poor in most communities is decreasing. With each house that is destroyed in the older parts of our cities, either by development or as a result of neglect, there is no new house to replace it. Hence each decade finds fewer properties available for rent. Where profits or dividends are to be realized from investment, it is not economically feasible for developers and investors to build new housing for the poor.

Attach B

c) No programs exist, that I know of, designed to meet the needs of this economic group. No federal, no state, no county, not township, no city or town program is available to reach this target group with adequate housing.

d) Many homes that could be used by the indigent, are left unused and abandoned in our communities because landlords can not afford to keep them open for use.

2) Hardship on children;

1) All of the families we have served have moved several times in the short lives of their children, moved not by choice but were forced to by economics. Their children show the effects of this turmoil in emotional problems and problems with school. Those of school age can not settle down to the routine of learning because their schools, teachers and classmates change two, three, and four times in one school year. They fall behind the other children their age, unless perceptive teachers and dedicated parents can offset this disturbance. Often times they are not in the same school long enough for teachers to have that type of impact, and their parents are so busy with coping and surviving, there is little time for this development.

2) These children may never have the chance to develop their potential unless their lives can be stabilized by a more permanent housing arrangement.

3) Children of the homeless do not eat healthily. Preparation of wholesome meals is not possible without a home.

4) Children's health is suffering. Nearly every family that has been brought through the program has had a series of youth health problems that generally were neglected because of homelessness.

In a word, the lives of children ~~is~~ are terribly affected by homelessness.

3) What might we do?

a) Find a way to save and rehabilitate the houses being torn down, so that these units can become homes for the poor.

b) Set up a task force to

i) do a good survey on homeless children in families, and available housing stock;

2) develop a plan of action, with guidelines for implementation;

3) call on all segments of society to cooperate in the efforts of the task force.

Otherwise, I fear we face in the future even more severe and dire problems among the growing under-class, i.e. more homeless children, less available housing stock, amidst a public malaiseof powerlessness.

Bruno Finnoc

C

HIGH QUALITY EARLY CHILDHOOD PROGRAMS AND THE STATE OF KANSAS

High quality Early Childhood Programs provide many benefits to Kansas children, families, and communities. Research findings have noted the following benefits:

I. BENEFITS TO CHILDREN

Who Attended High Quality Early Childhood Programs

A.) SCHOOL SUCCESS

1.) Were assigned to special education programs less frequently;
2.) Were retained in grade less often;
3.) Were more likely to graduate from high school and to pursue postsecondary education or training.

B.) SOCIAL AND EMOTIONAL COMPETENCE

1.) Exhibited more appropriate classroom and personal behavior during the primary and secondary school years;
2.) Showed greater achievement motivation and commitment to schooling;
3.) Rated themselves more competent in school;
4.) Were more responsible, talkative, and initiating in social situations.

C.) IMPROVED OPPORTUNITIES FOR HEALTH

1.) Had greater access to health care and improved physical health;
2.) Demonstrated improved nutritional status and better nutritional practices;
3.) Received better dental care.

II. BENEFITS TO FAMILIES

1.) Mothers viewed themselves and their children as more competent;
2.) Parents' involvement in the program led to changes for other children in the family similar to benefits found for enrolled children.

III. BENEFITS TO COMMUNITIES

1.) Cost savings between $3 and $7 for every $1 spent on a year of Early Childhood education;
2.) Lowered reliance on social and welfare services and associated cost savings for children who had attended high quality Early Childhood Programs;
3.) Reduced unemployment and enhanced lifetime earnings potential for children who had attended high quality Early Childhood Programs;
4.) Lower crime rates and less delinquent behavior during the teen years for children who had been enrolled in Early Childhood Programs;
5.) Increased earning powers of mothers due to their expanded opportunities to participate in training and employment;
6.) Fewer pregnancies and births through age 19 for graduates of Early Childhood Programs;
7.) Improved access for community residents to educational, health, and social service systems.

PREPARED BY: BRUNO FINOCCHARIO, Executive Director of The Community Service Center of Catholic Charities in Kansas City, Kansas -and- President of the Kansas Association for the Education of Young Children (KAEYC).

* Research Data Provided By The National Association for the Education of Young Children (NAEYC).
* Research findings noted, in some instances, were restricted to Low Income Families.

Attach C

United Community Services of Johnson County, Inc.
5311 Johnson Drive, Mission, Kansas 66205
913/432-8424

TO : House Federal & State Affairs Committee

FROM: Barbara Buehler, Chairman
UCS Legislative Committee

DATE: March 3, 1988

I am Barbara Buehler, a volunteer and board member of United Community Services of Johnson County. UCS is a community planning organization affiliated with the United Way.

I appreciate the opportunity in this special hearing on children to speak before your committee, Mr. Chairman, and because I know time is limited will focus my remarks specifically on child care.

A major report on child care just published by Kansas City Consensus, an advocacy group concerned with the quality of life throughout that metropolitan area, states the following:

"Because of the dramatic increase in the number of single-parent and working-couple households, the non-family paid child care system - primarily family child care homes and child care centers....has become an essential component of our economic infrastructure."

This is interesting terminology - using the word "infrastructure" in a human services framework. I had previously always heard it

Attach D

used to indicate roads and bridges, and the like. But we believe it to be appropriate here. "Infra-" means "below", or a support or foundation for a system - and that applies to child care today.

We certainly concur that today the provision of child care outside the home is essential, particularly when we consider that the fastest growing segment of the work force is women with young children. We commend you for introducing a bill to establish a commission which will give added weight to child care issues, and which will develop a critically needed master plan for Kansas children.

A LOOK AT JOHNSON COUNTY

You have compiled, and heard about from many sources, statewide information and statistics on the number of Kansans in poverty, the number of subsidized child care slots that available dollars will buy, and so forth. I would like to briefly update you on the situation in Johnson County - the area with which UCS is most familiar. In this so-called affluent area we have 1,500 families with incomes below federal poverty standards who have at least one child under 18. Of those, 680 families have a female head of household. In 1987 an average of 800 households per month

received public assistance benefits, yet an average of only 158 households received state-funded child care assistance through SRS. One can deduce that many more low-income heads of household could use state child care, and thus become working, contributing citizens, if this care were available.

Until last week there were 160 potentially eligible families registered on a waiting list for child care slots in Johnson County. I am happy to note that an allotment of $109,000 to the Olathe area SRS for purchase of child care services has allowed SRS workers to begin paring down that list. The problems remain in Johnson County, however, that:

1) Only a small minority of licensed and registered child care facilities will accept SRS contracts because of the cost differential between what they must charge and what SRS can pay, and,

2) Providers, especially home care providers, say that payments lag, and cause them cash flow problems.

A LOOK AT OUR FUTURE

Beyond these dilemmas, we ask the question: What is the cost of not providing adequate child care? In the year 2000, only 12 years away, children now toddlers will be entering

high school and children now six will be entering the work force. According to the statistics, many will be from disadvantaged homes, less educated and less skilled than the more fortunate. If we do not make sure now that they have care in licensed, qualified facilities, we will have created a social underclass of disadvantaged adults, perpetuating the cycles of poverty in which they are caught. In an economic framework, they will not be fully contributing members of a society which will badly need their support.

A Kansas Commission on Child Care, the extension of child care benefits contained in the KanWork bill, and other initiatives, all will address these issues. We are hopeful that this spotlight, trained on the system of caring for our most vulnerable residents, will result in measurable advances this year and in the near future. We ask that you make a genuine commitment to the effort - by investing dollars, and your time and leadership, today to ensure that affordable, accessible, available and high quality child care is placed in the first-priority category it deserves.

Thank you for your interest and attention.

CCTEST: 3/3/88

Nancy Perry

TESTIMONY

BEFORE

HOUSE FEDERAL AND STATE AFFAIRS COMMITTEE

"ISSUE RELATED TO WOMEN AND CHILDREN"

HOUSE BILL 2849

MARCH 3, 1988

PRESENTED BY:

NANCY J. PERRY, PRESIDENT & CHIEF PROFESSIONAL OFFICER

UNITED WAY OF GREATER TOPEKA
5100 SW 10TH STREET
TOPEKA, KS 66604
(913) 273-4804

Attach E

Good afternoon Mr. Chairman and honorable members of the committee. My name is Nancy J. Perry, I am President and Chief Professional Officer of the United Way of Greater Topeka.

I am here to address issues relating to women and children, and particularly HB2849. I would like to thank you for allowing me to express the concerns of many funders and providers of child care services regarding these very critical issues.

The United Way strongly supports the need for quality child care in our community as well as throughout our entire state, and we urge you to support HB2849. But quality child care is not enough in and of itself. The needs are great, the issues are complex and the ramifications are of such magnitude, that we must tap the best minds in our state to address this issue in a comprehensive, non-duplicative and efficient way.

The issue of child care is no longer just a family or women's issue, it has become a top priority for companies, government agencies, schools, hospitals and employers competing for qualified employees. The movement is so powerful that this month, the U.S. Chamber of Commerce, for the first time in history endorsed the concept of federal child care legislation.

According to the U.S. Department of Labor, 50% of mothers with infants younger than one year are in the workforce, and 70% of mothers with children under 13 work outside the home. Estimates indicate that by 1990, two-thirds of all preschool children will have mothers in the workforce. Contrary to popular belief, 71% of all mothers who work outside the home do so to support their family - not merely because they want to.

In Shawnee County alone, there were 2,299 families classified below federal poverty guidelines, and of these families, 58% were headed by women who had children age six or younger. Without affordable, quality child care, how will these mothers remain in the workplace, or be able to obtain employment.

Many states across the nation are developing innovative approaches to the issue and are attempting to establish funds for the training of child care providers. The Kansas Commission on Child Care is what Kansas needs. It would allow a qualified as well as an interested group of individuals to report back to our governor and legislature with a master plan for the continuum of care for Kansas children. Child care needs, and the availability of competent child care facilities are of a major concern. The commission will be able to provide the necessary background information concerning where we've been, as well as a recommendation for a master plan for the future which will work for the state of Kansas.

We must be aware of the growing need for child care, and take appropriate measures to ensure that child care needs are met throughout the state. The children of today are our leaders of tomorrow. It is up to us, state and community leaders, business and organizational executives, and parents to provide for them in positive developmental ways. Due to societal changes it is no longer a burden that rests solely on the family. We as a whole must reach out and offer assistance and guidance through expanded, quality, low-cost child care. It is my belief that a Kansas Commission on Child Care could provide the answers that are needed to make sound judgments and decisions.

In conclusion, I would once again like to thank you for allowing me to express the views and concerns of many funders and providers of child care services. I would also like to express our sincere belief that child care and indeed the health and well being of our children, is of paramount importance to the future of the great State of Kansas. HB2849 provides an opportunity for Kansas to be a national leader in the development of a comprehensive, non-duplicative and efficient master plan for the continuum of care for Kansas children.

Thank you.

KANSAS CHILDREN'S SERVICE LEAGUE

To protect, enhance and promote the welfare of children —since 1893

TOPEKA OFFICE:
2053 Kansas Ave.
P.O. Box 5314
Topeka, KS 66605
(913) 232-0543

Testimony before House Federal and State Affairs
Joint Hearing on Children's Issues
March 3, 1988

By: Melissa Ness, MSW, JD Child Advocate for Kansas Children's Service League

Kansas Children's Service League is a state-wide non-profit organization. Our efforts are focused on protecting, enhancing, and promoting the welfare of Kansas children. We provide a variety of services dependent largely on local needs.

In 1987 we served:

*348 families through our Parent/Child Services
*487 youth through our Youth in Crisis Services
*175 families through our Pregnancy and Parenthood Services
*188 children were enrolled in Head Start Services

We also provided:

*11,387 days of family foster care and respite care
*Ran a group shelter providing 3,046 days of emergency care with 24 hour intake.

We conducted adoptive assessments for 67 families and placed 41 children in adoptive homes. Additionally, we conducted 51 adoptive searches for adults.

KCSL is also a member of the Children's Coalition. We are a broad based thirty member organization. Children cannot vote or lobby for policies and investments they need to grow up healthy and secure but as child advocates we can on their behalf. We very much appreciate the opportunity to speak to you on behalf of those Kansas children. It is the day to day work of many of our organizations that can provide you with the information you need to determine what those sound investments are and what those policies should be.

In order for children to have the best chance for survival we must ask:

1. Do they have adequate food and nutrition?
2. Do they have adequate shelter?
3. Do they have access to comprehensive medical services?
4. Are there adequate community intervention and support services for families in crisis?

We know it is clear that the decline in the status of children is directly linked to the significant cuts in social programs in early 1981.

Among the legislators in this room, 20 of you have children, 55 in all. If your children were representative of society, consider the following:

*1 in 6 or 9 of your children would be poor
*1 in 8 or 6.8 of your chidlren would become teen parents
(1 in 5 of those or 1 would receive inadequate prenatal care)
*1 in 6 or 9 of your children would have no health insurance
*1 in 7 or 7.8 of your children would be at risk of dropping out of school.

If you are a parent over the age of 65 your child is 1.7 times more likely to be poor than you were; if you are over 55 years of age they will be 2.1 times more likely and if you are over 45 years of age they will have a 2.5 times more likely chance.

In order to reduce those odds you must ask yourself:

1. What services are currently available for my child?
2. Do I have access to those services?
3. Where are the gaps in those services?
4. What are viable solutions to meeting children's survival needs?

There are no single, quick or cheap fixes but we know based on data from a variety of sources that there are cost effective and humane solutions. The Children's Coalition has chosen their legislative priorities based on the crucial factors mentioned previously.

In short they include:

*An increase in AFDC cash grants.
*Increasing the number of available day care slots.
*Increasing foster care provider rates.
*Increasing the number of slots for child protective service workers.

You not only have statewide support behind you but national support for putting more dollars into programs which help children survive.

The first graduating class of the 21st century enters first grade in 1988. What will their future hold? What investments will we be willing to make on behalf of our future leaders, legislators parents, workers, college students... your children.

To us the answer is clear. Early and significant investment in basic survival needs of Kansas children is a good investment.

KALHD priority level #1 G
Su' tted to Governor 7/15/87

KANSAS ASSOCIATION OF LOCAL HEALTH DEPARTMENTS

"... Public Health in Action"
Columbian Building, 112 W. 6th, #500, Topeka, KS 66603
913-354-1605

ISSUE PAPER: STATE SUPPORT OF LOCAL HEALTH DEPARTMENTS

I. Issue Definition:

Public health in Kansas is an area that has been neglected and allowed to struggle with limited resources. While the health of Kansas is touted as a major priority for all, in reality, the public health care system has suffered from benign neglect and far too few dollar. Kansas has been successful in initiating health departments in 94 of its 105 counties, but a high percentage do not offer even the most basic of services. Communicable disease control has been the backbone of public health and yet some counties do not offer sexually transmitted disease screening. Other counties lack environmental and sanitation services, inspection services, clinic services, and other basic public health services.

II. Background

Public health services have been a part of Kansas government since 1885. In recent years, the number of local health departments has increased and they have provided the bulk of sanitation services, clinic services, and home health to the citizens of Kansas while the State agency has provided administrative oversight. Local health departments have relied on the "judgement" of the State agency for its share of the State general fund appropriated to local health departments. Since the State agency has received limited resources, the share going to local health departments has been very restricted.

Kansas has a history of inadequate support for local health departments. Kansas ranked fourth from the bottom in contributions to local health in a study completed in 1982 by the United States Conference of City Health Officers.

The Association of State and Territorial Health Officers Foundation stated in their 1983 publication that local health expenditures averaged $7.28 per capita. State governments provided 27% of that expenditure or $1.97 per capita. Kansas provided only 36 cents per capita that year and only 96 cents for fiscal year 1988. Kansas has just reached half the average contribution to local health departments in 1983. In 1984, the national average contribution of states increased to 30% of local expenditures.

Attach G

The 1980 Legislature directed the Statewide Health Coordinating Council to study public health services in Kansas. The council submitted their findings to the legislature by December 1, 1981. The report documented the need for increased state support for local health. The committee studied public health services for almost two years but spent very little time determining the financial role the State should play in supporting public health. Their recommendation for $.75 was passed by the 1982 legislature and has never been fully funded. The funding last year for basic services was $1,354,506. Full funding would require an additional $630,844 or a total of $1,985,350 as recommended by KSA 65-241.

Local public health agencies need State support if they are going to protect the public's health and the environment. The counties most needing services are often the counties with the least resources to support those services. Every county should have the ability to provide at least basic public health services (See Basic Services for Local Health Departments).

III. Options

Option #1: If Kansas is going to meet all of its public health needs, it should be at least willing to contribute the average State contribution to local health departments. The 1983 average was $1.96. If multiplied by the estimated State population of 2,364,236, the State contribution would be $4,633,903.

Option #2: Provide full funding of KSA 65-242. This bill sets up the following formula:

55 counties at $7,000 minimum	385,000
50 counties with a population of 2,113,800 at $.75 per capita	1,585,350
Cost of full funding	1,985,350
Funds authorized, FY 1988	1,354,506
Net cost of total funding	$630,844

Option #3: Do nothing.

IV. Recommendation

Clearly the need for increased State support has been documented by the SHCC report, a comparison with other states, and the Basic Services document of KALHD. Since funds are limited in Kansas, KALHD is recommending Option #2.

V. Fiscal Impact: $630,844

VI. Legislative Implications: None

THE PUBLIC HEALTH FOUNDATION
1220 L Street, N.W., Suite 350, Washington, D.C. 20005 (202) 898-5600

January 23, 1986

Mr. Charles R. Murphy
President
Kansas Association of Local
Health Departments
2030 Tecumseh
Manhatten, KS 66502

RECEIVED JAN 27 1986

Dear Mr. Murphy:

Per your written request of October 23, according to our FY 1983 data, the following information represents answers to the three questions you posed:

1. The average expenditure of local health departments (LHDs) in 1983 on a per capita basis of state and local funds is $7.28. This figure is based on 38 state health agencies (SHAs) that reported this data.

2. Of that figure, 27% was provided by state revenues, and 73% by local revenues.

3. In terms of state funds provided to LHDs through the SHA and all other sources combined, Kansas ranks 31st of 37 SHAs reporting this data with a figure of $746,000. New York ranked first with a figure of $68.5 million.

The breakdown of total SHA funds provided to LHDs for Kansas is as follows: 81.1% from Federal grant and contract funds, 17.1% from state funds and 1.8% from fees and reimbursements.

It should be noted that some state health agencies did not report in 1983, others had no LHDs (according to the ASTHO Foundation's definition of an LHD), and several other SHAs reported that some or all LHD data was unobtainable. These SHAs were excluded in all calculations.

I regret any delay in getting this information to you. I hope I have satisfactorily answered your questions and you find this information useful. Enclosed, please find an invoice relating to the services provided. If there are any problems or you have any further questions, please feel free to contact me.

Sincerely,

Michael A. Barry

Michael A. Barry
Statistical Assistant

MAB/mec

VII. Impact on Other Agencies: None

VIII. Supporting Documents: (See Attached)

Local Health Department Expenditure of State Funds, FY 1984

State & Territories	Population	State Funds *	Per Capita Allocation
Alabama	3,893,978	6,535	$ 1.68
Alaska	401,851	1,416	3.52
Arizona	2,718,425	3,492	1.29
California	23,667,837	191,013	8.07
Colorado	2,898,735	3,689	1.27
Connecticut	3,107,576	3,670	1.18
Florida	9,746,421	88,815	9.11
Georgia	5,463,087	29,033	5.31
Hawaii	964,961	5,175	5.36
Idaho	944,038	2,172	2.30
Illinois	11,427,414	18,526	1.62
Indiana	5,490,260	141	.03
Iowa	2,913,808	8,547	2.93
Kansas	2,364,236	815	.35
Kentucky	3,660,257	19,462	5.32
Louisana	4,206,089	15,940	3.79
Maryland	4,216,941	27,935	6.62
Michigan	9,262,070	49,657	5.36
Minnesota	4,075,970	11,412	2.80
Mississippi	2,520,631	4,786	1.90
Missouri	4,916,759	4,725	.96
Nebraska	1,569,825	50	.03
Nevada	800,493	807	1.01
New Jersey	7,365,011	4,801	.65
New York	17,558,072	83,247	4.74
North Carolina	5,881,385	14,988	2.55
North Dakota	652,717	488	.75
Oklahoma	3,025,495	16,262	5.38
Oregon	2,633,149	1,304	.50
Pennsylvania	11,864,751	21,456	1.81
South Carolina	3,122,814	26,318	8.43
Tennessee	4,591,120	7,917	1.72
Texas	14,227,574	8,421	.59
Utah	1,461,037	1,568	1.07
Virginia	5,346,797	35,265	6.60
Washington	4,132,204	2,907	.70
West Virginia	1,950,258	4,870	2.50
		Average	$2.97

Source: Public Health Foundation

* Thousands of Dollars

	FY 1988
State Aid to Local Units	2,203,932

	FY 1988
Total Projected Expenditures	2,203,932

FUNDING SOURCE	FY 1988
SGF Prenatal Care Collaborative Program	400,000
SGF ATU-Child Care Licensure Inspections	192,500
SGF ATU-General Public Health Prog.	1,354,506
SGF ATU-Home Visitor/Healthy Start Prog	104,926
SGF ATU-Adult Care Home Visitation Prog	65,000
SGF ATU-Acquired Immune Deficiency Testing	87,000
SGF ATU-Adolescent health Promotion	0
SGF ATU-Commodity Supplement Food Prog	0
SGF ATU-WIC Supplement	0
SGF ATU-Regional Nutritionist	0
SGF ATU-Health Promotion Older Kansans	0
SGF ATU-Lay Visits for Young Families	0
SGF ATU-Countywide Wastewater Plans	0
SGF ATU-Inventory Class V UIC Facilities	0
Total	2,203,932

PLAN FOR FINANCING—DA 410R

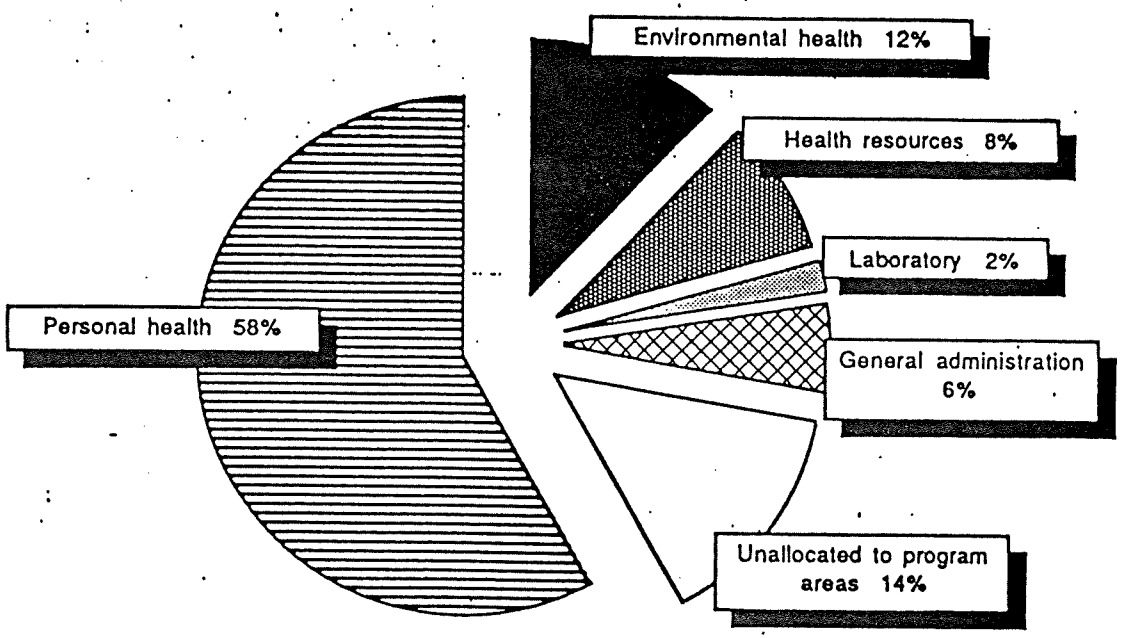
DIVISION OF THE BUDGET

DEPARTMENT OF ADMINISTRATION, STATE OF KANSAS

AGENCY NAME Department of Health an
AGENCY—SUBAGENCY CODES 264-00 FUNC
PROGRAM TITLE AND CODE Aid-to-Count
SUBPROGRAM TITLE AND CODE Summary

FUND CODE	FUND/ACCOUNT TITLE	RECORD CLASS	FY 19 84 ACTUAL	FY 19 85 ESTIMATE	DOB USE ONLY	FY 19 86 LEVEL A	FY 19 86 LEVEL B
	Federal and State Aid to Local Units						
	State Aid						
000	State General Fund (MCH)	2					
000-3300	Child Care Licensure	2	125,000	125,000		125,000	125,000
000-3400	T.B. Outpatient Clinics	2	145,000	145,000			
000-3500	Mothers and Infants	2	40,000				
000-3700	Lively Program	2	50,000				
000-3800	General Health Programs	2	178,419	704,224		704,224	704,224
000-3900	Home Visitor/Healthy Start	2	134,135			104,926	104,926
000-4100	Adult Care Home Visitation	2	63,799	65,000			65,000
000-4200	Food Service and Lodging	2	79,076	105,833		131,800	131,800
000-N5	Wastewater Management	2					
	Subtotal - State Aid to Counties		815,429	1,145,057		1,065,950	1,130,950
	Fee Funds						
55 00	Local Air Quality Regulation Services	2		50,000		50,000	50,000
	Subtotal - Fees Aid to Counties			50,000		50,000	50,000
	Federal Aid						
69-9900	Migrant Health	2	35,000	40,000		40,000	40,000
70-9900	Veneral Disease Control	2	62,700	62,700		66,964	66,964

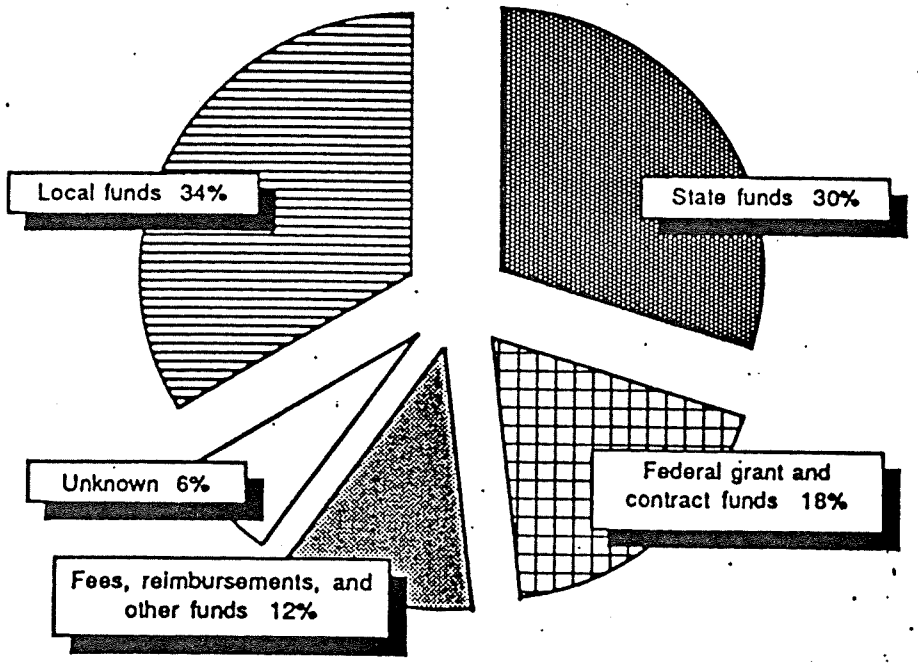
FIGURE 8.
LOCAL HEALTH DEPARTMENT EXPENDITURES,
BY PROGRAM AREA, FISCAL YEAR 1984



TOTAL: $2,342 MILLION

SOURCE: PUBLIC HEALTH FOUNDATION • April 1986

FIGURE 7.
LOCAL HEALTH DEPARTMENT EXPENDITURES,
BY SOURCE OF FUNDS, FISCAL YEAR 1984



TOTAL: $2,342 MILLION

SOURCE: PUBLIC HEALTH FOUNDATION • April 1986

KALHD priority level #2
Submitted to Governor 7/15/87

KANSAS ASSOCIATION OF LOCAL HEALTH DEPARTMENTS

"... Public Health in Action"

FY 1989

AIDS PREVENTION AND CONTROL

I. Issue Definition

The public health aspects of acquired immunodeficiency syndrome (AIDS) should be handled as other communicable diseases in that positive blood tests should be reported to health departments and contact follow-up should take place. Mandatory blood tests should be required under some circumstances and all medical information should be kept confidential as it is with other communicable diseases.

II. Background

AIDS is a fatal disease caused by a virus that is transmitted by sexual intercourse and blood, the latter usually is through sharing of contaminated needles by intravenous drug abuse. Since AIDS was first reported in the United States in mid 1981, public health services has received reports of about 36,058 cases with a case fatality ratio of 58%. Approximately 70% of the cases has occurred in homosexual/bisexual men and 17% have occurred in intravenous drug abusers. While the percent of cases in these groups has remained constant, there has been a significant increase in heterosexual cases. AIDS is a public health problem that merits serious concern and is a major priority of the U.S. Public Health Service. The AIDS virus is spread by sexual contact and needle sharing and may be transmitted from infected mother to infant during pregnancy or birth, or shortly after birth (probably through breast milk). The risk of infection with the virus is increased by having multiple sexual partners, either homosexual or heterosexual. Through June 18, 1987 there have been 74 AIDS cases in Kansas with a case fatality ratio of 64%.

The current recommendations for the prevention and control of AIDS is through education in schools, the workplace and the general public and through anonymous testing of individuals in high risk groups. There is no contact follow-up. Positive blood tests are not reported to local or State health officials and no contact follow-up is made. The number of people estimated to be infected with the AIDS virus in the

112 West Sixth Street, Suite #500, Topeka, Kansas 66603 913-354-1605

United States is about 1.5 million. All of these individuals are assumed to be capable of spreading the virus sexually (heterosexually or homosexually) or by sharing needles and syringes or other implements for intravenous drug use. Scientists predict that 20%-30% of those infected with the AIDS virus will develop AIDS within five years. Traditionally the control of communicable diseases has been to report known cases to official public health agencies, so their contacts can be investigated. Also, individuals who are infected and capable of transmitting the infection are reported to public health officials so their contacts can be investigated.

III. Options

A. Continue with education and anonymous testing and hope that it diminishes further spread of the AIDS virus.

B. Continue education and voluntary anonymous testing of high risk individuals and mandate testing of immigrants and prisoners in local jails and State prisons.

C. Supply increased funding for AIDS with the following priorities.

1. Support the continued testing, counseling, and education of individuals with high-risk behaviors.
2. Support public health departments in their effort to do contact follow-up of cases and those with positive HIV test results.
3. Offer voluntary testing in clinics for family planning and sexually transmitted diseases and for anyone thought to be at risk.
4. Mandate testing in prisons and jails.
5. Provide voluntary testing for individuals not in high-risk groups.
6. Continue with education about AIDS in schools, workplaces, and for the general public.

IV. Recommendation

The Kansas Association of Local Health Departments recommends option C. AIDS is a sexually transmitted disease and testing, counseling, education and follow-up are necessary public health components. Testing in prisons and jails would be productive in segregating positive individuals from those who tested negative. Because drug abuse and homosexual activity occurs during incarceration, separation of the prisoners could prevent transmission of the infection and prevent the

treatment costs which will fall back on local or State governments operating the prisons and jails.

Many of the patients attending family planning and sexually transmitted disease clinics may be in high risk categories and therefore testing should be offered and followed by counseling about the risks of promiscuity. The follow-up of positive HIV tests will help public health authorities control the spread of this infection. These practices have been successful in syphilis and other communicable diseases.

V. Fiscal Impact

The cost of performing the procedures under option C would be high but case treatment costs are extremely high. The cost to draw the blood for the test and provide counseling is estimated at $15.00 per person. The number of positive tests will probably be small and the number of contacts to be followed should not be overwhelming.

VI. Legislative Implications

Legislation would be needed to mandate testing in prisons and jails. There may be the need to strengthen the anti-discrimination laws to protect individuals who are found to be positive on mandated and voluntary testing.

VII. Impact on Other Agencies

Option C and accompanying legislation would have an impact on the KDHE laboratory and epidemiology unit, local health departments that would test and counsel individuals, State Prisons and County jails, and private physicians that would do voluntary testing.

VIII. Supporting Documents

Surgeon General's report on Acquired Immune Deficiency Syndrome. Facts about AIDS-winter 1987-U.S. Public Health Service. Public Health and the Law-AIDS Screening, Confidentiality, and the Duty to Warn. Larry Gostin, J.D. and William J. Curran, J.D., LLM, SMHYG. APHA 77;361-365, 1987.

6/87

KALHD priority level #5
Sub··tted to Governor 7/15/87

KALHD

KANSAS ASSOCIATION OF LOCAL HEALTH DEPARTMENTS

"... Public Health in Action"

FY 1989

Child Care Program Enhancement
Submitted to Governor Hayden
July 15, 1987

I. Issue/Problem Definition

Local health departments are asked by the Kansas Department of Health and Environment to inspect licensed child care facilities in their respective counties. Funding for this activity is based on the number and type of facilities not the amount of local effort required to perform these functions for KDHE.

II. Background

K.S.A. 65-512 delegates the duty of inspecting child care facilities to KDHE. The Department has contracted with local health departments, where available, to perform the required annual inspections and associated tasks such as, providing orientation investigations and preparing information for enforcement proceedings.

Local health departments are reimbursed for licensing related activities based upon the number of licensed facilities. KDHE has requested increased funding for Local health departments in their "C" level budget in previous years.

In addition to activities related to licensed child care facilities, local health departments review applications to operate registered family day care homes and investigate complaints related to these facilities. No funding has been available to Local health departments from the state for this activity. Some cities no longer take part in the child care licensing program due to inadequate funds and other complications.

III. Recommendation

The KALHD requests the Governor's office to provide additional funding in the KDHE budget for Local health department activities related to child care facilities. This funding would include reimbursement for complaint investigations and the processing of applications for registered facilities in addition to the existing licensure evaluations.

IV. Legislative Implications

None, unless a decision was made to revise the ceiling on the license fee to increase revenues.

V. Impact on Other Agencies

None.

VI. Fiscal Impact

FY 1988	Increase	FY 1989
$191,444	$161,556	$353,000

112 West Sixth Street, Suite #500, Topeka, KS 66603 913-354-1605

TO: Committee on Federal and State Affairs

FROM: Kathy Johnson, Parent of a child with a disability, and Resource Coordinator for Families Together, Inc.

RE: House Bill No. 2849

Mr. Chairman and Members of the House Federal and State Affairs Committee

I am the parent of a six year old child with Cerebral Palsy. I work with parents across the state of Kansas in my position as resource coordinator for Families Together, Inc. Families Together, Inc. is an orgazination that provides services for parents of children with disabilities.

I would like to support House Bill No. 2849 and speak to a related childrens issue now before the legislature in the form of H.B. 2053 concerning the school district equalization act; affecting the definition of preschool-aged exceptional children. This bill would extend services to children with disabilities who have attained the age of three years.

My daughter has been fortunate enough to have recieved services both as a infant and as a preschooler. I have seen the benefits first hand and I know that other exceptional children and their families would benefit too.

Thank you for the opportunity to address this committee on a related childrens issue.

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Winston Barton, Secretary

THE SPEAKERS PUBLIC HEARING ON CHILDREN AND FAMILY ISSUES

Chairperson and members of the committee, I am Jan Allen, Commissioner of Adult Services, State Department of Social and Rehabilitation Services. I am pleased to be here with you today to discuss briefly the needs of Kansas families for quality child care that is accessible and affordable. Mothers are working out of economic necessity.

According to SRS area quarterly reports submitted in December, 1987, 3,152 families were receiving child care benefits. SRS provides partial reimbursement to low and marginal income families that are either employed or are participating in an education or job training program, and for children who have a handicap or have been abused or neglected.

Both nationally and in Kansas, there is an increasing demand for quality child care, especially for infants and school-age children. It is estimated that by 1990, 60 percent of all children will be cared for during the day by someone other than their parent.

Without child care at a reasonable cost, low income families cannot work and become self-sufficient. This is one of the most significant barriers to achieving self-sufficiency for ADC families and for remaining self-sufficient. In January, SRS purchased child care for 4,469 children. Of the 3,152 families receiving services in December, 1988, 61 percent had income below the poverty level.

Because of a decline in the funding available for the program, the average number of children receiving services per month dropped from 5,283 in FY 1980 to 2,883 in FY 1986. In FY 1987, however, that number grew to 3,179, as funding increased from $3.7 million in FY 1986 to $4.2 million in FY 1987. For FY 1988, $7,018,466 was appropriated to meet increased child care needs and to assure that ADC working parents would receive child care. The proposed federal and state welfare reform initiatives, would increase the number of ADC recipients required to enroll in Job Preparation Programs.

(See attached Table: Child Day Care Purchase of Service Summary of Annual Expenditures and Children Served)

As I have indicated, parents are eligible to receive partial reimbursement for child care when:

- employed or a participant in an approved education/training program;
- are public assistance recipients; and
- their monthly income meets SRS guidelines.

Child care may be purchased without regard to family income if a child has been determined in need of the special services due to a handicap, abuse or neglect.

SRS may purchase child care from any licensed or registered facility selected by the parent who has a purchase of service contract. A relative may be selected by a parent, if approved by SRS and a contract is negotiated.

Of the 3,000 families receiving services in December, 1988, 57 percent were income eligible, 42 percent were public assistance clients, and 1 percent were eligible without regard to income.

Of the children receiving services in December, 1988, 63 percent had employed parents, 27 percent had parents participate in a education or training program; 4 percent were handicapped, and 6 percent were in need of protective services.

Closing Remarks

In closing I would like to thank you for this opportunity to share with you the need of parents for quality child care in Kansas and would be happy to entertain questions.

Winston Barton, Secretary
Office of the Secretary
Social and Rehabilitation Services
913-296-3271
Date: March 3, 1988

CHILD DAY CARE PURCHASE OF SERVICE

SUMMARY OF ANNUAL EXPENDITURES AND CHILDREN SERVED

YEAR	CHILDREN (Average Number Per Month SRS Payments Made)	TOTAL ANNUAL EXPENDITURE	AVERAGE ANNUAL COST PER CHILD	AVERAGE MONTHLY COST PER CHILD
FY '79	5,264	$6,595,674	$1,253	$104
FY '80	5,283	$6,922,495	$1,310	$109
FY '81	4,959	$6,335,492	$1,278	$106
FY '82	2,786	$4,117,997	$1,478	$123
FY '83	1,729	$2,394,836	$1,385	$115
FY '84	2,256	$3,004,273	$1,332	$111
FY '85	2,730	$3,523,744	$1,290	$108
FY '86	2,883	$3,787,760	$1,314	$110
* FY '87	3,179	$4,206,415	$1,323	$110
FY '88 Projected	4,775	$7,018,466	$1,470	$123
FY '89 Recommended	4,775	$7,018,466	$1,470	$123

* Obtained from SRS Information Services Dated July, 1987

Prepared by Adult Services

TESTI NY ON EARLY CHILDHOOD HEA : NEEDS AND

THE HEALTHY START HOME VISITOR PROGRAM

MARCH 3, 1988

Representative Robert H. Miller, Chair

Mr. Chairman and Members of the Committee, my name is John Pierpont, and I am here today on behalf of the state's Children and Youth Advisory Committee. As you know, the Children and Youth Advisory Committee is charged with responsibility for advising the legislature, Governor's Office, and state agencies regarding the needs of Kansas children and their families. The Advisory Committee commends you for holding these hearings. Advocates for our state's most vulnerable citizens have much to teach us, but often go unheard because what they have to offer is not limited to the particulars of a certain bill or the budget request of a state agency. Therefore, hearings of this sort become all the more important.

The Advisory Committee has asked me to speak today regarding the health needs of young children, and about the Healthy Start/ Home Visitor program in particular. A 1987 document on maternal and child health sponsored by the Southern Legislative Conference and the Southern Governor's Association reports that two to ten dollars are saved for every dollar spent on prenatal care; that the cost of treating five high-risk premature babies might pay for providing prenatal care for as many as 149 women; that a person's best chance to be a healthy adult is to have been a healthy child; and that, as study after study concludes, prenatal care is the single most significant factor in determining a

newborn's health. Post-natal care is the second most significant factor.

In Kansas, approximately 6,000 mothers do not obtain adequate prenatal care; one in 16 babies is a low-birthweight baby; fewer than half of the children and pregnant women eligible for the WIC program actually receive services; and fewer than half of the eligible medical assistance clients use EPSDT (Early and Periodic Screening, Diagnosis and Treatment) services. The public health operated Maternal and Infant Program is available in only 29 of 105 Kansas counties. Healthy Start/Home Visitor programs are available in only 44 counties.

Healthy Start/Home Visitor programs promote newborn and child health by providing information, referrals, support, and often transportation, to parents with or expecting a newborn. Parents receive information on pregnancy and delivery, child health needs, nutrition, and child development. They learn about WIC and EPSDT services, and they have contact with a supportive person who is knowledgeable about parenting and child care.

Healthy Start programs are operated by local health departments on the county level where home visitors are recruited, trained, and supervised. The Kansas Department of Health and Environment provides technical assistance, quality control, and partial funding for local programs. (Local and county agencies pay 53% of costs and KDHE pay 47%). KDHE funds for Healthy Start/Home Visitor programs come from federal grants and state appropriations. For Fiscal Year 1988, $298,270 has been budgeted for Healthy Start.

The Department of Health and Environment has drawn up a three-year plan for the implementation of Healthy Start programs in every county in Kansas by 1991. The Children and Youth Advisory Committee fully supports this plan and urges you to use whatever measure of influence you have to assure its funding and implementation.

In closing, I will leave you with two facts about Healthy Start/Home Visitor programs. First, home visitor programs, when properly executed, have been shown to reduce the incidence of child abuse to infants; the incidence of preventable childhood diseases; and the number of serious childhood injuries in the families served. It is the **only** program with hard data to prove that it prevents child abuse and neglect.

Second, Healthy Start programs begin at the end of pregnancy. They do not replace prenatal care programs. They extend the benefits begun by prenatal care programs. Both programs are vital to our children's health. The Children and Youth Advisory Committee urges you to support these pre- and post-natal care programs, and to ensure that, in Kansas, they reach every child in need. Thank you.

John Pierpont, Coordinator
Children & Youth Advisory Committee

3/6

THE SHELTER inc.

P.O. BOX 647, LAWRENCE, KS. 66044
843-2085

Date: March 3, 1988

To: House Federal and State Affairs Committee

From: Judy Culley, Administrator, The Shelter, Inc.

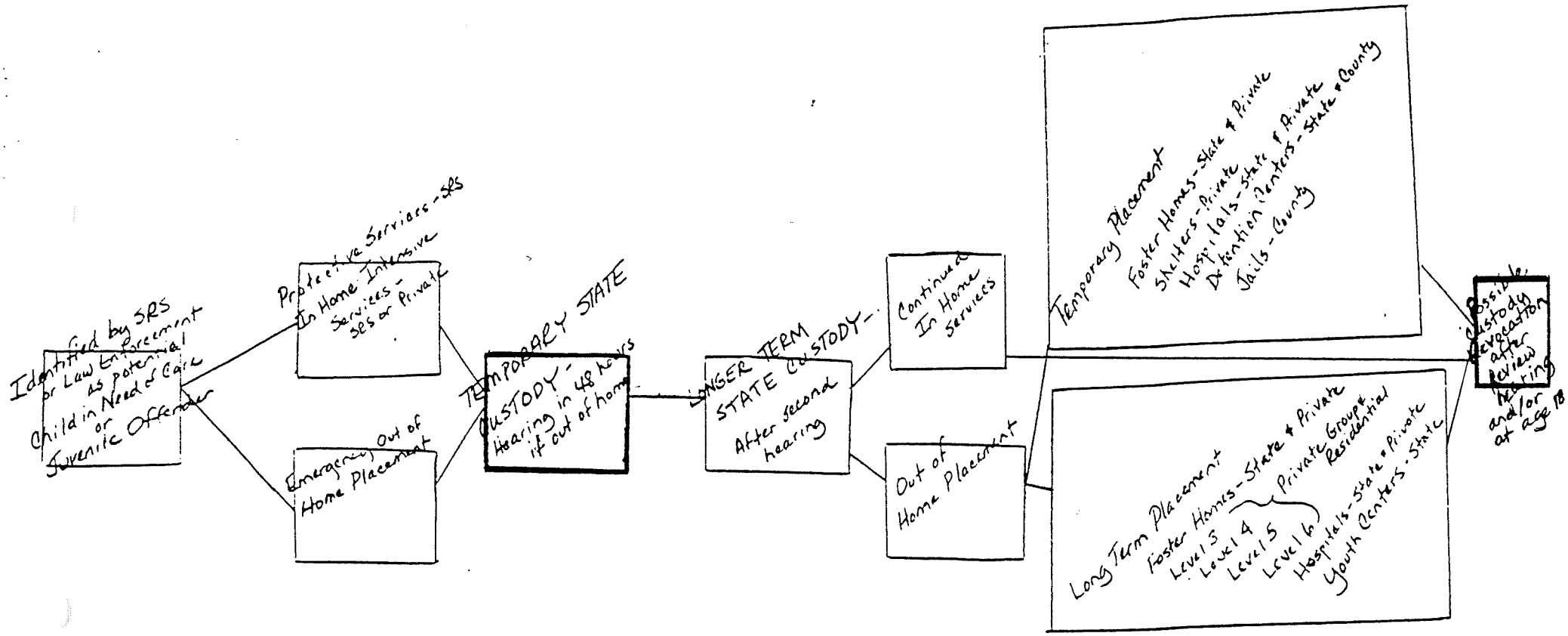
Re: Children in State Custody

The state is involved directly and indirectly in the lives of many children through its medical programs, its educational programs, its recreational programs, etc. The needs of all children are critical. The group of children for whom the state appears to have the most responsibility are the children who are actually in the state's custody, who are legally and physically dependent on the state for their well-being. Their needs are met through the foster care line item in the SRS budget, through the youth center budgets, the state hospital budgets, etc., all of these budgets having different state/federal matches. As the administrator of an emergency shelter in Lawrence, I am familiar with the needs of children in the state's custody, our facility serving as emergency/temporary placement for those children, both at the time they are first removed from their homes by SRS or law enforcement and between longer term placements after they have been in custody for some time.

For those who have not been involved with this system before, attached is a simplified diagram of the process whereby a child goes from being identified as in need of services, either as a potential Child in Need of Care or as an alleged Juvenile Offender, through the system of state custody to the point that custody is revoked. The process can obviously be stopped at different points along the way, and is much more complex than is indicated in this diagram. However, simply stated, the children between the two darkened boxes in this diagram are dependent upon the state, upon this legislature, for their needs to be met.

In order for their needs to be met, all of the services that are listed between those two boxes need to be available to them. They are children with extreme problems, whose needs change almost daily, and who have probably already received a number of services prior to being placed in custody. The only way to respond is to have a continuum of viable services, including intensive in-home services, family foster care, group home and residential care, hospital care and youth center care. Unfortunately, due to the problems surrounding limited resources, along with the number of state and private budgets involved, different services seem to get more or less emphasis, appearing to come in and out of style at different times. We can look at many ways to improve different individual services. Only after all these services are honestly adequately funded rather than competing with each other, after each child has access to various services without unnecessary barriers, and after SRS has enough staff to manage the cases for the children in the state's custody, will we as a state be sufficiently addressing the needs of the children whose lives have been entrusted to us.

Attach K


Identified by SRS or Law Enforcement as potential Child in Need of Care or Juvenile Offender
Protective Services - SRS In Home Intensive Services - SRS or Private
Emergency Out of Home Placement
TEMPORARY STATE CUSTODY - Hearing in 48 hours if out of home
LONGER TERM STATE CUSTODY - After second hearing
Continued In Home Services
Out of Home Placement
Temporary Placement
Foster Homes - State & Private
Shelters - Private
Hospitals - State & Private
Detention Centers - State & County
Jails - County
Long Term Placement
Foster Homes - State & Private
Level 3
Level 4
Level 5
Level 6
Private Group Residential
Hospitals - State & Private
Youth Centers - State
Possible custody revocation after review hearing and/or at age 18

Testimony - Kansas Children Issues
March 3, 1988

Somewhere children dance
to the joyous music of Life
and elsewhere
they only cling
to existence
They are all ours.

I walked to my car
from the hospital ward
into my third century of times
having made this journey.
I'd just finished
a regular Sunday morning visit
with Greg.

Greg is a child
I have grown to love
as he's gifted me
by sharing his life's journey -
a journey
of intense anger
at unmet needs
a journey
of lashing out
at the world
that has been
so unprotecting
and wounding
a journey
whose depth was verbalized
in prayer one stormy day:

"Dear God,
I Love You very much. I hope
I do have a package up in Susie
St. John's office (Susie is
Greg's social worker) and I'll
get it tomorrow. I'm sorry
(Greg turns to me and says,
"You know what I did one time?
I flipped God off. I was so
angry at Him for putting me here
on this earth that I flipped
Him off!" Then Greg continued.)
I'm sorry for flipping You off
God. Sometimes my anger is so
much. I really do like the staff.
I Love You God. Amen."

But there were new paths
of the journey
we'd talked about today -
the journey of leaving the hospital
and risking the care
of a family who are saying,
"COME! We want to share
our home with You, Greg."

Attach 4

As I sprinted to my car
filled with the hopes and fears
I have for Greg
the fears and hopes united
in the image
of what Greg was doing
as we talked
HE WAS BUILDING
putting together a model
carefully fitting together
small pieces.

Is that now what he'd done
in the past 36 months
at the hospital
putting together small pieces
of his life
learning slowly and meticulously
that he could accept care
from other people
that some of his needs
could be met
that his anger was okay
but hurting himself
and others was not.

One day we read the parable
Jesus told
of the man who gave away all
to gain the Treasure in the field.
I asked him what his Treasure was
and he replied
"TO BE A NORMAL KID".

This step he takes on February 27, 1988
to share a home
with Sheila and Paul
is a giant step
toward that Treasure.

And my feelings
of pride in him
and gratitude
for Paul and Sheila
burst through
like the first green
of spring's tulips
waiting/hoping
for more growth
and GLORY!

"Sister Get the Feelings Out"

Sister Theresa
Bangert

Program Purpose

The purpose of TFC is to provide a community based family setting along with other therapeutic services and supports for emotionally disturbed youth. TFC can be an alternative for hospital or level 4 and 5 group home placements, or post-hospital and group home treatment.

Description of the Program

TFC provides for the care and rehabilitation of severely emotionally disturbed youth from ages eight through seventeen. Services provided by TFC include therapy for the youth and natural families when possible, as well as support and training for foster families.

Youth placed with TFC are constantly monitored in regards to mental health, medical care, home environment, recreation, educational needs and training in independent living skills.

Admission Criteria

TFC is for children and teenagers who are in special need of psychiatric services, assistance with family relations, close supervision, structure, medical services and continuing special education. Youth qualifying for the program have persistent problems and may be unable to live with SRS foster parents or in group home settings. Most youth have been in state or other psychiatric hospitals for extended periods of time and need the continuing supervision similar to what they received while in the hospital. Youth referred must be in SRS custody.

Referrals to TFC can be made by calling Robert Heckler LSCSW (Coordinator of TFC) at 273-3576 or Carrie Stutzman LMSW (Staff Social Worker) at 273-7513.

Foster Parents of TFC

Foster parents of TFC are genuinely committed to foster care. In order to become a foster parent the couple or individual must commit to foster care on a long term basis and undergo twelve hours of intensive training and bi-weekly training & support meetings thereafter. Foster parents and TFC staff work as a team to provide care for the troubled youth using knowledge of parenting skills, the developmental needs of the child and knowledge of emotional illnesses.

Most foster parents pursue their respective occupations while working for TFC. Foster parents are required to take respite time off and are paid for taking both respite and vacation. Foster parents are encouraged to pursue personal interests and hobbies.

To meet the licensing requirements, foster parents attend regular biweekly meetings with staff and other foster parents for education and support. Parents share their problems and concerns as well as their successes with other TFC foster parents. This informal sharing enables the foster parent to build on the experience of others in caring for their foster child.

''Foster godparents'' is an idea that began during the biweekly foster parent meetings. The purpose of the foster godparents is to allow the foster parents to place their TFC children with other parents in the program for respite care. The TFC parents receive the needed time away from the child and the child enjoys the new environment and relationship of the godparents for the two or three days of respite care. This concept reduces stress to prevent burnout. It also allows families to be able to maintain normal family relationships, and gives the foster child a greater chance of staying in the home until completing his/her treatment.

When a crisis occurs TFC staff is available any time, day or night, to help the TFC parents defuse the situation and help the child gain control of their behavior.

TFC has gone beyond the tradition of foster care to enhance the success of treating emotionally disturbed children in a less restricted environment.

Sister Therese Bengert
Bob Hec[illegible]

How Do TFC Parents Feel About The Program

"I think the kids really get a feel for what it's like to have a home." *C. Fleischer*

"The staff is very supportive, a caseworker is always there when you need them." *L. Klus*

"The support from the staff is great." *P. Oshel*

"The great thing about TFC is that everybody works together as a team for the benefit of the child."
L. Loberg

A CATHOLIC CHARITIES AGENCY

Topeka Catholic Social Service is a Member Agency of United Way

Therapeutic Foster Care Program of Topeka (TFC)

A Catholic Social Service Program
Funded by SRS

4m

TESTIMONY

HOUSE FEDERAL AND STATE AFFAIRS

MARCH 3, 1988

Thank you Chairman Miller and Committee Members for the opportunity to speak on the needs of children and their families. My name is Eleanor Lowe and I'm a volunteer citizen advocate and past president of Kansas Action for Children.

For the past few years, one of Kansas Action for Children's goals is to promote family-centered, home-based services to troubled families. I would like to explain how that has evolved into the Family Preservation Project in Kansas - where it came from, a little bit about the concepts and where it may be going. Also, I want to highlight some of the activities of Kansas Action for Children and specifically our work in promoting public awareness, understanding and wider community involvement in this Project which is being implemented by SRS.

By 1977, Government reports estimated that nationally over one-half million children were in foster care. Congressional hearings, held over a four year time span, looked at what happens to these children. They found that as important and needed as foster care is, that:

1. too often it is used as the first resort rather than the last when a child or family is in trouble;

Attach M

2. that children moved from one foster home to another;

3. that it is expensive - more money was and still is being spent on separating children from their families than in keeping them together;

4. that little was done to help parents change their habits or their circumstances, so those children who did return home to their families often confronted the same problems they had left.

These Congressional Hearings resulted in the passage of P.L. 96-272 - or the Adoption Assistance and Child Welfare Act, setting out a wide range of requirements for states to follow - tying Federal funds to reforms.

At the heart of these reforms is the delivery of services to families to prevent unnecessary placement of children outside their homes. Some of you may recall when former Chief Justice Alfred Schroeder, in his address to the joint session of the 1985 Legislature, talked about some of these concerns. He said, and I quote, "Just as cases should not be permitted to 'float' in the court system, so these children should not be permitted to 'float' in the overall social service system."

Since the passage of P.L. 96-272, this reform movement has reached almost all the states in one form or another. I would like to draw your attention to the enclosure in your packet from the National Conference of State Legislatures, April 1987 issue,

and a reprint of an articles called "There's No Place Like Home." I hope you'll read it when you get a chance.

So what is the Family Preservation Project in Kansas? In 1987, SRS chose 5 of their 17 management areas to pilot the family preservation project. The areas were: Garden City, Salina, Emporia, Wichita and Topeka-Lawrence - covering 32 counties. SRS workers and supervisors received extensive training in the family-centered approach. Let me give you some of the distinguishing characteristics of family-based services:

1. For the most part, workers work with families in their homes, working with the family as a unit;
2. Services are intensive and time limited;
3. Workers carry small caseloads for shorter periods of time;
4. Workers receive special training in risk assessment and problem solving;
5. Workers try to focus on family strengths, rather than problems. The family is encouraged to move toward greater self-sufficiency.

KAC established ten community advisory boards in these counties - in Wichita, Topeka, Lawrence, Emporia, Abilene, Garden City, Dodge City, Liberal, Salina and Concordia. The Advisory Boards sponsored ten community meetings on Family Preservation - most were last September. KAC provided volunteers for this effort. I attended six of those community

meetings. People from all disciplines attended - from the schools, courts, foster parents and group home providers, county and district attorneys, law enforcement, health related areas, and even a few legislators.

In November, KAC took responsibility for arranging the first statewide conference on Family Preservation - attended by over 300 people (a 100 more than we originally expected). National experts were there, local projects were discussed, concerns were addressed. We even had one workshop called "high anxiety." 29 endorsing organizations were recognized.

SRS is now working with a limited number of families in the pilot areas using the family-based approach.

In Phase II of this project, SRS is taking the project statewide, extending the training to 6 more management areas this year - Pittsburg, Parsons, Chanute, Osawatomie, Olathe and Pratt.

In closing, I want to share some thoughts from a speaker at a national conference held in Minneapolis last September. She says so well what I think many of us believe:

> "People can be independent and empowered only when they have life's basic necessities. Family counseling alone cannot do much for those with no home, no income, not enough food and inadequate medical services. The key to adequate human services lies in our being able to create a continuum of family resources and supports - counseling

and therapy, to be sure, but also jobs and job training, housing and emergency cash assistance, medical care and day care. Family-based services is at the heart of this continuum, because it is fundamentally not a categorical service but a way of thinking, a philosophy which is relevant - indeed essential - to all types of services that reach children and families. Family-based services can provide the common language and the common ground for collaboration between all of us."

Thank you very much.

Eleanor Lawe

There's No Place Like Home

Some states are finding that in-home treatment for abused children and their families is more effective and less expensive than foster care.

By Shelley Smith

States have been almost too successful in demanding reports of child abuse cases. An explosion of reported incidents of abuse and neglect—they've increased 160 percent in the past 10 years—have overloaded caseworkers and forced many states to choose the easiest expedient to protect children from abusive parents: foster care.

But foster care, at one time considered the compassionate answer to a child victim in need, carries with it a number of problems. Child welfare experts have identified the phenomenon of "foster care drift," in which thousands of children get lost in the system and are moved among a series of foster and group homes. Such children lack stability and the opportunity to develop permanent relationships with caring adults.

And it's expensive. Costs range from $2,500 per child in Nevada to $7,500 in New York for annual foster family care. Many states are facing a critical shortage of available families, in part because of the increasing number of women in the work force. And finally, foster care is only a stopgap measure. Most abused children are eventually returned to their homes and the parents who abused them in the first place. The children may have been sheltered for a time, but without counseling for the abusive parent, the cycle often begins again.

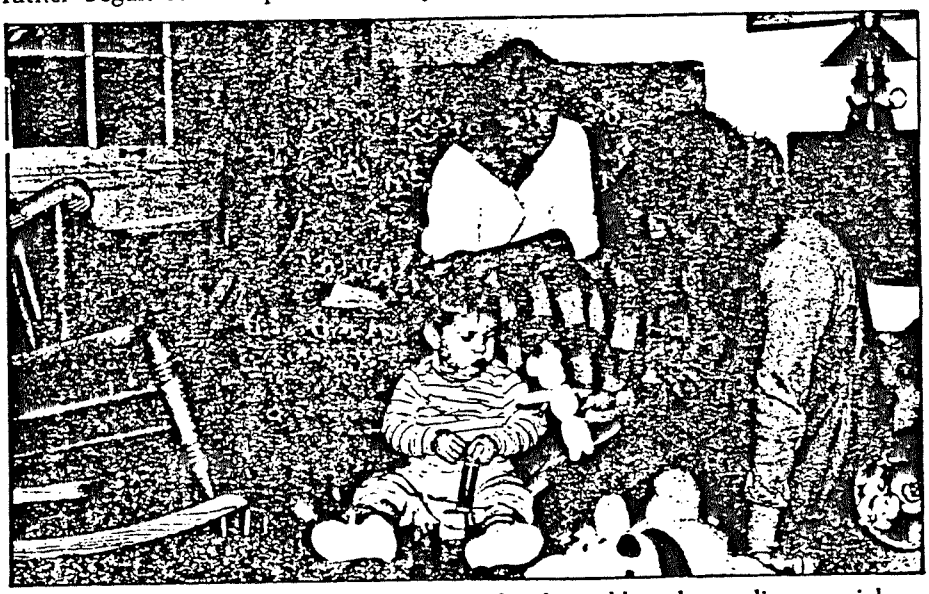
New home-based programs such as Homebuilders Inc., however, provide in-the-home counseling and treatment to get at the root of family problems that created the cycle of abuse and neglect in the first place. In Washington, where the official policy is to "keep families together unless the child is endangered," according to Senate Judiciary chairman Philip Talmadge, the state uses Homebuilders, a private agency, to intervene in abuse cases in the Seattle, Tacoma and Spokane areas.

One recent success story concerns a family of five referred to the agency by a public health nurse suspicious about repeated concussions suffered by a 3-year-old and the ability of the slim, pale 22-year-old mother and her unemployed husband to properly care for their premature 3-month-old baby girl. During a short-term, in-home treatment period, the Homebuilder caseworker helped the parents enroll the 3-year-old in a special school program to deal with the uncontrollable and destructive behavior his mother thought proved him to be "a bad seed." The family moved to a newer apartment in a safer neighborhood, the father began to take part in family counseling at the community mental health center and enrolled in a job training program. And both parents learned parenting skills so they could begin to solve their children's behavioral problems without resorting to abuse. Several months after the in-home service terminated, the family was still together, and had successfully weathered a number of problems. Homebuilders worked with each family member in the home at a cost of $2,937. According to Homebuilders' figures, the average state price tag to place two children in foster care would have been about $15,000.

The agency has built an impressive record. Since 1974, Homebuilders has worked with 895 children whom state workers had slated for foster care. One year after termination of the in-home treatment, 88 percent of the families were still together.

"A year in foster care is a long time in a child's life," says Iowa Senator

Photo: Homebuilders Inc.



In Washington, Homebuilders Inc. addresses family problems by sending a social worker into the home to provide personalized counseling and treatment.

Shelley Smith is project manager of NCSL's Child Welfare program.

Charles Bruner, "and it's expensive for the state." Iowa was one of the first states to use private in-home services when it initially financed Families Inc. in 1974 with reallocated funds after the legislature closed down a juvenile home.

Like Homebuilders, Families Inc. caseworkers go into the home, rather than removing threatened children to foster care. The agency provides 24-hour crisis intervention, therapy, parenting education and skills development. It also puts families in contact with day care, provides employment assistance and assists with housing needs, as well as other basic services. The program presently operates in nine eastern Iowa counties and has served some 1,500 families. Senator Bruner and other members of the Human Resources Appropriations Subcommittee are considering ways to expand and improve the state's home-based service program.

In order to "maximize families' ability to take care of themselves and to reduce their dependence on long-term services," the Children's Program of the Edna McConnell Clark Foundation grants some $3.5 million each year for projects to improve family life for children, and recently launched a major initiative to assist states in developing intensive home-based services. The Foundation presently funds 10 pilot projects in as many states, and Children's Program director Peter Forsythe is convinced that home-based programs are a cost-effective and sound alternative to traditional child welfare services.

"Family preservation workers compress almost a year's worth of traditional service hours into the relatively brief crisis period in a family's life when lasting and permanent changes are most likely to occur," Forsythe says. Families involved in family preservation programs receive assistance for up to three months, whereas the typical foster case lasts nearly two years.

In Florida, state Representative Helen Gordon Davis is working with the Department of Health and Rehabilitative Services to expand the state's home-based Intensive Crisis Counseling Program, which operates in 21 counties. The program, modeled after Homebuilders, is "the easiest and least expensive way to immediately address problems between parents and children," according to Davis. A 1983 study conducted by the Florida auditor general determined the program had an 85 percent success rate in keeping children at home six months after the service ended. And in Maryland, the state Department of Human Resources tested intensive home-based services in an 18-month project that successfully reunited 600 children in foster care with their natural families.

If home-based programs are as successful as they appear to be, why aren't states using them more?

The answer lies mainly in the complicated child welfare financing sys-

. Most states are just starting to ...e a look at how their financing systems affect the provision of services. Lawmakers are asking whether stipends for foster families and group-care providers actually encourage foster placement simply because foster care funds are more readily available than alternatives. They are examining flexible reimbursement systems that would decategorize child welfare programs and allow workers to choose home-based or foster care services depending on the needs of the child and his family.

Washington's Homebuilder's program is a radical departure from traditional social services reimbursement policies. And because the agency signs a performance contract with the state, the agency's reimbursement is based on its successes. Success is difficult to define and measure in social services, but legislators are becoming increasingly interested in service delivery experiments that tie the social value received to the public cost incurred.

In Iowa, Senator Bruner and Representative Mark Haverland recently convened a special work group to study the state's child welfare financing system. Washington Senator Talmadge says his state is considering a major overhaul of its child welfare finance system that would permit money to follow children and families by basing expenditures on the needs of the families rather than trying to fit them into existing treatment programs. Pilot programs are being considered.

And the Missouri legislature will consider an interim legislative committee's recommendation of changes in the foster care system that includes expanding in-home service options. "Missouri's foster care system is in a state of crisis," says Representative Kaye Steinmetz, who chaired the interim committee. "Children are not getting the care they deserve, foster parents are untrained and angry, and residential treatment centers have long waiting lists."

The welfare of children has traditionally been a serious concern for many lawmakers. These days, they're turning their attention more and more away from tinkering with child abuse statutes and incremental increases in agency budgets, and more toward finding approaches that keep children and families together through counseling and other services while keeping state costs down.

Service and Cost Results of Family-based Programs

Name and Place of Program	Average Duration of Service	Average Cost per Family	Success (maintaining intact family at termination of service)
Families Inc. West Branch, Iowa	4.5 months	$ 4,000	91%
Family Strength Concord, N.H.	4.4 months	$ 4,224	67%
Home & Community Treatment Madison, Wis.	1 year	$10,000	66-75%
Homebuilders Tacoma, Wash.	4-6 weeks	$ 2,600	98%
Intensive Family Support Hillside Children's Center Rochester, N.Y.	10 months	$ 4,213	90%
Oregon Intensive Family Services	90 days	$ 1,131	91%

Source: Family Preservation Project, Child Welfare League of America, 1986.

TO: The House Federal and State Affairs Committee

FROM: Katie Mallon, President
Kansas Action for Children, Inc.

Kansas Action for Children is a private, not-for-profit, organization of Kansas citizens. Our mission is to ensure that the needs and rights of children in Kansas are identified and met. Rather than helping children on a case by case basis through direct service, our members are volunteers who are committed to advocating for needed changes in public policies and systems serving children.

Now in our tenth year of operation, we are seeing significant growth in the number of people like ourselves who believe that changes are urgently needed. Our newsletter mailings have quadrupled and now reach 2,400 Kansans.

You have heard about the needs of children today. They are not new or different. The problem is that the response to those needs has eroded. Things were better for kids 10 years ago than they are now.

The points I want to make are that public opinion favors change, that you, our elected representatives, are responsible for providing leadership in making changes, and that the time to act is now.

In 1986, Louis Harris and Associates completed the first national survey of public attitudes toward the problems of children in the United States. Among the major findings of this survey were:

> Nearly 3 out of 4 adults think problems affecting children have gotten worse since they were growing up;
>
> Of all the institutions that affect children, government is given the poorest rating in meeting its responsibilities to children;
>
> Not only does the public think government is spending too little on programs for children, but majorities indicate that they are willing to increase their taxes for a range of children's programs.

There is other evidence of this growing public concern for children. Hardly a day goes by without an article in the newspaper concerning children's problems. Television is devoting much of its public service time to "FOR KIDS SAKE" and other feature programs on children's problems. Businesses are sponsoring messages. Long John Silvers and Toyota say "give the gift of time." Dual Herbicide says use our products to conserve the land for your grandson. Children fill the halls of congress singing "We are the future, we are the Children" all holding bottles of Coca Cola.

Attach #1

The unevenness of local communities' efforts to meet children's needs highlights the negative impact of the continued vacuum of leadership on these issues at the state level. The people who voted for you did so because they believed that you would enact laws and prescribe policies that would be in their best interest. The voters are concerned about children, and about their own future in a world where children are not being helped to become productive adults.

Look at this cover of TIME magazine. "Americans are living longer and enjoying it more - but who will foot the bill?" Will the 100,000 children living in Kansas under the poverty level pull themselves up by the boot straps and contribute? You should listen to your constituents. But you also have a message to take to them. You know what the problems are and you have access to the solutions. One definition of a leader is a person who sees a parade and steps out front.

Act out of conscience, or act out of self interest, but act now. The National Alliance of Business published a report in 1986 that explains the urgency. Here are some of their projections for the next 12 years.

> The good news is that the number of new jobs expected to be created will exceed the number of new entrants into the labor force.
>
> The bad news is that unless action is taken now, the number of high school dropouts, already about a million a year, will increase. At the same time three out of every four jobs will require some education or technical training beyond high school.
>
> A growing percentage of new entrants into the labor market will be black, Hispanic, immigrants, from single parent families, or poor.
>
> Teen pregnancy will become more common than ever. Many of those young mothers will not finish high school.
>
> Two working parent families will become more common, increasing the demand for child care during working hours.

The potential members of the high school class of 2000 are in Kindergarten this year. The potential members of the college class of 2000 are in third grade. If you fail to act now, many abused children will be in jail or abusive parents. The teen mom is likely to be a grandmother. The undernourished child will be chronically ill. The child without medical care, permanently disabled. The uneducated child, on welfare.

You have the power, you have public support, you have the responsibility. Do it.

Michael D. Brown, RN, BSN
2424 Sunset Court
Topeka, KS 66604
March 3, 1988

Members of the Kansas House Federal and State Affairs Committee and staff, my name is Mike Brown. I am a Kansas registered nurse specializing in maternal-child health. I hope to persuade your committee to consider stimulating more state-wide public and private efforts to help Kansas children prevent serious health complications from sexual activity, such as PRETEEN and teen pregnancies.

1. Unfortunately, people are giving Kansas children 17 years old or younger serious health complications from sexual activity that can lead to many significant negative consequences that can last lifelong for those children and their families.
   a. It is a felony, under Statute 21-3519, to promote sexual performance by a child under 18 years old. Yet, according to the Kansas Department of Health and Environment (KDHE), during 1986 over 3,800 Kansas children under 18 years either were treated for a sexually transmitted disease (STD), had a baby, obtained an induced abortion, or had a stillbirth.
   b. It is a felony, under Statute 21-3503, to take indecent sexual liberties with a Kansas child under 16 years old. Still, according to the KDHE, in 1986 almost 800 Kansas children udner 16 years either were treated for an STD, had a baby, obtained an induced abortion, or had a stillbirth.
   c. It is a felony, under Kansas Statute 21-3511, to engage in sexual solicitation of a Kansas child under 12 years old. However, during 1986, according to the KDHE, 39 Kansas children 11 years or younger, including 13 only 1-3 years and 11 just 4-6 years were treated for STDs such as incurable genital herpes and sterility-causing gonorrhea and chlamydia.
   d. The Centers for Disease Control report that at least 69 percent of

Attach 0

Americans diagnosed with Acquired Immune Deficiency Syndrome (AIDS) likely contracted that disease from sexual activity. The Governor's Task Force on AIDS, in their December 1987 report AIDS in Kansas, implies that it would not be a surprise for any of the above more than 3,800 Kansas children to be infected already with AIDS-causing Human Immunodeficiency Virus (HIV). In addition, how many other Kansas children had sexual activity that exposed them to possible infection with HIV in 1986, but those children simply did not show up in the above statistics?

2. In 1987, Vincent, Clearie, and Schluchter published a report of a study in which the western half of a South Carolina county underwent a public health campaign since October 1982. The goal of the campaign was to decrease the occurrence of unintended conceptions among unmarried girls 14-17 years old. Campaign messages were targeted at parents, teachers, ministers and representatives of churches, community leaders, and children enrolled in the public school system. The messages stressed development of decision-making and communication skills, self-esteem enhancement, and understanding of human reproductive anatomy, physiology, and contraception. The estimated rate of pregnancy, (live births plus stillbirths plus induced abortions) per 1000 female population, for girls 14-17 years old in the experimental half of the county dropped sharply since the campaign began, compared to the pregnancy rate for the same age group of girls in the eastern half of the same county. The drop in the pregnancy rate for girls 14-17 years old in the experimental half of target county was still significant compared to the pregnancy rate for the same age group of girls in three similar South Carolina counties. I point out the above study to show that some people have developed EFFECTIVE methods of helping children prevent serious health complications from sexual activity.

Reducing Adolescent Pregnancy Through School and Community-Based Education

Murray L. Vincent, EdD; Andrew F. Clearie, MSPH; Mark D. Schluchter, PhD

The resident population of the western portion of a South Carolina county has undergone a public health information and education intervention since October 1982. The purpose of the intervention has been to reduce the occurrence of unintended pregnancies among unmarried adolescents. Intervention messages are targeted at parents, teachers, ministers and representatives of churches, community leaders, and children enrolled in the public school system. The messages emphasize development of decision-making and communication skills, self-esteem enhancement, and understanding human reproductive anatomy, physiology, and contraception. The estimated rate of pregnancy ([live births plus fetal deaths plus induced abortions] per 1000 female population) for females aged 14 to 17 years in the county's western portion has declined remarkably since the intervention began, and the changes are statistically significant when compared with three sociodemographically similar counties and also with the eastern portion of the county.

(*JAMA* 1987;257:3382-3386)

ANNUALLY in the United States, approximately 700 000 unmarried females aged 19 years or younger become pregnant. Of these pregnancies, 85% are unintended.[1] The negative health and social outcomes of unintended, premarital, adolescent pregnancy and subsequent premarital childbirth and childrearing present to the medical and public health communities a challenge of the greatest magnitude.[2] Over the past decade, numerous federal, state, and local efforts have been implemented to reduce the occurrence of unintended adolescent pregnancy. To date, however, there have been few reports of success in obtaining the outcome objective—significant reduction in unintended pregnancy among unmarried adolescents.[3-5] Studies of sex education effectiveness in terms of knowledge gain, attitude changes, and self-report behavioral changes do exist; however, the assumption of related reduction in pregnancy remains unproved.[6-9]

For editorial comment see p 3410.

The factors contributing to unintended adolescent pregnancy are many and include socioeconomic, family, cultural, and educational components.[10] A public health education model employing multiple strategies is the intervention of necessity. In other public health arenas, multiple intervention strategies at a high dosage level have shown success.[11,12] In this article, we report the success of a public health education model, a comprehensive school/community approach that has reduced remarkably the occurrence of pregnancies in females less than 18 years old.

From the Departments of Health Promotion and Education (Dr Vincent) and Epidemiology and Biostatistics (Dr Schluchter), School of Public Health, University of South Carolina, Columbia; and the Carolina Institute, Summerville, SC (Mr Clearie).

Reprint requests to the Department of Health Promotion and Education, School of Public Health, University of South Carolina, Columbia, SC 29208.

METHODS

Program Intervention

The School/Community Program for Sexual Risk Reduction Among Teens has been in place in the western portion of a South Carolina county since October 1982, and will continue through September 1987. The western portion of the county is delimited by the boundaries of a public school district. The eastern portion of the county is congruous with the boundaries of a second public school district. The residents of the county are divided roughly in half by the two school districts. The entire county population is sociodemographically homogenous and can be characterized accurately as rural, low income, and undereducated. According to the 1980 census, 58% of the county residents are black and 42% white.[13] There is negligible migration into or out of the county. The county economy is agriculturally dependent. There is no public transportation.[14] Before the implementation of the School/Community Program, the county ranked among the top 20% of 46 South Carolina counties in regard to estimated pregnancy rate (EPR) for females aged 14 to 17 years ([live births plus fetal deaths plus induced abortions] per 1000 female population).[15]

The implementation process of the School/Community Program is arranged in a hierarchy of objectives: The *outcome objective* is to reduce over time the occurrence of unintended pregnancy among never-married teens and preteens. The *primary behavioral ob-*

jective is to postpone initial voluntary sexual intercourse among never-married teens and preteens. The *secondary behavioral objective* is to promote, among never-married teens and preteens who choose to become sexually active *and* who do not desire a pregnancy to occur, the consistent use of effective contraception. The *educational objective* is to promote the postponement of initial voluntary intercourse as the positive, preferred sexual and health decision.

The educational objective has five subcomponents addressing the modifiable factors, as reported in research studies,[10] that contribute to unintended pregnancy among unmarried adolescents: (1) to increase decision-making skills, (2) to improve interpersonal communication skills, (3) to enhance self-esteem, (4) to align personal values with those of the family, church, and community, and (5) to increase knowledge of human reproductive anatomy, physiology, and contraception.

The achievement of the School/Community Program objectives is effected initially through the education of adults in the target community. Aware adult professionals and lay members direct their concerns and efforts toward youth in the community. This approach is an application of social learning theory and diffusion theory. School district teachers have been provided with three different tuition-free university graduate-level courses related to facets of sex education. Two thirds of the district teachers, administrative staff, and special services professionals completed at least one of these three–credit hour courses. Teachers completing all three courses acquired extensive knowledge and skills regarding reproductive anatomy/physiology, human growth changes, child/adolescent decision-making processes, family planning and contraception, ethical/value influences on sexual behavior, developing self-esteem in youth, methods to elicit parent-child interaction, community medical and public health resources, curriculum organization, and teaching methodologies for use with children and adolescents.

These trained teachers, assisted by project staff, have implemented sex education in all grades (kindergarten through grade 12) and subject areas in the intervention school district since August 1983. An integrated curriculum approach is utilized. Whereas there is no specific course called "sex education," teachers integrate units of instruction within their biology, science, social studies, and other courses to address the educational subobjectives. In effect, they are passing on the concepts they as adults have acquired in their graduate coursework preparation.

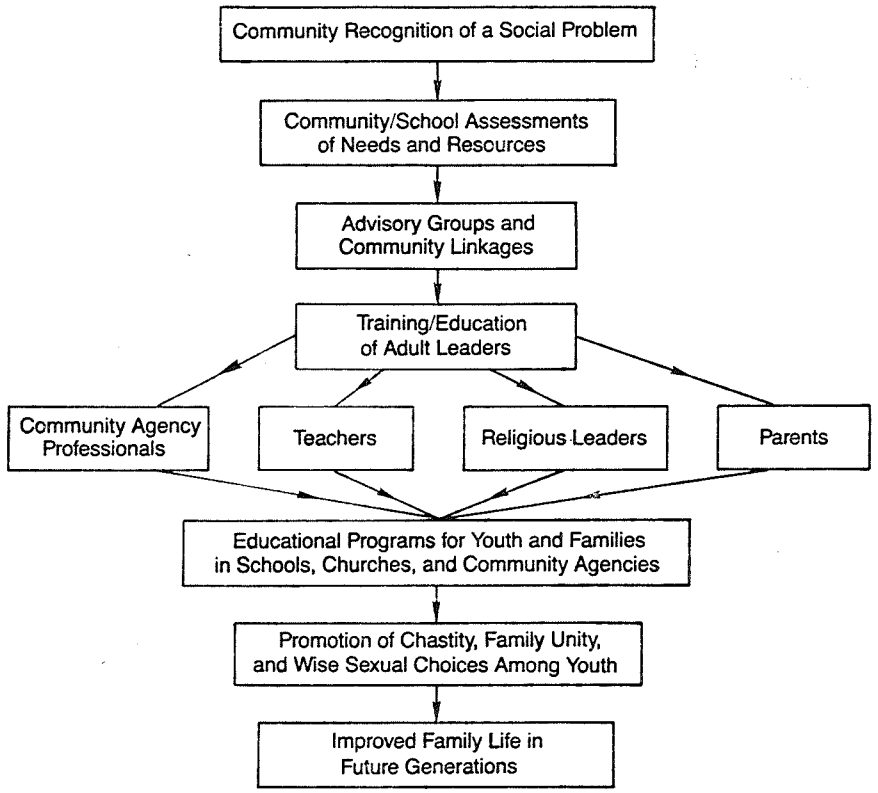


Fig 1.—School/Community Program intervention model.

Clergy, church leaders, and parents are continually recruited to attend mini-courses (five sessions of two hours each) that address the five educational subobjectives. Instructional topics include much of the same content provided for teachers. The primary goal for this group of adults is to improve their skills as parents and as role models for youth in the community. For example, some churches have capitalized on this training and initiated classes and special events for youth in their church community.

Program staff utilize the local newspaper and radio station and take advantage of all opportunities to promote the program messages implied in the objectives. Organizations seeking a speaker or wishing to have a special event are solicited to use the network of resources provided in the project. National Family Sexuality Education Week was capitalized on with speakers, newspaper articles, and appearances by students on statewide television. These community awareness activities have a broad-based health focus and are not always specifically sex-related. Alcohol and drug abuse, nutrition, weight control, and smoking have been highlighted. Generic to all activities are the emphases on problem solving, ie, considering alternatives, assessing risks and consequences, making informed choices, and assuming personal responsibility for the outcomes of one's actions.

The hypothesis being tested is that a positive relationship exists between a decrease in unintended teen pregnancy in a designated population and an intensive school and community-based educational program. Saturation of the community through large quantities of pregnancy-prevention messages constitutes the method to elicit adult and youth response. Figure 1 illustrates the schematic flow of the target groups and intervention methods.

Evaluation

Calculation of EPR.—Trends in annual, age-specific EPRs for females aged 14 to 17 years are used to assess the program outcome objective. The rates are devised using data collected by the Office of Vital Records and Public Health Statistics, South Carolina Department of Health and Environmental

Table 1.—Profiles of Counties Used in the Evaluation of the School/Community Program (1982 Residence Data)*

	Target County	Comparison County 1	Comparison County 2	Comparison County 3
Population	18796	27928	19154	39456
% Nonwhite†	58	58	62	63
Population/square mile	46	46	46	41
Annual per capita income, $	5875	5338	5398	5386
% Adult population without high school diploma	57	58	60	57

*Source: *Statistical Abstract of South Carolina*, 1983.
†In the target and comparison counties, as well as the state of South Carolina, there are no significant racial or ethnic population subgroups other than white and black.

Table 2.—Population, Estimated Numbers of Pregnancies and Annual Age-Specific Estimated Pregnancy Rates (EPRs)* for Females Aged 14 to 17 Years†

	Year				
Geographic Area	1981	1982	1983	1984	1985
Intervention portion of target county					
Population	333	328	324	319	319
Pregnancies	18	22	20	8	8
EPR/1000 females	54.1	67.1	61.7	25.1	25.1
Comparison portion of target county					
Population	407	402	396	391	391
Pregnancies	26	28	25	23	18
EPR/1000 females	63.9	69.7	63.1	58.8	46.0
Comparison county 1					
Population	1190	1140	1090	1030	980
Pregnancies	57	66	44	58	59
EPR/1000 females	47.9	57.9	40.4	56.3	60.2
Comparison county 2					
Population	870	820	770	720	670
Pregnancies	33	26	34	35	36
EPR/1000 females	37.9	31.7	44.2	48.6	53.7
Comparison county 3					
Population	1630	1580	1530	1490	1440
Pregnancies	53	71	69	75	79
EPR/1000 females	32.5	44.9	45.1	50.3	54.9

*EPR = (live births + fetal deaths + induced abortions [pregnancies])/1000 female population.
†Source: South Carolina Department of Health and Environmental Control.

Control (DHEC). The rate is expressed as the number of pregnancies that occur per 1000 females in a population. The numerator of the rate equals the sum of live births plus fetal deaths plus induced abortions. These indicators are recorded by the town and county of residence of the female. The DHEC has established a cross-reporting system of these events with neighboring states. The data supplied by the DHEC represent the most accurate accounting of these events irrespective of where within the state or within neighboring states the events occurred.

The denominator of the annual rate represents the estimated number of females aged 14 to 17 years present in the population for that year. For the year 1980, the denominator represents the census enumeration. For subsequent years, the denominator is a population subgroup estimate that is calculated by the DHEC. The formula for age-specific EPR is (live births + fetal deaths + induced abortions)/(estimated number of females in the 14- to 17-year age group) × 1000.

Comparison Areas.—Intervention effectiveness is evaluated by comparing annual EPRs in the intervention (western) portion of the target county with those of four other areas. The first comparison area is the nonintervention (eastern) portion of the target county, defined geographically by the boundaries of the second school district. For these intracounty comparisons, the annual vital events (live births, fetal deaths, induced abortions) for the entire county are allocated to the intervention or comparison portion of the county based on the recorded town of residence of the female. The denominators for the intracounty rates are yearly estimates of the number of females aged 14 to 17 years residing in each portion of the target county based on the 1980 census enumeration.[13]

As noted below, the intervention program may have some spillover effect on the comparison portion of the target county. Therefore, three other South Carolina counties were selected as comparison counties, based on their sodiodemographic similarity to the target county in 1982. Selected demographic characteristics of the target and comparison counties are shown in Table 1.

Statistical Analysis.—Effects of intervention on trends in EPRs were examined by comparing the average EPR for the preintervention period (1981-1982) with the average EPR for the postintervention years, and comparing changes preintervention vs postintervention between areas. The average EPR for a given period was calculated as the sum of the annual EPRs for the years involved divided by the number of years summed. The variances of the average EPRs and of differences in average EPRs were computed assuming the annual number of vital events in each area to be binomially distributed and assuming independence of rates between areas and between years. Significance of differences in average EPR was assessed using Z statistics computed from the observed differences and their estimated standard errors. Since 1983 was the year when training of adults, teachers, and parents was initiated, average postintervention rates were calculated with and without 1983 included. Discussion of results focuses on the years 1984-1985.

RESULTS

Table 2 presents the annual estimated number of females aged 14 to 17 years, number of vital events, and the EPR per 1000 females for the two portions of the target county and the three comparison counties. The annual EPRs are also plotted in Figs 2 and 3. It is interesting to note in Table 2 the trends in absolute numbers of pregnancies and EPRs in the five areas. There was a sharp reduction in the number of pregnancies after 1983 in the target area, whereas the number of pregnancies remained relatively constant in the three comparison counties. Whereas the EPR in the intervention portion of the county decreased in 1984 and 1985, EPRs in the comparison counties increased. The population estimates, provided by the DHEC, declined each year in the three comparison counties more so than in the target county, and this contributed to the increased EPRs in those counties. Nevertheless, the intervention portion EPR declined from previous levels in excess of 60/1000 females to 25/1000 females in 1984 and 1985.

Table 3 gives average EPRs for the five groups for the preintervention

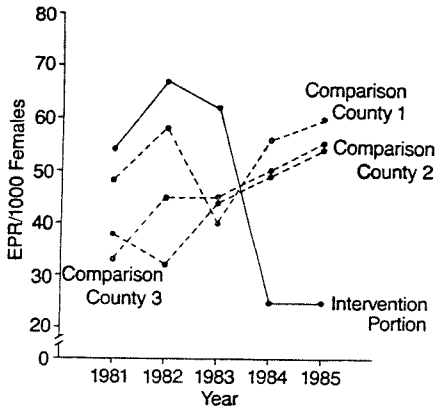


Fig 2.—Age-specific estimated pregnancy rates (EPRs) for intervention portion of a South Carolina county and three other comparison South Carolina counties for females aged 14 to 17 years. Rate equals (live births plus fetal deaths plus induced abortions) per 1000 female population. Source of data was South Carolina Department of Health and Environmental Control.

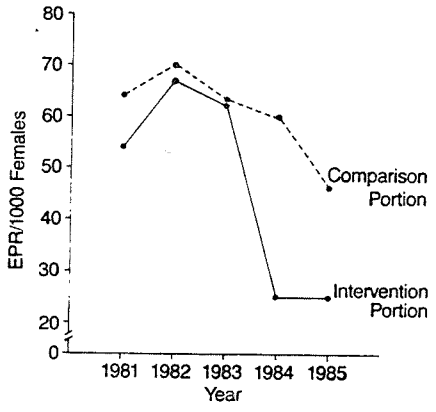


Fig 3.—Age-specific estimated pregnancy rates (EPRs) for intervention and comparison portions of a South Carolina county for females aged 14 to 17 years. Rate equals (live births plus fetal deaths plus induced abortions) per 1000 female population. Source of data was South Carolina Department of Health and Environmental Control.

Table 3.—Average Estimated Pregnancy Rates (EPRs) Before and After Intervention

	Before Intervention (1981-1982)		After Intervention			
			1983-1985		1984-1985	
	Average EPR	95% CI*	Average EPR	95% CI	Average EPR	95% CI
Intervention portion of target county	60.6	51.3, 79.2	37.3	25.3, 49.3	25.1	12.9, 37.3
Comparison portion of target county	66.8	49.6, 84.0	56.0†	42.9, 69.1	52.4‡	36.7, 68.1
Comparison county 1	52.9	43.9, 61.9	52.3†	44.5, 60.1	58.3‡	48.1, 68.5
Comparison county 2	34.8†	26.0, 43.6	48.8	39.6, 58.0	51.2‡	39.6, 62.8
Comparison county 3	38.7†	32.0, 45.4	50.1	43.6, 56.6	52.6‡	44.6, 60.6

*CI indicates confidence interval.
†Average EPR differs significantly ($P<.05$) from that of intervention portion of target county.
‡Average EPR differs significantly ($P<.01$) from that of intervention portion of target county.

Table 4.—Change in Average Estimated Pregnancy Rates (EPRs) After Intervention

	1981-1982 vs 1983-1985		1981-1982 vs 1984-1985	
	Change in Average EPR	95% CI*	Change in Average EPR	95% CI
Intervention portion of target county	−23.3†	−45.1, −1.5	−35.5‡	−57.3, −13.7
Comparison portion of target county	−10.8	−31.4, 10.8	−14.4	−37.5, 8.7
Comparison county 1	−0.6	−12.6, 11.4	+5.5	−8.3, 19.0
Comparison county 2	+14.0	1.5, 26.5	+16.4	1.9, 30.9
Comparison county 3	+11.0	2.2, 20.6	+13.9	3.3, 24.5

*CI indicates confidence interval.
†Change in average EPR differs significantly from the change in average EPR for comparison county 2 ($P=.004$) and comparison county 3 ($P=.004$).
‡Change in average EPR differs significantly from the change in average EPR for comparison counties 1, 2, and 3 ($P=.002$, .0001, and .0001, respectively).

years (1981-1982) and for the postintervention periods (1983-1985 and 1984-1985). In the preintervention years, the intervention and comparison portions of the target county had similar average rates of 60.6 and 66.8 pregnancies per 1000 females (Table 3). During the same preintervention period, comparison county 1 had an EPR of 52.9/1000 females, which was not significantly different from the intervention group, whereas comparison counties 2 and 3 had significantly lower EPRs ($P<.05$) than the EPR in the intervention group (34.8 and 38.7/1000 females, respectively).

Little change in EPR was noted in the intervention group in 1983. However, in 1984 and 1985, the EPR declined markedly in the intervention group, to a level of 25.1 pregnancies per 1000 females. In the postintervention period 1984-1985, the EPR in the intervention portion of the target county was significantly lower ($P<.01$) than the average EPRs in the other four groups (Table 3).

Comparing changes in average EPR between 1981-1982 and 1984-1985 (Table 4), the EPR decreased significantly between these two periods in the intervention group (estimated decrease, between 13.7 and 57.3 pregnancies per 1000 females, 95% confidence interval). A smaller, nonsignificant decrease between the two periods occurred in the comparison portion of the target county, whereas the EPR increased significantly in the second and third comparison counties.

The amounts of change in EPR for 1981-1982 vs 1984-1985 did not differ significantly between the intervention and comparison portions of the target county, due in part to the decrease noted in the comparison portion. The increase in EPR noted among the comparison counties differed significantly from the decrease in EPR seen in the intervention group.

COMMENT

Two and three years after the implementation of the School/Community Program, the EPR for the intervention portion of the target county shows a remarkable, sustained decline. This downward trend is not observed in the comparison counties. The contrast is impressive since comparison counties 2 and 3 show EPR increases each year from 1983 to 1985 and county 1 shows increases in 1984 and 1985.

The power of the School/Community Program is even more evident when comparing the intervention and comparison portions of the target county. It must be expected that the program

messages and their effect will infiltrate the comparison portion of the county. The western and eastern portions of the county are not truly distinct and separate entities. The county is served by one newspaper and one radio station, both of which are involved in the dissemination of program information. Teacher residency, church attendance, and employment sites provide for situations where intervention and comparison residents will intermingle. Additionally, data regarding sexual knowledge, attitudes, and behavior are collected from sixth- through 12th-grade students each year in the comparison school district. Although this involves only one hour, the testing sensitizes students, teachers, and parents in the comparison portion as to project activities. Even with this spillover effect, the intervention portion had a statistically significant lower average EPR in our analyses after intervention (Table 3) as compared with the comparison portion of the target county.

Although two years of postintervention data may seem an insufficient basis for definitive conclusions, the numbers are very encouraging. There is no evidence to suggest that major threats to validity exist. The target and comparison counties have not changed over time in terms of sociodemographic profile. No programs have been initiated or discontinued in the comparison counties that might affect the occurrence of pregnancies among 14- to 17-year-old females. One can speculate as to other factors that could have influenced the changes in pregnancy rates. The efforts of the School/Community Program conceivably could have resulted in increased activities by the public health family planning division, or an increased awareness and response by community physicians in the target county. No substantiation exists that such responses did occur. Additionally, the major publicity regarding heterosexual risk for acquired immunodeficiency syndrome did not materialize until mid-1985 and 1986.

Naturally, the inquisitive mind wishes to determine *how* the program has influenced this dramatic change; which of the intervention components is most cost-effective; which sequence of interventions is superior; what dosage level is necessary, etc. These important attribution questions can be speculated on, but not answered in precise terms. Our purpose has been to address the concern of unintended adolescent pregnancy via the various social and educational avenues in the community with a barrage of multiple interventions. And while we cannot satisfy the specific methodological queries, we can offer guidance to those who should care to replicate our work in other communities.

The School/Community Program is a model with certain distinguishing characteristics. Essentially, federal funding supports the professional resources of a school of public health that are directed toward a receptive community and its public schools to address a serious social and public health concern. The effect of the concern is not limited to an unfortunate select few: in this case, the adolescent who is unintentionally pregnant. The concern affects the community at large, and only by recruiting the community at large (the parents, the teachers, the clergy) to participate can the concern be diminished.

The structure of the School/Community Program can be transported to other areas of the United States where unintended adolescent pregnancy is a social and public health problem. We strongly recommend that efforts modeling the School/Community Program have three necessary ingredients: (1) adequate funding to recruit professional personnel and to allow enough time to implement and fine-tune a program; (2) a receptive intervention population made more responsive through appropriate information dissemination strategies; and (3) the inclusion of the entire community in the educational process of the program.

We look to other researchers to replicate the model and determine whether similar results can be realized elsewhere.

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