Approved May 5, 1991
Date

MINUTES OF THE HOUSE COMMITTEE ON FEDERAL AND STATE AFFAIRS.

The meeting was called to order by Representative Kathleen Sebelius at
Chairperson

1:30 ~~a.m.~~/p.m. on Wednesday, March 20, 1991 in room 526-S of the Capitol.

All members were present except:

Representative Arthur Douville - Excused

Committee staff present:
Mary Galligan - Kansas Legislative Research Department
Lynne Holt - Kansas Legislative Research Department
Mary Torrence - Office of the Revisor
Connie Craig - Secretary to the Committee

Conferees appearing before the committee:
Doug Bowman, Coordinator, Children and Youth Advisory Committee
Ronda Barrett, Kansas Prevention Project
John Poertner, University of Kansas
Barbara Huff, Keys For Networking
Juliene Maska, Victims' Rights Coordinator, Office of the Attorney General
Melissa Ness, Kansas Children's Service League
Carolyn Hill, Youth Services, S.R.S.
Bruce Linhos, KALPCCA
Richard Morrissey, Deputy Director, KDHE

Chair Sebelius called the meeting to order.

HB 2010, HB 2542, and HB 2555

Chair Sebelius explained that HB 2010 came out of a special Interim Committee on Judiciary, and is a procedure for establishing a children's services planning commission. HB 2542, which came out of a S.R.S. Task Force this summer, is somewhat similar to HB 2010. HB 2555 is also a product of the recommendations of the S.R.S. Task Force dealing with establishing local children's youth authority projects. Representative Sebelius added that she intended to also appoint a subcommittee to look at the three bills together.

Doug Bowman, Coordinator of the Children And Youth Advisory Committee, commented on the three bills, pointing out the good points and flaws. In closing, he added that pilot projects make sense, but that "re-tooling" existing programs should not be overlooked. He submitted written testimony outlining his comments, Attachment #1.

Ronda Barrett, Kansas Prevention Project, gave testimony on the three bills as they relate to developmental disabilities. She explained what the Kansas Prevention Project does, how it was established, and how it is funded. She added that HB 2010 and HB 2542 could be a vehicle for interagency prevention planning, and asked the Committee that any modification to a standing commission include the prevention responsibilities submitted in her written testimony, Attachment #2. Included in her testimony is an outline of goals, Attachment #3, a pamphlet on developmental disabilities and the S.R.S. prevention plan, Attachment #4, an overview of the plan, Attachment #5, and a draft of the Task Force Report, Attachment #6.

John Poertner, University of Kansas, told the Committee that he enjoyed being on the Children's Subcommittee of the Legislative Task Force this past year, and in particular he spoke about the pilot study for the Local Children's Authority, HB 2555. He read from written testimony, Attachment #7, which addressed reform of the Kansas child welfare system. He added, in response to a question from a Committee member, that there is no problem in decentralizing federal money, and explained that, essentially, it is a matter of purchase of service agreements. All you have to do is make sure that S.R.S. writes their contracts so that federal regulations are satisfied, and the federal dollars will keep coming in. In the matter of decategorization, the Center for Study of Social Policy in Washington, D.C. is looking at this particular issue here in Kansas, and recommends that Kansas maximize the state's possible claims on federal dollars. Even though the federal money is going to be categorical, the matching state dollars could be used in a noncategorical way.

Barbara Huff, Keys for Networking, asked the Committee to support HB 2555. She read from her written testimony, Attachment #8, to show the need for flexible funds in order for families to have access to programs and services that allow them to keep their children at home and in their communities.

Juliene Maska, Victims' Rights Coordinator, Attorney General's Office, asked the Committee to support the three bills. The Attorney General Stephan feels that there is a need for a coordinated system of programs and policies to address the needs of children's services, Attachment #9. In response to a question from a Committee member, Ms. Maska, stated that a designee is desirable over the main player because not at all times can the Attorney General attend, and some of the Assistant Attorney Generals are experienced in specific areas of these laws that would be considered.

Melissa Ness presented testimony to the Committee on the three bills, Attachment #10, hoping to give a form on how the Committee can move through the testimony and proposals set before them.

Carolyn Hill testified to the Committee that S.R.S. supports the development of a more effective collaborative effort at the state and local level, and believes that these bills should be consolidated along with SB 227, Attachment #11. She added that additional studies should not be undertaken without thorough review of the studies which have recently been completed, and that they provide strong policy guidance without additional study. In regards to a recent court case dealing with expanded SSI eligibility that could impact a significant number of the kids that are currently in the Foster Care system, the status is now that S.R.S. has entered in negotiations with Kansas Legal Services to assist in efforts to achieve eligibility. Staff is know trying to identify children who are not already eligible but could be, so that application can be made for those children. We are also proposing that other funds generated remain available to serve children and families rather than going in to the state general funds.

Bruce Linhos shared with the Committee the questions that he had as he studied the three bills as outlined in his written testimony, Attachment #12. He stated that he does support the need for reform of the child welfare system, however, he added that the existing system should be carefully studied. He encouraged the Committee to refer these proposals to an interim, and make sure that resulting recommendations are not shelved. He pointed out that Kansas places some of the more severly need children in several private agencies in Kansas City, Missouri, and that we pay a school fee that goes on top of the fee paid to these private agencies which totals about $1 million a year. That doesn't happen when children from Missouri placed in Kansas.

Richard Morrissey testified on the three bills in regards to the problem of linking separate service delivery systems and try and close the gaps where needed services are not available because of certain boundaries. He closed by adding that KDHE recommends that a time limited commission such as proposed in HB 2010 analyze policy issues and recommend legislation for 1992, Attachment #13. In response to a question from a Committee member, Mr. Morrissey added that decategorizing resources is aimed at categorical grants and particular requirements related to the ability use funds without the limitations of those requirements where there is a need for a particular client or population to provide better service to children.
Attachment #14 is written testimon from Dr. Michael Lubbers who was unable to attend the hearing.

Chair Sebelius adjourned the meeting.

GUEST LIST

FEDERAL & STATE AFFAIRS COMMITTEE

DATE 20 March 91

(PLEASE PRINT) NAME	ADDRESS	WHO YOU REPRESENT
Kenda Bartlett	Ft. Leavenworth	Concerned Women for Amer. of KS
Ken Gentry	Topeka	Dept. of Education
Linda Clanton	401 Topeka, Topeka	K-DHR
Kay Farley	Topeka	OJA
John Rogers	University of Kansas	School of Social Welfare
Carolyn Risley-Hill	Topeka	SRS
N. Judy Keenan	Topeka	Children Youth Adv. Comm
Don Bowman	"	"
June Leasley	Topeka	DOC
Dave McKenna	"	"
Kevin Siek	"	KCDC/KDHR
Will Belden	Topeka	LWVK
Bob Hartman	Wichita	Ks. Children's Service League
Melissa Ness	Topeka	Ks Children's Serv. League
Thomas McBride	Lawrence	observer
Lori Wagnon	Topeka	observer
R ANDERSON	OTTAWA	
Cindy Kelly	Topeka	KASB
Bruce Linhos	Lawrence	KALPCCA
Ronda Barrett	Kansas City	Kansas Prevention Project
Laura Severance	Kansas City	Legislative Intern
Sam Crawford	Shawnee, Ks	observer.

STATE OF KANSAS

CHILDREN AND YOUTH ADVISORY COMMITTEE

SMITH-WILSON BLDG.
300 S.W. OAKLEY
TOPEKA, KANSAS 66606-1898

(913) 296-2017

KANS-A-N 561-2017

TESTIMONY BEFORE FEDERAL & STATE AFFAIRS COMMITTEE
Rep. Kathleen Sebelius, Chairperson
March 20, 1991

Madam Chairperson and members of the committee, thank you for the opportunity to testify today. My name is Doug Bowman, and I represent the Children and Youth Advisory Committee.

We have no doubt that each of these proposed bills is well-intended and deserving of our careful scrutiny. I will comment on each one seperately, and then make some closing comments.

HB 2010

The proposed Kansas children's services planning commission is not a new idea. Last year it was proposed with the name, "Master Planning Commission". When one approaches the task of identifying needed children's services, there is much work already completed. A number of commissions and task forces have documents on your bookshelves already. This last fall we created a plan of our own: "Toward The Year 2000". One of our objectives was to compile these various recommendations into a single, comprehensive plan.

If this bill becomes law, we suggest that the commission it creates begin by reviewing the existing literature. We would be more than happy to assist in this and any other task.

HB 2542

The proposed governor's commission, as established in this bill, has a few flaws. Its members shall consist of five citizens appointed by the governor, four members of the governor's cabinet, the chief justice of the supreme court, and the commissioner of education. When nine of the total eleven members are serving at the pleasure of the governor, the commisssion's credibility may suffer. We would strongly recommend that the legislature be

represented on this body, just as it is on the Children and Youth Advisory Committee.

We do applaud the local emphasis on policy planning found in Section 6. This is a feature also found in SB 227, currently in Government Organization. We believe that much good can be achieved by the creation of local groups of advocates for children who will analyze resources, policies, and problems on a local basis.

HB 2555

The proposed creation of local children's authority pilot studies is one which generates much interest and many questions. On several occasions, I've heard the comment that this might be another reincarnatation of the county welfare system. Undoubtably, this proposal would give these local entities broad powers that may impinge upon current government responsiblities. We feel certain fundamental state obligations should be excluded from the proposed bidding process. For example, the state simply can not delegate duties in the areas of child protective services and juvenile justice matters.

Additional questions arise over the feasibility of decategorizing federal funds. We are unaware of any jurisdiction that has successfully done so. As in the previous proposal, we would recommend legislative participation in the state children's authority. We would also repeat our praise of the emphasis upon local groups being involved in critical policy decisons.

GENERAL COMMENTS

There are features common to HB 2542 and HB 2555 that are to be commended. The emphasis upon local participation in policy decisions is long overdue. The creation of flexible funds that can be used to creatively address the needs of families currently falling into the gaps in our system is also laudable. The use of outcomes-based criteria insures that we get our money's worth. Both proposals seem to be calling for a delivery system more focused on the needs of the families being served with an emphasis on prevention strategies.

At a time of fiscal crisis, when many children's programs are underfunded, we must proceed cautiously. In general, pilot projects make a lot of sense. In our efforts to design a state-level oversight body, we should not overlook the possibility of "re-tooling" the existing machinery. The Children and Youth Advisory Committee and the Advisory Commission on Juvenile Offender Programs could serve in this capacity.

March 20, 1991

Madam Chairperson and Members of the House of Representatives Federal and State Affairs Committee,

The Kansas Prevention Project has developed a state plan for the prevention of developmental disabilities. This project is a part of a national effort to promote planning for the prevention of childhood disability. The project has been funded by the Kansas Planning Council for Developmental Disabilities Services and the Advisory Commission for Children with Special Health Care Needs.

The prevention project organized a interdisciplinary Task Force with representatives from various state agencies, professional associations, advocacy groups and consumers. The Task Force has developed a state prevention plan entitled "Prevention Pays: Preventing the Causes of Developmental Disabilities in Kansas." The plan sets forth a broad agenda of maternal and child health, education and welfare issues currently facing Kansas and makes recommendations on these issues.

The plan's main focus is on primary prevention or strategies which reduce the likelihood of disability ever occurring. It contains elements of secondary prevention such as intervention into conditions which could cause a permanent disability as well as tertiary, or third level prevention, including rehabilitation services for children with serious problems. The plan's main

emphasis is on assuring that healthy babies are born, that children mature and are able to make wise lifestyle choices and that parents are empowered to fulfill their responsibilities as parents.

In developing the Kansas plan the project reviewed 30 prevention plans and projects from other states to see what strategies might be applicable to Kansas. We also collected information on over 70 prevention programs or efforts within our state.

As a part of the project the Task Force was asked to make a recommendation on where the oversight of prevention efforts should be housed within state government. The Task Force identified both lead and planning agencies for each issue which is addressed in the state plan.

The very nature of prevention planning and the interrelated aspects of the issues identified by the Task Force require an interagency approach which will promote cooperation and collaboration among the departments of Health and Environment, Education and Social and Rehabilitation Services.

Either HB 2010 or 2542 could be a vehicle for interagency prevention planning. It is a concern of the Task Force that the focus of these commissions will be on issues related primarily to child welfare and social problems. In order to assure a comprehensive prevention approach we would purpose the addition of

the following responsibilities in HB 2542 and/or HB 2010:

> **to promote governmental and private sector prevention activities and to oversee prevention issues, policies and programs which promote the maximum independence of individuals and strengthen families; which avoid or minimize physical or mental disability or dysfunction; which reduce the likelihood of dependency on governmental and private sector support, treatment and rehabilitative services; and which encourage future cost savings through early intervention or treatment.**

As the Committee on Federal and State Affairs reviews these bills we would also suggest that in these times of tight fiscal constraints the legislature review the possibility of modifying an already existing commission to accomplishing the purposes set out in HB 2010 and HB 2542. We would recommend that any modification to a standing commission include the prevention responsibilities which we have submitted for your consideration.

Respectfully submitted,

Ronda Barrett
Kansas Prevention Project

The KANSAS Prevention of Developmental Disabilities Plan - Agency Overview
Prevention Project - Children's Rehabilitation Unit - University of Kansas Medical Center - 913-588-5900

1/91 Prevention Goal	Lead Agency: The agency with primary responsibility for service delivery.	Agencies with supplementary planning responsibilities
Goal 1 - Prepregnancy Risk-Factor Identification	Kansas Department of Health-Environment (KDHE)	SRS/Income Support & Medical Svcs.
Goal 2 - Comprehensive School Health Programs	Kansas Department of Education (KSDE)	SRS/Alcohol & Drug Abuse Svcs. (ADAS) KDHE
Goal 3 - Prenatal Care	KDHE	SRS/Income Support & Medical Svcs.
Goal 4 - Nutrition	KDHE	KSDE; SRS/Income Support & Medical Svcs.
Goal 5 - Drug Use & Pregnancy	SRS/ADAS	KDHE, KSDE, SRS/Youth Services
Goal 6 - Adolescent Pregnancy	KDHE	SRS/Income Support & Medical Svcs. SRS/Youth Svcs. KSDE,
Goal 7 - Primary Health Care for Children	KDHE	SRS/Income Support & Medical Svcs.
Goal 8 - Child Safety	KDHE	Kansas Department of Transportation (KDOT), KSDE, SRS/Youth Services, SRS/Vocational Rehabilitation Svcs.
Goal 9 - Identification & Intervention	KDHE	SRS/MHRS, Coordinating Council for Early Childhood Development, KSDE, SRS/Youth Services, SRS/Income Support & Medical Svcs.
Goal 10 - Child Abuse	SRS/Youth Svcs.	KDHE, KSDE
Goal 11 - Training and Support Services For Adolescents and Adults with & Mental Retardation with Cognitive Disabilities	KSDE	KSDE, KDHE, SRS/Vocational Rehabilitation Svcs., SRS/Mental Health & Retardation Svcs.

PUBLIC FORUMS

You are invited to a public forum to learn more about the Plan and to present your comments on these issues. Copies of the plan may be picked up in advance at the listed distribution site. The forums are scheduled at the following locations and times:

Emporia - March 6 - 4:00 PM
Emporia High School Little Theater
Contact: Judy Ball (316) 343-2302
Distribution Site: Lyon County Health Department & Emporia SRS Office

Hutchinson - March 11 - 4:00 PM
Hutchinson Community Student Union
Contact: Joyce Collins (316) 665-4509
Distribution Site: Reno County Health Dept.

Wichita - March 12 - 4:00 PM & 7:00 PM
Kansas Children's Service League
Contact: Judy Reno (316) 268-8425
Distribution Site: Sedgwick County Health Stations

Johnson County - April 2 - 4:00 PM
Johnson County Health Dept., Lamar Ave.
Contact: Ronda Barrett (913) 588-5900
Distribution Site: Johnson County Health Dept. & Johnson/Leavenworth Regional Center-Regent's Center

Kansas City, KS - April 8 - 4:00 PM
Wyandotte County Library - West Branch
Contact: Ronda Barrett (913) 588-5900
Distribution Site: Wyandotte County Health Dept.

Topeka - April 11 - 7:00 PM
Topeka Association for Retarded Citizens
Contact: Sabra Diehl (913) 232-0597
Distribution Site: Shawnee County Health Dept. & Topeka SRS Office

Hays - April 18 - 3:00 PM
Ft. Hays State University - Memorial Union
Contact: Vickie Runge (913) 625-5678
Distribution Site: University of Kansas Medical Center Outreach Program

CHILDREN'S REHABILITATION UNIT
UNIVERSITY OF KANSAS MEDICAL CENTER
39TH & RAINBOW BLVD
KANSAS CITY, KS 66103

DID YOU KNOW ---

that 70,300 Kansans have a developmental disablity?

that these people are limited in their ability to care for themselves, learn, communicate and make a living?

that your tax dollar provides billions of dollars of services to disabled persons?

AND

that 50% of the known causes of developmental disabilities are preventable?

Kansas has no organized plan to prevent the causes of developmental disabilities

BUT

Something is being done to correct this.

A statewide Task Force has developed a plan for the state of Kansas.

Prevention is a partnership among professionals, government, voluntary organizations and agencies.

Prevention aims to:

- Improve maternal & child health, education & social services
- Assure adequate program funding
- Increase awareness of the preventability of disability
- Increase accountability of program effectiveness
- Advance knowledge through research

SPONSORED BY:

The University of Kansas Medical Center
Children's Rehabilitation Unit
913-588-5900

Services for Children with Special Health Care Needs/Kansas Department of Health & Environment

Kansas Planning Council on Developmental Disabilities Services/Mental Health & Retardation Services/Kansas Department of Social & Rehabilitation Services

PREVENTION PAYS: PREVENTING THE CAUSES OF DEVELOPMENTAL DISABILITY

Goal 1: Expand pre-pregnancy education and counseling programs to help families plan for the birth of healthy babies.

Goal 2: Improve the health of Kansas school children by expanding health education and services in the schools.

Goal 3: Assure that all pregnant women have access to adequate prenatal care.

Goal 4: Increase the availability of programs that support adequate nutrition of mothers and children.

Goal 5: Reduce the number of babies who were prenatally exposed to drugs, alcohol and tobacco, and expand treatment for those who were.

Goal 6: Reduce the number of babies born to adolescent mothers and provide support to pregnant adolescents to reduce low birthweight and developmental disabilities.

Goal 7: Expand the availability of primary health care to all children to prevent disabilities caused by childhood diseases.

Goal 8: Reduce the number of children who die or are permanently disabled as a result of preventable injuries.

Goal 9: Expand services and provide information about screening, early identification, referral, intervention and follow-up in order to correct or reduce the effects of disability(s) in young children.

Goal 10: Reduce the incidence of child abuse in order to prevent permanent educational and physical disabilities.

Goal 11: Expand training and support services in family life education to help people with mental or learning disabilities become more responsible adults and effective parents.

THE KANSAS PREVENTION OF DEVELOPMENTAL DISABILITIES PLAN - OVERVIEW

Prevention Project - Children's Rehabilitation Unit
University of Kansas Medical Center - 913-588-5900

Prevention Goal	Rationale
Goal 1: Prepregnancy Risk-Factor Identification	Preconceptional identification of high risk pregnancy factors (e.g., nutritional deficits, chronic health conditions like diabetes, drug/alcohol use) and the provision of intervention services to these women will increase the likelihood of early entry into prenatal care, thereby increasing the potential for a positive pregnancy outcome.
Goal 2: Comprehensive School Health Programs	Children and youth who have opportunities to learn and practice sound principles of healthy living are more likely to become healthy parents of healthy babies. The estimated 450,000 children who attend Kansas schools (approximately 20% of the States' population) form a prime audience for prevention of health problems, health promotion, health protection and the early identification of health problems.
Goal 3: Prenatal Care	Studies have documented that comprehensive prenatal care initiated in the first trimester (with minimum of 9 visits) has improved pregnancy outcome.
Goal 4: Nutrition	The optimal health and well being of mothers an their children depends on nutrition issues being addressed in all programs serving women of child bearing age and their families.
Goal 5: Drug Use & Pregnancy	Babies who have been exposed to illegal drugs or legal substances such as tobacco and alcohol consistently show reductions in birth weight, body length and head size. Studies have shown that prevention/early intervention with treatment can improve the pregnancy outcomes of drug-using women. Their children, who have been prenatally exposed to drugs, can benefit from early intervention programs which, combined with a stable rearing environment, may mitigate the effects of the early drug exposure.

Goal 6: Adolescent Pregnancy	Infants born to adolescent mothers are the single largest group at risk for poverty. They are also at high risk for low birth weight and developmental disability.
Goal 7: Primary Health Care for Children	Primary health care for children plays a role in the prevention of developmental disability by providing a source of a medical and health base which will provide continuity of care and a source of health information and counseling (Wallace 1989).
Goal 8: Child Safety	Unintentional injury is the leading cause of long-term disability and death among children and youth in the United States. Prevention interventions involving awareness and education combined with engineering, legislation, regulation and enforcement have demonstrated considerable effectiveness in reducing rates of preventable injuries.
Goal 9: Identification & Intervention	Early intervention reduces the incidence of childhood disabilities by preventing secondary and tertiary disabilities or complications. Recognizing that, a statewide comprehensive early intervention system needs to be in place. Such a system should provide the coordination of interagency programs and be family focused.
Goal 10: Child Abuse	Prevention of intentional physical, mental and emotional injury of children will also protect them from potential developmental disabilities. Prevention of child abuse will help to break the cycle of abusive behavior in future generations.
Goal 11: Training and Support Services Adolescents and Adults Cognitive Disabilities	Children of parents with cognitive disabilities are at increased risk for developmental delays stemming from inadequate skills on the part of the parent. Current parent education programs often fail to address the special education needs of this population.

PUBLIC FORUMS:

Emporia - March 6 - 4:00 PM
Contact: Judy Ball (316) 343-2302

Wichita - March 12 - 4:00 & 7:00 PM
Contact: Judy Reno (316) 268-8425

Hutchinson - March 11 - 4:00 PM
Contact: Joyce Collins (316) 665-4509

Johnson County - April 2 - 4:00 PM
Contact: Ronda Barrett (913) 588-5900

Kansas City, KS - April 8 - 4:00 PM
Contact: Ronda Barrett (913) 588-5900

Topeka - April 11 - 7:00 PM
Contact: Sabra Diehl (913) 232-0597

Hays - April 18 - 3:00 PM
Contact: Vickie Runge (913) 625-5678

PREVENTION PAYS:

PREVENTING THE CAUSES OF DEVELOPMENTAL DISABILITIES IN KANSAS

DRAFT

FEBRUARY, 1991

Sponsored by:

The University of Kansas Medical Center
Children's Rehabilitation Unit

Services for Children with Special Health Care
Needs/Kansas Department of Health and Environment

Kansas Planning Council on Developmental Disabilities
Services/Mental Health and Retardation
Services/Kansas Department of Social and
Rehabilitation Services

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Kansas Prevention Task Force
for Prevention of Developmental Disabilities

Andy Aelmore
State Coordinator
Vietnam Veteran's Family
Assistance Program

Vernon Branson, M.D.
Kansas Advisory Commission
on Children with Special
Health Care Needs

Sheryl Lorance-Brotton
Early Childhood Handicapped Programs
Wichita Public School District

Martha Claflin, Ed.S.
Kansas Division for Early Childhood

Rene Clark, Ed.N., R.N.
Associate Professor of
Pediatric Nursing
University of Kansas Medical Center

Dolores Collins
Consumer Member
Topeka, KS

Joe DeLaTorre
Special Assistant for Public Liason
Office of the Governor

Sabra Eastin Diehl
Director of Childhood Development
Topeka Association for
Retarded Citizens

Michael Dix
Coordinator
Kansas Head & Spinal Cord Injury
Prevention Project
Head Injury Association of Kansas

Phillis Ellis
Coordinator
School Psychology & School Work Services
Special Education Section
Department of Education

Camille Heeb, M.D.
American Academy of Pediatrics
Kansas Chapter

Mary Hillin
Manager, Mental Health & Home Care Programs
SRS/Medical Services

Gary Hulett
Special Assistant for Health
and Environment
Office of the Governor

Mary Ann Humphries
Coordinator, Healthy Start
Lay Home Visitor Program
Kansas Department of Health
and Environment

Sharon Turner-Jackson
Director of Community Services
Greater Kansas City March of Dimes

Dave Jones
Executive Director
United Cerebral Palsy of Kansas

Karen Juola
Child Care Center Program Specialist
Job Preparation Program
SRS/Adult Services

John Kelly
Executive Director
Kansas Planning Council for
Developmental Disabilities Services

Linda Keeney
Director, Children & Families Section
Kansas Department of Health & Environment

Cassie Lauver
Director, Services for Children
with Special Health Care Needs
Kansas Department of Health &
Environment

Joyce Markendorf
Coordinator, Health Services for
Schools and Adolescents

Sarah McCamman
Nutritionist, Children's
Rehabilitation Center
University of Kansas Medical Center

Jim McHenry, Ph.D.
Executive Director
Kansas Child Abuse Prevention Council

Judy Moler, J.D.
Executive Coordinator
Coordinating Council for
Early Childhood Developmental Services

HOUSE FEDERAL AND STATE AFFAIRS
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Attachment #6 - Page 3

Al Nemec
Commissioner
SRS/Mental Health &
Retardation Services

Kate-Ames Oliver
Program Consultant
SRS/Alcohol & Drug Abuse
Services

Ann Rollins
Director
The Governor's Office of Children
and Families

Rebecca Ruble, M.D.
Assistant Professor
Department of Family Practice
University of Kansas Medical Center

Rita Kay Ryan, R.N., M.N., Ph.D.
Coordinator, Health Services for
Mothers and Children
Kansas Department of Health &
Environment

Iris E. Sanders, R.N.
Nursing Consultant
Kansas Department of Health
& Environment

Jeanie Schiefelbusch
Intervention Specialist
Johnson & Leavenworth Regional
Prevention Center

Richard Schiefelbusch, Ph.D.
Director, Center for Life-
Span Studies
University of Kansas

Patricia Scholesser, M.D.
Topeka, KS

Dorothy Sillett
Consumer Member
Merriam, KS

Perry Skinner
Consumer Member
Overland Park, KS

Josie Torrez
Consumer Member
Topeka, KS

Rosalinda Underdahl
Administrator of Admissions
& Release
SRS/Mental Health & Retardation
Services

Debra Voth
Director of Early Education
Center of T.E.C.H.
Reno County Public Schools

Russell Willbourn
Federal Programming, Office of
Transportation Safety
Kansas Department of Transportation

Janet Wilson
Program Specialist, Health
and Physical Education
Kansas Department of Education

Prevention Project Staff

Allen Erenberg, M.D.
Professor & Chairman
Department of Pediatrics
University of Kansas Medical Center

Ronda Barrett
Project Coordinator
Children's Rehabilitation Unit
University of Kansas Medical Center

Jean Ann Summers, Ph.D.
Director
Kansas University Affiliated Program
University of Kansas

KANSAS PREVENTION TASK FORCE
MISSION STATEMENT

The Kansas Prevention Task Force is dedicated to maximizing the positive potential of all Kansas citizens. Research has unequivocally demonstrated that it is possible to reduce both the incidence of disabling conditions, and the impact of those conditions on the people they affect. Therefore, the purposes of prevention planning and activities are to:

A. reduce the occurrence, both before and after birth, of physical and environmental factors that may cause disabling conditions which limit the cognitive, physical, or emotional potential of the persons they impact;

B. remediate or correct those limitations when they do occur; and

C. provide rehabilitation and environmental support to maximize the independence, productivity, and integration of persons who have disabilities.

Recognizing that broad and interrelated biological,social, and environmental factors contribute to disabling conditions, our mission is to develop a comprehensive interagency approach involving interagency and interdisciplinary collaboration at all levels. The goal is to develop an ongoing, coordinated effort to address a range of prevention-related issues through:

A. expanding and coordinating health, education, and social services related to prevention;

B. expanding and coordinating public and private funding streams for prevention-related services;

C. increasing public awareness of prevention-related issues and providing public education regarding health and social behavioral changes that maximize human potential;

D. providing pre- and in-service training to professionals to enhance their capacity to provide prevention-related services;

E. developing and maintaining a data collection and evaluation system to monitor the need for and the effectiveness of prevention-related activities; and

F. encouraging basic and applied research to further understanding of prevention strategies.

INTRODUCTION

HOW DID PREVENTION EFFORTS BEGIN IN KANSAS?

The Kansas Prevention of Developmental Disabilities Project began as a result of prevention initiatives which were spearheaded by the President's Committee on Mental Retardation (PCMR). In the 1980's the PCMR began to focus on assisting states in planning for prevention of mental retardation. The PCMR's prevention activities were developed to help states reach the goal "to reduce the occurrence of mental retardation by half before the end of the century" which was cited in Executive Order 11776 issued by President Richard M. Nixon, in November, 1974.

The University of Kansas Medical Center - Children's Rehabilitation Unit received seed money from Services for Children With Special Health Care Needs in 1987. The funding enabled the new Kansas Prevention Project to begin collecting data on developmental disability prevalence as well as prevention services and activities in the state. The project produced the report Now Is The Time, a proposed plan with preliminary reports about needs and services that affect families and communities.

A statewide prevention task force was convened in 1988. It was composed of professionals and delegates from voluntary organizations in many fields including health, education and social service. A mission of the Task Force was to begin to develop a state plan for the prevention of developmental disabilities. In the Spring of 1989, the Kansas Planning Council on Developmental Disabilities Services provided funding to further refine the Project's prevention goals and to begin prevention activities in Kansas.

The Prevention Project sponsored a statewide conference on Prevention of Childhood Disabilities in December of 1989. The conference received support from Kansas Governor Mike Hayden. United States Senator Robert Dole delivered the keynote address to about 200 Kansas citizens. In conjunction with the conference four local Community Action Teams (CATs) participated in special training in order to plan and implement local prevention projects within their respective communities.

Additional prevention activities have included the development of a Prevention Resource Network. The resource network developed collection of prevention plans and/or programs from throughout the country, a topical resource file on different causes of developmental disability, and a collection of Kansas prevention programs and initiatives. The Children's Rehabilitation Unit's Prevention Resource Network has provided information about various prevention topics to individuals throughout the state.

WHAT DOES THE TERM DEVELOPMENTAL DISABILITY MEAN?

The term developmental disability is a functional category applied to a variety of childhood conditions. The legal definition of developmental disability was established by Public Law 95-602 (The Rehabilitation, Comprehensive Services and Developmental Disabilities Amendments of 1978). This statute defined a developmental disability as a severe, chronic disability of a person which:

(A) is attributable to a mental or physical impairment or combination of mental and physical impairments;
(B) is manifested before the person attains the age of twenty-two;
(C) is likely to continue indefinitely;
(D) results in substantial functional limitations in three or more of the following areas of major life activity: (1) self-care, (2) receptive and expressive language, (3) learning, (4) mobility, (5) self-direction, (6) capacity for independent living, and (7) economic sufficiency; and

(E) reflects the person's need for a combination and sequence of interdisciplinary, or generic care, treatment, or other services which are of life-long or extended duration and are individually planned and coordinated.

This definition allows children to qualify for services by meeting this functional criteria rather than obtaining a specific diagnosis of a chronic disease or condition.

WHAT IS INCLUDED IN THE KANSAS PREVENTION OF DEVELOPMENTAL DISABILITIES STATE PLAN?

The Kansas Prevention Task Force has identified eleven issues in the state of Kansas which contribute to the prevalence or reduction of developmental disabilities in our state. A goal has been written which addresses each issue. These goals follow the human lifespan and include women's preconceptual health status, school health programs, prenatal care, maternal and child nutrition, drugs and pregnancy, adolescent pregnancy, children's health, unintentional injury, identification of and early intervention with children at risk for a developmental disability, child abuse and the reproductive status and parenting skills of adolescents and adults with cognitive disabilities. The Kansas Prevention Plan is a plan for all Kansans. The recommendations provide a guide for development and improvement of services and training provided by state agencies and institutions of higher education. At the same time, the recommendations will provide a focus for private sector initiative and development.

The sections that follow focus on each of these goals. Following a description which explains the Task Force's selection of that issue, the specific objectives and recommendations are presented. These recommendations are organized into categories of (1) services, (2) funding, (3) consumer and public awareness, (4) pre- and in-service training, (5) data collection and evaluation and (6) basic and applied research. Following the recommendations are the Task Force's designation of the state agencies most responsible for attending to that goal.

Finally, the plan identifies other key players who could contribute to the achievement of the objectives of that goal.

The Kansas Prevention of Developmental Disabilities Task Force has developed the following goals, objectives and recommendations. They have been developed as a standard to direct the continuation of maternal and child health services, to guide the development of new services and to measure progress in these areas for our state.

The future of Kansas rests with her children. It is incumbent upon the citizens of our state to assure the healthy birth, growth and development of Kansas children.

PREPREGNANCY RISK-FACTOR IDENTIFICATION

GOAL 1: EXPAND THE RANGE AND AVAILABILITY OF REPRODUCTIVE RISK-FACTOR IDENTIFICATION, EDUCATION AND CONSULTATION PROGRAMS.

Organized programs which, prior to pregnancy, counsel women about their maternal health status, are a relatively new movement. These programs operate upon the premise that "a healthy pregnancy begins before conception" (Wallace, 1989, p.10). Programs which promote preconceptual health help a young woman to examine her reproductive health profile. They include a self-appraisal of the woman's nutritional status and habits; her social history (i.e., use of drugs like alcohol and tobacco); and her possible exposure to toxins in the home or work environment. The woman's family background is reviewed for possible hereditary factors such as high blood pressure, sickle cell disease and mental retardation, any of which could compromise a pregnancy outcome. Medical, reproductive and drug histories are reviewed with the client and simple explanations and suggestions for improving her health status, before considering pregnancy, are given to the woman. Referrals to services such as smoking cessation classes, genetic counseling, nutrition counseling, regular medical care, drug treatment etc. are made when appropriate.

The state of North Carolina has implemented such a program in all of it's Family Planning Clinics (Weinfeld, Rose & Moos, 1987). Ongoing evaluation of this program by the University of North Carolina shows its influence upon participant's early entry into prenatal care. According to the North Carolina Department of Health, 68% of the clients who received pre-conceptional health counseling entered prenatal care during the first trimester of pregnancy compared to 56% who received only family planning services and 32% who received no services (Grissom, 1989).

The birth of a healthy newborn is not a chance occurrence. The proposed addition of a prepregnancy health assessment, counseling and referral to intervention services included as a component of the health history for all Kansas women of reproductive age will help these women to become more knowledgeable of and responsible for their reproductive health. The end result should be an increase in the number of women receiving early and continuous prenatal care and thus increasing the likelihood of a positive pregnancy outcome.

Objective

By the year 2000, preconception counseling will be implemented in 75% of local health departments and Planned Parenthood agencies providing pregnancy testing and/or family planning services.

Performance Indicator: The number of local health departments with a preconceptional counseling program.

Baseline Data: There are no known comprehensive local preconceptional counseling programs currently in operation (8/19/90).

Objective Source: Kansas Prevention Task Force

Agency Planning Responsibility:

Lead Agency - Kansas Department of Health and Environment (KDHE); SRS/Medical Services and Income Support.

Other Key Players:

Kansas Public Health Assn.; Kansas Nurses Assn., Kansas Chapter-The American College of Obstetricians and Gynecologists, Perinatal Assn. of Kansas, Kansas Chapter - American Academy of Family Practice, Local Health Departments, Planned Parenthood, Inc., Kansas Medical Society, Board of Regents (Regents), Kansas Planning Council on Developmental Disabilities Services (D.D. Council).

Recommendations:

I. Develop resource/guidance materials outlining the components of preconception risk assessment and related counseling to be used, and expanded by local health departments and/or family planning programs.

   * Promote the use of preconceptional risk assessment in collaboration with existing professional organizations (e.g., Kansas-American College of Obstetricians and Gynecologists, Kansas-American Academy of Pediatrics, Nurses Association of the American College of Obstetricians and Gynecologists, Kansas Medical Society, Kansas Nurses Association, Kansas-American Academy of Family Practice).

II. Maintain and/or increase funding for reproductive programs serving identified and high-risk reproductive clients.

   * Obtain federal and/or state funds to support expansion of family planning services, to include preconception counseling, by local health departments and/or family planning programs.

   * Obtain funding to support comprehensive genetic services, including statewide genetics outreach clinics.

III. Intensify consumer and public awareness of the need for pre-pregnancy planning, early and continued prenatal care, and risks that impact the fetus and pregnancy outcomes.

   * Identify strategies to reach targeted risk populations with public awareness information in collaboration with existing public and private health care providers and consumer advocacy/coalition groups.

   * Promote collaboration among community based agencies/groups to facilitate distribution of public awareness information.

IV. Expand pre- and in-service training of health professionals on reproductive risk factors.

* Promote training for nursing and medical students and health care professionals in the identification and evaluation of patients/clients at high risk for negative pregnancy outcomes.

* Inform health care providers of available resources to assist with the identification and referral of clients with potential reproductive risk factors.

V. Monitor the entry date into prenatal care and the pregnancy outcomes of women who have received pre-conceptional counseling to evaluate the effectiveness of pre-conceptional counseling programs.

VI. Analyze the trends in prenatal care adequacy and perinatal outcomes in counties where preconception risk assessment and counseling were implemented by local health departments and/or family planning programs.

COMPREHENSIVE SCHOOL HEALTH PROGRAMS

GOAL 2: IMPROVE COMPREHENSIVE HEALTH PROGRAMS PROVIDED TO CHILDREN AND ADOLESCENTS IN KANSAS SCHOOLS.

The birth status of future generations of Kansans is dependent, to a degree, upon the health status of parents. The time to begin assuring the state of parent's health is during childhood, long before individuals attain the ability to conceive and bear children. Kansas schools provide a population primed for learning healthy behaviors, receiving preventive health services and detecting health problems. An estimated 450,000 children attend Kansas schools and account for approximately 20% of the population of the state. Failure to provide learning opportunities about health to this "captive audience" is, at best, a missed opportunity. Kansas schools are moving toward providing comprehensive health programs for all children. Comprehensive health programs include education, health services, and a healthy school environment (Henley & Wilson, 1990).

Comprehensive health education provides a coordinated, sequenced program of study in grades K-12 and includes instruction about: good health habits, nutrition, health maintenance, injury control, alcohol and other drug use, anti-smoking, human genetics, consumerism, mental and emotional health, human sexuality/AIDS education and the achievement of healthy pregnancy outcomes.

Comprehensive health services provide: health screenings (e.g., hearing, dental, vision, scoliosis), early identification of health problems, intervention, faculty/staff wellness programs and fitness assessments for school age children and youth.

A healthy school environment ensures that annual health and safety inspections are made of school building and grounds and that all potential environmental hazards are corrected. It also provides a learning atmosphere that is free from violence and disruptive behavior.

Kansas schools are making strides toward providing comprehensive health education. According to the compiled 1989 principal's building report, 85% of the schools reported having a written curriculum plan for comprehensive health education. However, according to the same report, only 79% of the schools actually provided comprehensive health education to students in grades K-9. At the high school level, (10-12th grades) only 25% of the schools provided comprehensive health education and only 9% of schools provided comprehensive health education to special education students (Wilson, 1990).

In 1987, the Kansas Board of Education approved an accreditation regulation requiring all school systems to provide elementary and secondary programs in human sexuality and AIDS education. By the Fall of 1989, 74% of K-9th grade students were receiving human sexuality/AIDS education. On the secondary level, only 34% of 10-12th grade students received the instruction. Only 19% of the special education students were receiving human sexuality/AIDS education.

The majority of school health services are provided by school nurses. The national recommendation for an optimal nurse/student ratio is one nurse per 750 students. The reported average case load in Kansas schools is one nurse per 1,141 students. Five rural Kansas school districts have no identified nursing services. An estimated 33% of local school districts have a policy which requires a physical examination upon initial school entry. All other districts recommend initial entry physical examinations but do not require them (Markendorf, personal communication, July 16, 1990).

In order to ensure a healthy environment, all Kansas schools are required by law to undergo an annual inspection by the local fire marshal. The local health officer also is required to perform an annual inspection of every attendance center. It is estimated that 50% of Kansas school attendance centers, largely in rural areas, do not receive these inspections.

The school improvement process, is a part of the proposed Kansas Outcomes Accredition Process. Inclusion of comprehensive health education and service in each school's improvement plan is a primary target for the future. Kansas schools are making advances in the provision of comprehensive school health programs. However, improvements remain to be made if Kansas children are to be adequately prepared to assume their role as parents of the future generations of healthy Kansans.

Objective

Increase the capacity of local schools and communities to provide comprehensive health programs for all students and school personnel.

Performance Indicator: The percentage of schools which address comprehensive health programs in the school improvement process.

Baseline Data: The number of schools addressing comprehensive health education and health services in their school improvement plan is currently unavailable.

Objective Source: Kansas Prevention Task Force

Agency Planning Responsibility:

Lead Agency - Kansas Department of Education (KSDE), KDHE, SRS/Medical Services and Income Support, Alcohol and Drug Abuse Services (ADAS).

Other Key Players:

Kansas Chapter National Education Assn.; United School Administrators of Kansas; Kansas Congress of Parents and Teachers; Local School Districts; Kansas Medical Society; Kansas Chapter of the American Academy of Pediatrics; Kansas School Nurses Organization; Developmental Disabilities Planning Council; Kansas Assn. of Health, Physical Education, Recreation and Dance; Kansas Federation of Teachers; Kansas Speech and Hearing Assn.; Kansas Assn. of School Health; Kansas State High School Activities Assn.; Kansas Assn. of School Boards; Kansas Assn. of Special Education Administrators; Local Health Departments; Kansas Assn. of Elementary School Principles; Kansas Assn. of Secondary School Principles, Kansas Home Economics Assn., Kansas Assn. of Vocational Home Economic Teachers; Kansas Advisory Council on Environmental Education.

Recommendations:

I. Improve health programs in elementary and secondary schools.

* Expand health education in Kansas schools to provide a coordinated, sequenced program of study in grades K-12.

* Increase by 15% the number of schools which provide sequential, comprehensive health education instruction for students in grades K-9.

* Increase by 20% the number of schools which provide comprehensive health instruction, including family life education, for students in grades 10-12.

* Increase by 25% the number of Special Education students who receive comprehensive health education.

* Increase to 95% the number of school attendance centers that have a First Responder Emergency Plan for injuries and medical emergencies.

* Expand the health services which are provided by Kansas schools to address the full range of screenings, interventions, health assessment and health counseling for school age children and youth.

* Increase to 50% the number of school districts which meet the nationally recommended ratio of one nurse to 750 students.

* Increase to 60% the number of local school districts that require a physical assessment upon initial school entry.

* Support or increase the capacity of local school districts to provide faculty/staff wellness programs.

- Maintain a healthy and safe environment that protects the well being of students, teachers and support staff.

II. Develop and/or increase funding for comprehensive health programs.

- Improve local school district's use of categorical funding to implement comprehensive health education.
- Develop a funding base to provide for comprehensive health services.
- Increase funding to local health departments for the employment of sanitarians to provide annual school building inspections.

III. Expand consumer and public awareness of the need for comprehensive school/community health programs.

IV. Expand pre- and in-service training to teachers, school administrators, school social workers, counselors, psychologists and school nurses on the implementation of comprehensive school health programs.

- Increase the number of school districts which include the development and improvement of school health education as a part of their local district in-service program.
- Increase the number of elementary and secondary teachers who participate in training workshops on comprehensive health education.
- Provide training for teachers in integrated and non-integrated classrooms on adapting human sexuality/AIDS and health education to meet the cognitive needs of special education students.
- Improve local school district's use of health services staff in providing in-service training to faculty and staff on health information and the provision of health services (e.g., asthma, epilepsy, playground safety; proper administration of medication, etc).

V. Assess the need for and maintain data on the availability of comprehensive K-12 health education, assessment and services; environmental inspections; and evaluate the effectiveness of these programs in Kansas schools.

- Maintain data on the number of school districts which incorporate comprehensive health programs in the school improvement plan.
- Support or increase the capacity of local school districts to evaluate their school's comprehensive health program.

VI. Support basic and applied research on effects/results of comprehensive health programs.

- Develop funding for research to identify effective methodology in school health programs.

UNIVERSAL ACCESS TO PRENATAL CARE

GOAL 3: PROVIDE UNIVERSAL ACCESS TO COMPREHENSIVE PRENATAL CARE SERVICES FOR WOMEN OF CHILD BEARING AGE.

Prenatal care is a critical component in the prevention of preterm delivery and low birth weight. Such care also provides an opportunity for early intervention into additional situations that can endanger the fetus such as, poor nutrition, substance abuse or chronic diseases. Good prenatal care includes client education and support as well as medical assessments and diagnostic testing.

Adequate prenatal care begins in the first trimester and continues at regular intervals. Prenatal care has been well documented as a cost-effective approach to prevention of infant morbidity and mortality. The Kansas Department of Health and Environment records show that in 1988, 5,288 pregnant women (14.1%) received inadequate prenatal care. Monmaney (1988) referred to a study in North Carolina which found that women who received less than adequate care were 30% more likely to deliver prematurely than those who had access to a full service program. High costs of neonatal intensive care, subsequent rehospitalizations during infancy, special education, and therapy costs throughout childhood are all associated with prematurity and low birth weight (LBW).

As a nation, our country has a higher incidence of LBW than other industrialized countries. For example, Sweden's LBW rate for 1979-1981 was 3.6%, Norway's was 4.2%, and the USA's was 7.4% (Szanton 1986). Approximately 6% of all babies born in Kansas in 1988 were of low birth weight (2,500 grams or under). A LBW baby is 40 times more likely to die within its first month of life than a baby of normal weight (Institute of Medicine, 1985). After that time, the risk of death is five times that of normal weight babies. LBW babies are three times more likely to present early neurodevelopmental handicaps. These babies are also at a significantly greater risk of developing long-term disabilities such as cerebral palsy, autism, mental retardation, vision and hearing impairments, school failure, and affective disorders (Baumeister, Dokecki and Kupstas, 1988).

Universal access to prenatal care provides an effective intervention to conditions which result in prematurity and low birth weight. As such, prenatal care is a primary prevention strategy which will allow the best possible start in life for future babies born in Kansas.

Objective

By year 2000, 90% of all Kansas residents, delivering live infants, will receive adequate prenatal care as defined by the Kansas Prenatal Care Index (care beginning in the first trimester and continuing for at least nine or more prenatal visits).

Performance Indicator: Percent of pregnant women receiving adequate prenatal care.

Baseline Data: 85.9% of all pregnant women received adequate prenatal care in 1988; and 70% of black women received adequate care in 1988.

Objective Source: Kansas Department of Health and Environment (KDHE), Bureau of Family Health 1990-2000 Operational Plan Draft.

Agency Planning Responsibility:

Lead Agency - Kansas Department of Health and Environment; SRS/Medical Services and Income Support.

Other Key Players:

Kansas Public Health Assn.; Kansas Nurses Assn., Kansas Chapter of the American College of Obstetricians and Gynecologists; Local Health Departments; Developmental Disabilities Planning Council; Kansas Action for Children; Kansas Chapter of the American Academy of Family Practice; Kansas Medical Society; Insurance Assn., Kansas Hospital Assn.; Regents.

Recommendations:

I. Assure access to comprehensive prenatal care for all Kansas women through public or private providers.

- Develop guidance materials outlining components of comprehensive prenatal care, including a risk assessment, to be used by the Kansas Maternal and Infant Program, obstetrical clinics and physicians in private practice.
- Support the use of nurses, social workers, dietitians, and health educators as members of the prenatal health care team.
- Support the use of advanced registered nurse practitioners (ARNP) and/or certified nurse midwives (CNM) to provide prenatal care.
- Support the implementation of enhanced prenatal services for Medicaid eligible women as outlined by Omnibus Budget Reconciliation Act of 1988 (OBRA 88).
- Advertise the availability of the Toll-Free "Let's Make a Difference" line to direct women to obstetrical care and social service resources.
- Provide orientation to obstetrical health care providers about resources which will remove barriers to prenatal care (e.g., lack of financial resources, transportation, psychosocial support).

II. Develop and/or increase funding to support universal access to prenatal services.

- Increase funding for the Kansas Maternal and Infant Program to facilitate access to program services for women in all Kansas counties.
- Support expansion of Medicaid eligibility for pregnant women up to current federal limits.

* Identify matching funds for federal dollars to support reimbursement by SRS of additional enhanced prenatal care services, as outlined in OBRA 88, provided by designated Title V agencies.

* Obtain funding to support comprehensive genetic services, including statewide genetics outreach clinics.

* Review data from the Kansas Medical Society's Delivering Physicians Survey (i.e., Doctors licensed to deliver babies) and assess the current number of physicians providing obstetrical care and barriers to service.

* Work with existing professional organizations, state agencies, associations and insurance companies to identify strategies to increase obstetrical care provider acceptance of the Medicaid eligible and/or uninsured prenatal client (e.g., fiscal and/or malpractice incentives for serving indigent clients and improvements in Medicaid reimbursement systems).

III. Expand consumer and public awareness of needs for prenatal care.

* Utilize American College of Obstetricians and Gynecologists, American Academy of Family Practice, March of Dimes, and Kansas Department of Health & Environment Office of Health & Environmental Education as resources for prenatal education information.

* Utilize community based agencies/ groups/coalitions to distribute information regarding the need for and availability of prenatal care for high-risk childbearing populations.

IV. Expand pre- and in-service training to health professionals on effective prenatal care procedures.

* Expand pre- and in-service training programs for physicians, nurses and other health care providers on assessments, risk identification and interventions related to maternal and child health.

* Develop public and private provider awareness programs on the availability of community health resources.

* Promote the use of a prenatal risk assessment to include risk of preterm labor in collaboration with professional organizations whose members provide obstetrical care.

V. Support basic and applied research on service delivery models and their impact on the use of prenatal care and on pregnancy outcome.

* Review results of "Barriers to Prenatal Care" survey to be implemented by the Perinatal Medical Council, Kansas Perinatal Program, Fall, 1990.

* Work with Perinatal Council to distribute results of survey to professional organizations, state agencies, community groups, etc. for use in modifying existing and/or initiating new strategies to promote early entry into and compliance with prenatal care.

NUTRITION FOR MOTHERS AND CHILDREN

GOAL 4: INCREASE THE AVAILABILITY OF PROGRAMS THAT SUPPORT ADEQUATE NUTRITION FOR MOTHERS AND CHILDREN.

Good nutrition before and during pregnancy is essential in assuring the birth of a healthy baby. The Surgeon General's Report on Nutrition and Health (1988) states that, "Research has demonstrated that both maternal prepregnancy weight and weight gained during pregnancy are important determinants of infant birth weight. Inadequate weight gain during pregnancy and low prepregnancy weight combined with low weight gain are associated with lower-than-average infant birth weights and greater risks for fetal or neonatal death and neonatal disease. These problems decline as weight gain increases" (p. 552). For example, teens who gain 24 pounds or less during pregnancy had infants with significantly lower birth weights than those who gained 25 pounds or more (Schneck, Sideras, Fox and Dupuis).

Breastfeeding is an unequaled method of providing food for the healthy growth and development of infants. It has a unique biological and emotional influence on the overall health of both the mother and the infant.

The prevalence and duration of breastfeeding have declined in Kansas for a variety of cultural, economic, social, and political reasons. In the United States in 1985, 56% of women breast fed their infants at hospital discharge, in 1989 only 44% were breastfeeding at discharge (Ryan, personal communication, May 15, 1990). This dramatic decrease in breastfeeding rate is a disturbing trend that can be reversed. Of all the factors that affect the initiation and continuation of breastfeeding; health care practices, particularly those relating to the case of newborn infants and their mothers, are identified as the most promising means of increasing the incidence and duration of breastfeeding.

Nutrition programs for women and children include WIC (Supplemental Food Program for Women, Infants and Children), which serves less than two thirds of the eligible Kansas participants; the school lunch and breakfast program; and the National Food Stamp Program. Nutrition programs are cost effective. For each $1.00 invested in WIC there is a $3.00 savings in subsequent health costs. Additionally, there are data to support efficacy the school lunch and breakfast program. Pollitt, Gersovitz and Gargiulo found that "the provision of breakfast may both benefit the student emotionally and enhance his/her capacity to work on school-type tasks" (p. 481).

In a land of plenty, and especially in the state which prides itself in being the country's bread basket, good nutrition for all children, before and after birth, should be considered a basic right.

Objective

Maintain the number of limited income children, age five years and younger, with growth retardation at a level of 10% or less.

Performance Indicator: Growth status (number of children birth to 5 years who are less than the 5th percentile height/length for age).

Baseline Data: 9.6% of children were enrolled in the WIC Program for short stature in 1988.

Objective Source: KDHE-Bureau of Family Health 1990-2000 Operational Planning Guide Draft and The Kansas Prevention Task Force.

Agency Planning Responsibility:

Lead Agency - Kansas Department of Health and Environment, KSDE, SRS/Medical Services and Income Support.

Other Key Players:

Kansas Dietetic Assn.; Kansas Chapter of the American College of Obstetricians and Gynecologists; Kansas Chapter of the American Academy of Family Practice; Kansas National Education Assn.; Local School Districts; United School Administrators of Kansas; Kansas Congress of Parents and Teachers; Kansas Medical Society; Kansas Public Health Assn.; LaLache League; Local Health Departments; Regents; Developmental Disabilities Planning Council; Kansas Cooperative Extension Service; Kansas Chapter of the American Academy of Pediatrics; Expanded Food Nutrition Education Program.

Recommendations:

I. Expand available nutrition resources for pregnant and lactating women and for infants and children.

   * Assure access to nutrition counseling by a registered dietitian for mothers identified at high nutritional risk who are enrolled in the Kansas Maternal and Infant Program.

   * Expand the Healthy Start program to serve all counties.

   * Assure access to nutrition counseling through Special Health Services by approved registered dietitians for children with special health care needs.

   * Increase the number of children participating in Head Start nutrition programs.

   * Have registered dietitians deliver nutrition services in both public and private settings for high risk women and children.

   * Increase access to food and nutrition programs (e.g., breakfast and lunch programs, especially in the summer).

II. Obtain and/or increase funding for programs which provide access to nutrition services (e.g., WIC, school breakfast and lunch programs, Medicaid, Maternal and Infant Program).

   * Serve all eligible women and children in the WIC program by increasing funding.

   * Obtain funding for Best Beginnings; Lactation Promotion and Breastfeeding Support Project.

   * Increase funding in order to serve all eligible women and children in the school breakfast and lunch programs and Medicaid Program.

- Expand Medicaid services for women and children to 185% of poverty level.

- Develop and provide funds for a Governor's task force, or special committee, to study ways to meet the food and nutrition needs of all Kansans.

- Expand funding to support nutrition services provided by Special Health Services approved registered dietitians and special food prescriptions for children with special health care needs.

III. Expand consumer and public awareness of the need for proper nutrition for mothers and children.

- Conduct a review of information sources, (posters, fliers, brochures and booklets) on reproductive health, general health promotion and nutrition which are available to women and men of child-bearing age through local health departments and private practitioners.

- Analyze the usage of available reproductive health and nutrition information by women and men of reproductive age.

- Develop marketing strategies designed to address the topics which are not addressed and audiences not reached by current reproductive health and nutrition public information efforts.

- Include and/or expand nutrition education components in programs serving children (e.g., school systems, local health department programs, Head Start, early intervention programs, Parents As Teachers, KAN-Be-Healthy).

IV. Expand pre- and in-service training to health professionals on the importance of nutrition in pregnancy outcome and childhood health (e.g. schools of nursing, medicine, and other health professionals).

- Develop and fund short-term clinical training rotations in nutrition specialties including working with children with special health care needs and lactation promotion.

V. Maintain data on availability and use of maternal and child health nutrition services.

- Expand the pregnancy and pediatric nutrition surveillance system to other programs including Maternal Infant Program, Healthy Start, school systems, Head Start, etc.

IV. Support basic and applied research on effective methods of prenatal care and intervention that improve pregnancy outcome and childhood growth and development.

DRUG USE DURING PREGNANCY

GOAL 5: ADDRESS THE VARIED ASPECTS OF INFANTS EXPOSED TO DRUGS IN UTERO

Recently the national media has given attention to the problems of babies who have been prenatally exposed to alcohol and other drugs. It is difficult to estimate the scope of the problem. In 1990, the U.S. General Accounting Office (GAO) conducted an audit of the medical records from ten hospitals in metropolitan areas in the United States. This audit found that drug-exposed births ranged from 13 per 1,000 births to 181 per 1,000. They found a relationship between the hospital's procedures for identifying drug-exposure in newborns and the numbers of babies thus diagnosed. Those hospitals with protocols for assessing maternal drug use identified more drug-exposed births than hospitals with limited or no assessment procedures (GAO, 1990). Illicit and licit drug use during pregnancy is typically thought of as an inner-city problem. However, controlled studies examining the drug habits of pregnant patients from both private obstetrical practices and public prenatal clinics have found no statistically significant differences in the use of drugs by the two groups. (Chasnoff, Harvey and Barrett, 1990)

Babies who have been exposed to illegal or legal substances, such as tobacco and alcohol, consistently show reductions in birth weight, body length and head size. In addition to these, drug exposure in utero can have a wide range of effects. They range from facial malformations and mental retardation to delivery complications and severe effects to the infant's central nervous system. Prematurity and growth retardation both result in higher hospital costs through increased use of Neonatal Intensive Care Units.

Alcohol is now recognized as causing serious consequences in fetal development. Researchers are recognizing a dose-response relationship with the most serious consequences resulting from heavy drinking during the first month of pregnancy. Fetal Alcohol Syndrome (FAS) has now surpassed Down Syndrome as the most frequent known cause of mental retardation. The long term consequences are costly not only to the individuals involved, but to society as well. Dr. Robert Sokol, Dean of the School of Medicine at Wayne State University in Detroit, has estimated that 1 out of 10 adults with mental retardation who are living in residential care has FAS (Rosenthal, 1990). The tragedy is that developmental disability caused by alcohol and other drug use during pregnancy is 100% preventable.

The long-term developmental effects of prenatal exposure to illegal drugs are more difficult to determine. There have been few well-designed clinical studies on the long-term effects in children who were prenatally exposed to drugs. Of those studies in process, the children are all under three years of age (GAO, 1990). Preliminary studies and observations from early intervention programs suggest that children who were prenatally exposed to drugs may have developmental delays, neurologic abnormalities which may affect their participation in a school environment, and a variety of psychosocial issues resulting from a chaotic home environment.

Prevention, intervention and treatment appear to be some of the most successful methods of addressing the national drug problem. A very serious issue in Kansas is the lack of alcohol and other drug treatment facilities which will address women's unique psycho-social needs as well as their need for prenatal care and child care. Fear of medical complications, potential liability and lack of access to prenatal care are the reasons often cited for excluding pregnant women from treatment. The state of Kansas funds several treatment programs which are specifically designed to serve medically indigent women and their children. These include three reintegration homes and three residential intermediate programs. Out-patient treatment is provided at another facility. As of January 1, 1991, 45 beds for medically indigent women and 30 beds for their children will be available to serve the entire state.

Objective

By year 2000, the proportion of pregnant women participating in prenatal care programs provided through local health departments who drink any alcoholic beverage 3 months prior to pregnancy will be reduced by 90% during the last three months of pregnancy.

Performance Indicator: Alcohol consumption 3 months before pregnancy compared to the last 3 months of pregnancy for WIC enrolled women.

Baseline Data: Currently unavailable. Will be available through the Pregnancy Nutrition Surveillance System. Reports for Kansas WIC Program, CDC (1991 and later).

Objective Source: KDHE, Bureau of Family Health 1990-2000 Operational Plan Draft and the Kansas Prevention Task Force.

Agency Planning Responsibility:

Lead Agency - SRS/Alcohol and Drug Abuse Services, KDHE, KSDE, SRS/Youth Services, SRS/Medical Services and Income Support.

Other Key Players:

Developmental Disabilities Planning. Council; Court Appointed Special Advocates; Kansas Assn. for the Education of Young Children; Kansas Childrens Service League; Kansas Regional Prevention Centers; Insurance Assn.; Assn. of Treatment Centers; Kansas Action for Children; Kansas Cooperative Extension Service; Kansas Division of Early Childhood; March of Dimes; Assn. for Retarded Citizens; Local Health Departments; Kansas Child Abuse Prevention Council; Kansas Medical Society; Kansas Chapter of the American College of Obstetricians and Gynecologists; Kansas Assn. of the Academy of Family Practice; Kansas Chapter of the American Academy of Pediatrics; Kansas Assn. of Special Education Administrators; United School Administrators of Kansas; Kansas Public Health Assn.; Kansas Nurses Assn.; Perinatal Assn. of Kansas; Kansas School Nurses Organization; Kansas Home Economics Assn.; Kansas Assn. of Vocational Home Economic Teachers.

Recommendations:

I. Develop and/or increase services for prevention and treatment programs for alcohol and drug-using women of child bearing age and their dependent children.

   * Increase the number of physicians who routinely assess their female patients of childbearing age for use of alcohol, tobacco and other drugs.

   * Support physician's capacity to counsel patients on the deleterious affects of drugs/alcohol and tobacco during pregnancy.

   * Support physician's capacity to refer their substance abusing patients to appropriate cessation and/or treatment programs.

   * Increase the number of residential treatment programs for drug using women which include a child care/treatment component.

* Increase the number of early intervention programs available to preschool children who were prenatally exposed to drugs/alcohol.

II. Obtain new and/or increase existing funding for prevention and treatment programs for alcohol and drug-using women of child bearing age and their dependent children.

III. Expand consumer and public awareness of the dangers of using alcohol and other drugs prior to and during pregnancy and the possibility of consequent diseases (e.g., AIDS, hepatitis and tuberculosis).

IV. Expand pre- and in-service training to health professionals, educators and social workers on the prevention, identification, effects and treatment of alcohol and drug use in women of child bearing age.

* Obtain funding to increase the number of qualified substance abuse professionals.

* Obtain funding specifically designed to increase the skills of health care professionals related to the prevention, identification, effects and treatment of alcohol and other drug use in women of child bearing age.

V. Initiate a study of the prevalence of alcohol/drug use among pregnant women of all income groups in a representative sample of Kansas communities.

VI. Support basic and applied research on effective methods of alcohol and other drug abuse prevention and treatment.

ADOLESCENT PREGNANCY AND PARENTING

GOAL 6: EXPAND THE RANGE OF PREVENTIVE SERVICES ASSOCIATED WITH ADOLESCENT PREGNANCY AND PARENTING.

Young maternal age is a significant concern when addressing prevention issues surrounding pregnancy. The babies of adolescent mothers are at risk for low birth weight and this risk increases with each pregnancy which occurs during the teen years (McAnarney, 1989). Adolescent mothers often do not receive early (first trimester) prenatal care. According to the March of Dimes, they are almost three times as likely as older mothers to receive late to no prenatal care.

Pregnancy complications in very young mothers (under age 15) may include toxemia, anemia, prolonged labor and premature labor (Boham & Placek, 1978). According to the Alan Guttmacher Institute, (1981) the maternal death rate of mothers under 15 years of age is 2.5 times that for young adult mothers (age 20-24). Poor eating habits, use of cigarettes, alcohol and drugs increase many teens' risk for a poor pregnancy outcome. However, good health care, especially prenatal care can greatly reduce the medical problems that may come with adolescent pregnancy.

The National Center for Health Statistics data demonstrates that the number of births to girls under 20 years of age reached a peak during the 1970's and has shown a reduction in the last decade (cited in Hayes, 1987). Kansas Department of Health and Environment records show 4,396 live births to mothers under 20 years of age in 1988 (Kansas Department of Health and Environment, 1989). This accounts for approximately 11% of all live births in the state. There were 4,344 live births to mothers between 15-19 years of age and 52 live births to mothers 10-14 years of age.

Birth outcomes are only one concern for children born to adolescent mothers. The development of a child who is raised by an adolescent mother is often problematic. Responsibilities of child rearing make it difficult for many adolescent mothers to complete their high school education. Hofferth (1987) observed that these children face increased risks of reduced intellectual and school achievement in addition to problems with self-esteem and social behavior. Numerous other researchers have found relationships between a mother's age and her child's school performance and achievement. There also appears to be a correlation between the number of years of school that an adolescent mother fails to complete and her child's I.Q. and other achievement scores (Hayes, 1987). There is a high correlation between school dropouts and adolescent pregnancy although some studies show that a portion of pregnancies occur after these young women drop out of school (Dryfoos, 1987). With limited education and poor employment prospects, these young mothers and their children often face a bleak future.

Objective

By the year 2000, reduce pregnancies among women 10-14 years old to 80 or fewer per year and among 15-19 year old women to 5000 or fewer per year for three consecutive years.

Performance Indicator: Number of pregnancies per target age-group (10-14 years old and 15-19 years old).

Baseline Data: 90 pregnancies among 10-14 year old women, and 5,813 pregnancies among 15-19 year old women in 1988.

Objective Source: KDHE, Bureau of Family Health 1990-2000 Operational Plan Draft.

Agency Planning Responsibility:

Lead Agency - Kansas Department of Health and Environment, SRS/Medical Services and Income Support, KSDE, SRS/Youth Services.

Other Key Players:

Kansas Public Health Assn.; Kansas Nurses Assn.; Kansas Chapter of the American College of Obstetricians and Gynecologists; Planned Parenthood, Inc.; Kansas Chapter of the American Academy of Family Practice; Local School Districts; Kansas Chapter of the American Academy of Pediatrics; Perinatal Assn. of Kansas; Kansas Medical Society; Developmental Disabilities Planning Council; Kansas Home Economics Assn.; Kansas Action for Children; Kansas Children's Service League; Local Health Departments; Kansas Teen Pregnancy Networks; Girl Scouts; Young Women's Christian Assn.; March of Dimes; United Cerebral Palsy; Kansas Assn. of School Health; Kansas Assn. of School Social Workers; Kansas Home Economic Assn.; Kansas Assn. of Vocational Home Economics Teachers.

Recommendations:

I. Expand and develop services for pregnant and parenting adolescents.

   * Expand public health family planning services, state-wide for adolescents.

   * Implement adolescent-specific services for the pregnant adolescent in prenatal and family planning programs.

II. Obtain state funding for the expansion of public health family planning programs.

   * Maintain and/or increase the state general fund allocations for adolescent health and prenatal care programs.

   * Increase the number of participative programs which help adolescents to learn and practice parenting skills.

III. Expand consumer and public awareness surrounding the issue of adolescent pregnancy and parenting.

   * Conduct a review of information sources (including audio & video public service announcements, posters, fliers, brochures, booklets and films) which address the prevention of adolescent pregnancy.

   * Increase by 20% the number of schools which provide comprehensive health instruction, including family life education for students in grades 10-12.

IV. Expand pre- and in-service training to health professionals, educators and social service providers which addresses effective adolescent pregnancy prevention strategies.

   * Develop pre-service and continuing education programs specifically designed to increase the professional skills relating to the health, psychosocial and economic needs of the adolescent child-bearing client.

- Develop a task force to coordinate state-wide efforts of health care professionals, teachers and social service professionals who educate teens, young adults and their parents about the health and lifestyle choices which promote healthy pregnancy and family life.

V. Maintain data on the incidence of adolescent pregnancy and pregnancy outcomes.

VI. Support basic and applied research on the impact of selected service's approaches on:

- Incidences of adolescent pregnancy.
- Prevention of adolescent pregnancy.
- Adolescent pregnancy outcome.
- Parenting skills of adolescent parents.

PRIMARY HEALTH CARE FOR CHILDREN

GOAL 7: EXPAND THE AVAILABILITY OF PRIMARY HEALTH CARE TO ALL CHILDREN.

Primary health care should be an entitlement of all children. Primary health care involves a number of things, but it's principal provision is a medical home (e.g., doctors office, clinic), where each child is known by the physician and staff. Such care includes well baby/child checks, immunizations, early detection of nutritional disorders, screening for possible vision, hearing and dental and problems as well as childhood developmental difficulties.

Immunizations for infectious diseases of childhood are an effective primary prevention strategy which is accessed through primary health care. Immunizations are regularly given for pertussis (whooping cough), polio, measles, mumps, rubella, hemophilus influenza type B, tetanus and diphtheria. If left unprotected against these diseases, children are vulnerable for serious disease, disability or death. Hemophilus influenza type B (HIB) is a leading cause of acquired mental retardation. It affects approximately one in five hundred children before the age of five. Immunizations for all of these illnesses are available at local health departments.

Access to medical care is a problem in some Kansas communities. According to the 1989 Kansas Medically Underserved Areas Report, 50 (48%) counties were classified as critically underserved for primary care which includes the specialties of Family Practice, General Practice, Internal Medicine and Pediatrics (Spangler & Windham, 1989). Combined with the medically underserved counties, Kansas is left with a modest 44 out of 105 (42%) counties which are adequately served for primary care (Spangler, et.al. 1989).

While primary health care is available to many Kansas residents, it is least available to low income families and families not covered by insurance plans. Some localities have a limited number of physicians who will accept Medicaid payments. This limits the accessibility of health care to children in low income families.

The issue of HIV infection in children poses new challenges for the end of this century. With an increasing number of HIV positive children being born and surviving for longer periods, a significant number of affected children will require developmental assessments in order to plan for their developmental and/or educational needs. Based on current projections, HIV infection may, by 1994, become the largest infectious cause of mental retardation and brain damage in children under age thirteen (Harvey & Decker, 1989).

Improvement in the delivery of primary health care services to children is an important element in the primary prevention of childhood disabilities. With creative thinking and the utilization of human and financial resources, primary health care can be accessible to all children.

Objective

By year 2000 primary care pediatric services, provided by public and private health care providers for children from low income families, will have been implemented in 50% of Kansas counties determined to be medically underserved.

Performance Indicator: Percent of counties determined to be underserved in 1988 or targeted areas of need providing primary care as determined by a comprehensive, statewide needs assessment.

Baseline Data: 65 Kansas counties were determined to be underserved in primary care in 1988. Specialties included in primary care are family practice, general practice, internal medicine and pediatrics.

Objective Source: KDHE, Bureau of Family Health 1990-2000 Operational Plan Draft.

Agency Planning Responsibility

Lead Agency - Kansas Department of Health and Environment; SRS/Medical Services and Income Support, Kansas Department of Education.

Other Key Players:

Kansas Public Health Assn.; Kansas School Nurses Organization; Kansas Assn. for the Education of Young Children; Developmental Disabilities Planning Council; Local Health Departments; Kansas Department of Health and Environment - Office of Child Care Licensing; Kansas Chapter of the American Academy of Pediatrics; Kansas Medical Society; Kansas Chapter of the American Academy of Family Practice; Kansas Action for Children; Children & Youth Advisory Committee; Insurance Assn.; March of Dimes; United Cerebral Palsy; Kansas Nurses Assn.; Local School Districts; Coordinating Council on Early Childhood Development; Families Together; Regents; Kansas Chapter - National Assn. of Social Workers; Kansas Nutrition Council; Kansas Head Injury Assn.; Kansas Assn. of School Health; Kansas State High School Activities Assn.; United School Administrators of Kansas; Kansas Assn. of School Social Workers.

Recommendations:

I. Expand and develop primary health care services to all infants and children.

   * Develop school-centered comprehensive child health projects to be piloted in one urban and one rural community to provide primary health care to medically and economically underserved children ages 5-12.

   * Develop staffing patterns for clinics serving medically and economically underserved populations which utilize mid-level and practicing or retired health care providers who donate their time.

   * Increase the capacity of primary care physicians to provide comprehensive health care including nutrition guidance, developmental assessments and anticipatory guidance in child development.

- Support the expansion of programs such as The Caring Program: Kansans Caring for Kids, sponsored by Blue Cross & Blue Shield of Kansas, The Kansas Hospital Assn. & The Kansas Medical Society providing health insurance for uninsured children.

- Expand the Healthy Start program, which includes education on immunizations and regular health care, to serve all counties.

- Encourage periodic health assessments for school age children (AAP periodicity schedule).

- Study the feasibility of mobil clinics for K-12 comprehensive primary health care services for medically underserved populations.

- Increase local health departments capacity to provide immunization services to infants and children by extending services to evening and weekend hours.

II. Develop and/or increase funding for primary health care for all children.

- Expand state funding for immunizations.

- Expand Medicaid eligibility for infants and children up to current federal limits.

- Work with existing professional organizations, state agencies, associations and insurance companies to identify strategies to increase pediatric care provider's acceptance of the Medicaid eligible and/or uninsured pediatric client (e.g., fiscal and/or malpractice incentives for serving medically indigent patients and improvements in Medicaid reimbursement systems).

III. Expand consumer and public awareness through community agencies, organizations and civic groups of the importance of comprehensive primary health care for all children.

- Provide information to families about the benefits and the importance of immunizations and where to get information and obtain immunizations.

- Increase parents knowledge regarding children's development milestones.

- Expand public information on the prevention of HIV infection in infants and children.

IV. Support and encourage the development of education programs for mid-level health care providers (i.e. nurse practitioners and physicians assistants).

V. Encourage compliance with the regulation which requires reporting of pediatric HIV infections.

VI. Support the development of applied research to compare and evaluate the outcomes of schools containing experimental school-centered comprehensive health projects and control schools with regular health services.

CHILD SAFETY

GOAL 8: REDUCE THE INCIDENCE OF UNINTENTIONAL INJURY IN CHILDREN AND YOUTH IN KANSAS.

According to the Executive Summary of the National "SAFE KIDS"campaign, accidents or preventable injuries are the leading killer of children. They account for nearly half of all childhood deaths; for every child that dies of cancer, 4 die from injury. Every year, one in four American children will sustain an injury which requires medical attention. Every year, nearly 8,000 children between the ages of 0 and 14 will die from preventable injuries, and approximately 50,000 children will be permanently disabled. As a result, unintentional injuries are the leading health risk to children (The National Coalition to Prevent Childhood Injury, 1988).

There were 983 fatalities, from all age groups, which were due to preventable injuries in Kansas in 1988. These included 34 deaths among children ages 0-4, 50 among children ages 5-14, and 187 among youth ages 14-24 (Kansas Department of Health and Environment, 1989). Children's deaths due to preventable injuries produce the largest number of potential years of life lost to society.

Deaths from injuries represent only a small portion of total injuries. A Massachusetts study of injuries in childhood noted that "for every death due to injuries among children 19 years of age and under, there are 45 hospitalizations and 1,300 visits to emergency room" (Gallaher, Finison, Guyer and Goodenough, 1984, p. 346). Unlike Massachusetts, Kansas has no statewide system to collect and analyze information about non-fatal injuries for children or adults. Injury incidence information is essential in the identification of problem areas and the planning of effective prevention strategies. Such information includes the cause and type of injury, location of the injury event, injury severity, medical costs, age of victim, etc. Good data not only will identify the frequency of various types of non-fatal injuries, but also those parts of the state where particular problems exist. It also will identify those who are at greatest risk for certain injuries. Appropriate prevention strategies can then be planned for the specific locations and populations most affected by injury.

Injury prevention involves a number of strategic activities such as, engineering, education, regulation and enforcement. One example of a comprehensive prevention strategy is that of automobile safety belts to reduce the severity of injury in motor vehicle crashes. Safety belts for motor vehicles were developed and improved by engineers. Although the effectiveness of safety belts in preventing death and lessening injury had been well documented and publicized, the use of safety belts in Kansas was low. The Kansas Safety Belt Education Office began its job of educating the public in 1981 using state and nationally developed materials. In 1985, the year before the mandatory safety belt law went into effect, the state's safety belt usage rate was 9.9%. The Kansas Safety Belt Law went into effect on July 1, 1986, and that Fall the annual survey, which measures front-seat use of harness safety belts in cars, vans, and pick-up trucks, showed that 23.3% of drivers were using safety belts. Enforcement of the law began on July 1, 1987, with traffic officers issuing tickets for non-compliance. That Fall the annual survey on safety belt use showed 42.3% of front-seat occupants of motor vehicles wore safety belts. Usage has shown a gradual increase, to 52% in 1989, due to a combination of factors including education, regulation, and especially enforcement (Miller, personal communication, August 10, 1990).

Unintentional injuries are not random occurrences over which we have no control. Prevention initiatives can reduce the number of child deaths and permanent disabilities caused by injury. Unintentional injury prevalence data will facilitate the development of effective injury prevention strategies which utilize education, engineering, regulation and enforcement.

Objective

Develop and promote a comprehensive plan model (involving awareness, education, legislation, regulation and enforcement) for reducing the rate and severity of unintentional injuries among children and youth within at least one Kansas community by 9/30/92 and within five additional Kansas communities by 9/30/93.

Performance Indicator: The number of cities, counties or other well-defined demographic areas which have implemented comprehensive plans for reducing the number and severity of unintentional injuries among children and youth.

Baseline Data: The number of communities with a comprehensive injury prevention plan is currently unavailable.

Objective Source: The Kansas Prevention Task Force.

Agency Planning Responsibility:

Lead Agency - Kansas Department of Health and Environment; Kansas Department of Transportation (KDOT), KSDE, SRS/Youth Services.

Other Key Players:

Developmental Disabilities Planning Council; Kansas Assn. of Chiefs of Police; Kansas Sheriffs Assn.; Kansas Peace Officers Assn.; Kansas Head Injury Assn.; Kansas Troopers Assn.; Kansas Emergency Medical Technical Assn.; SAFE KIDS Coalition; Assn. Emergency Room Nurses; Board of Emergency Medical Services; Kansas Law Enforcement Training Center; Red Cross; Safety Council of Western Missouri and Kansas; Kansas Bureau of Investigation; Kansas Public Health Assn.; Kansas Farm Bureau; Kansas Cooperative Extension Service; Kansas School Nurses Organization; Kansas Hospital Assn.; Kansas State Firefighters Assn.; Kansas State Assn. of Fire Chiefs; Kansas Assn. of School Health; Kansas State High School Activities Assn.; United School Administrators of Kansas; Kansas Highway Patrol, Safety Sargents.

Recommendations:

I. Develop and/or expand prevention program models which can be implemented at the community and county levels.

   * Prepare a comprehensive inventory of organizations and programs within the state which are directly or peripherally involved in the prevention of unintentional injury and death (mechanism of injury including motor vehicle crash occupant, cyclist/ pedestrian, fires/burns, drownings, choking/poisoning and falls.)

   * Develop a statewide injury prevention coalition and promote the development of similar injury prevention coalitions at the community level.

   * Identify areas of special need, related to unintentional injury incidence and underdeveloped program interventions; and work with and through existing organizations and programs to address those needs.

II. Obtain and/or increase funding for programs which address the prevention of morbidity and mortality resulting from unintentional injuries.

   * Inventory current program funding sources and consider ways that these funding sources could increase their support for existing programs and proposed initiatives.

   * Identify new funding sources to enhance the effectiveness of existing programs and to support proposed initiatives.

III. Expand consumer and public awareness regarding the seriousness, personal relevancy and preventability of unintentional injuries.

   * Coordinate the dissemination of informational releases to the media on a regular, consistent basis.

- Ensure that individuals and organizations with a need to know (such as parents, education and recreation professionals, law enforcement, legislators and the media) are kept apprised of germane issues and developments related to preventable injuries.

- Develop and make available consumer and public information materials regarding unintentional injuries.

IV. Expand pre- and in-service training to educators, health professionals, youth leaders, social service providers and others who can effect changes in Kansas regarding unintentional injury and it's prevention.

- Ensure that existing professional training curricula (for educators, school nurses, allied health professionals, physicians, recreation professionals and law enforcement) include information regarding the seriousness and preventability of unintentional injuries.

- Increase the number of school districts which include injury prevention (i.e., student instruction, maintenance of recreation equipment, First Aid & CPR Training, etc.) as a part of their local district in-service program.

- Include injury prevention in the in-service programs of professionals (e.g., physicians, nurses, social workers, recreation professionals).

- Increase to 95% the number of school attendance centers that have a First Responder Emergency Plan for injuries and medical emergencies.

V. Develop a traumatic injury information retrieval and analysis system for the purpose of clarifying the extent and etiology of traumatic injuries in Kansas, targeting specific needs with specific interventions and measuring the effectiveness of prevention interventions.

- Identify specific information needs.

- Identify specific information sources and work with those sources to establish an effective reporting system.

- Identify specific change-makers who can facilitate the retrieval of such information and obtain their support in this effort.

- Develop a system to analyze injury incidence information for use in planning state and local injury prevention initiatives.

VI. Support basic and applied research on unintentional injuries among children and youth, and the effectiveness of prevention programs.

- Identify and assess the effectiveness of prevention program intervention studies in other areas, and determine their potential usefulness for Kansas.

- Initiate local and area wide longitudinal studies to determine unintentional injury trends in specific populations, and to determine the relative effectiveness of program interventions.

IDENTIFICATION AND EARLY INTERVENTION

GOAL 9: EXPAND SERVICES AND PROVIDE INFORMATION ABOUT SCREENING, EARLY IDENTIFICATION, REFERRAL, INTERVENTION AND FOLLOW-UP.

Newborn screening can provide families and professionals with important information about inherited disorders and also can assist them in planning for treatment and early intervention, and future pregnancies. Screening for certain disorders often is conducted early in life, prior to the first onset of symptoms. All states currently test for phenylketonuria (PKU), hypothyroidism and galactosemia at birth, and many states test for other genetic metabolic disorders as well (Peterson & Cleveland, N.D.).

The success of the newborn screening programs has resulted in large numbers of infants at risk who have been identified early and treated so that developmental disability is prevented (Peterson & Cleveland, N.D.). Screening programs which detect the most frequently occurring genetic, metabolic disorders should be available to all families.

The passage of PL 99-457 gives states five years of federal planning money to set up comprehensive multidisciplinary statewide systems to provide early intervention services to infants and toddlers with developmental delays, as well as support services for their families. PL 99-457 assures all eligible infants and toddlers the right to appropriate early intervention services (Mental Health Law Project, 1989). Such services will have a positive impact on infants born prematurely and/or those with developmental delays.

The Journal of the American Medical Assn. recently reported on an early intervention program which was designed to enhance the development of low birth weight, premature infants. The study combined home visits and child development center interventions. The children were assessed at regular intervals and final assessments were made at 36 months of age. The researchers found that I.Q. scores of the children in the intervention group were significantly higher than those in the follow-up group. The intervention group also had significantly fewer behavior problems reported by mothers (The Infant Development Program, 1990). Other studies have reported that a $1 investment in preschool education yields a $7 saving in later eduction and reduced special education costs (Baumeister, Dokecki and Kuptas 1988).

Babies born with a disability often may need more help and may need more planning from their parents and other service providers in order to develop needed skills (NICHCY, 1988). In addition, parents need time to cope with the emotions and stresses of the reality of their child's disability. Every effort should be made from hospitals, social service agencies and personnel to provide information and support for the entire family.

Objective

By the year 2000 a statewide, early intervention system for the provision of health services, education, and social services will be in place for young children and their families.

Performance Indicator: 1995 - Data on numbers, services, adequacy of services, (kinds, quantity, match with medical outcome of services) in place with measurable steps to lead to full service by 2000.

Baseline Data: There is no baseline data on an overall system. There is data available on numbers serviced through Medicaid, EPSDT, health departments; numbers in licensed child care and immunization records; data available on day care providers.

Objective Source: The Kansas Prevention Task Force.

Agency Planning Responsibility:

Lead Agency - Kansas Department of Health and Environment; SRS/Medical Services and Income Support, SRS/Mental Health and Retardation Services, SRS/Youth Services, KSDE, with advise from the Coordinating Council for Early Childhood Developmental Services.

Other Key Players:

Kansas Medical Society; Kansas Chapter of the American Academy of Family Practice; Kansas Chapter of the American Academy of Pediatrics; Local School Districts; Developmental Disabilities Planning Council; Kansas Division of Early Childhood; Families Together; Kansas Hospital Assn.; Keys for Networking; Local Health Departments; Kansas Assn. for Rehabilitation Facilities.

Recommendations:

I. Expand screening and early intervention services for infants and children.

- Expand newborn and developmental screening services to make them available to all children.
  - Expand and coordinate developmental screening efforts for children utilizing existing systems in Health, Education and Social Services.
  - Explore annually the feasibility of expanding newborn screening for metabolic diseases to include additional diseases.
  - Strengthen existing screening and early intervention services through the training of professionals to utilize appropriate instruments in their work settings.
- Develop and maintain a statewide system of early intervention services, appropriate to meet the needs of children and families.
  - Emphasize and strengthen the role of the Coordinating Council on Early Childhood Developmental Services in the development of such a system.
  - Provide necessary empowerment of the Coordinating Council on Early Childhood Developmental Services by either administrative or legislative procedures.
  - Assure uniformity and continuity of regulations and reporting systems across agencies.

II. Develop/maintain/and advocate for increased funding for screening and early identification and intervention services.

- Assure uniformity of eligibility requirements across funding agencies.

- Increase state funding and maximize resources for early intervention services for all eligible children and families.

III. Encourage the expansion of consumer and public awareness of the importance of early identification, and intervention and the usefulness of screening and follow-up services.

- Work with the Coordinating Council For Early Childhood Developmental Services to organize efforts for Child Find and public awareness of screening and intervention services.

- Develop a community level interagency response system to parent inquiry and referral.

IV. Promote multidisciplinary training for students and professionals in developmental screening, identification, evaluation and early intervention of high-risk children.

V. Collect and maintain data on the incidence and prevalence of conditions leading to developmental disability(s).

- Improve physician compliance with the mandate which requires reporting of children diagnosed with handicapping conditions.

- Publish an annual report of cumulative totals of reported handicapping conditions and the way this information will impact the provision of services to children and families.

- Revise mandated reporting of children diagnosed with a handicapping condition to include punitive measures for non-compliance.

CHILD ABUSE

GOAL 10: REDUCE THE INCIDENCE OF CHILD ABUSE

Non-accidental injury, including child abuse, is recognized as a cause of mental retardation and related developmental disabilities. Child abuse is found in all income levels of our society. While abuse may take several forms, head injury is the most likely to result in a developmental disability. ReKate, McClelland and ReKate (1983) estimate that between 25-40% of all child abuse hospital admissions are for head injures. They state that about 10% of the severe injuries in children age five and younger, which are seen in Emergency Rooms, have an abusive origin.

Other studies corroborate these findings. Peclet, et al. (1990) studied children who had been admitted to National Children's Hospital in Washington, D.C. They found that of the hospitalized children who were victims of child abuse, 40% had head or facial injuries. These children were the youngest of all injury groups with an average age of 2.0 years, and had the most severe injuries and the longest length of stay in the hospital. Peclet observed that 40% of the child abuse victims were admitted to the hospital's ICU. Their average hospital cost ($20,359) was the highest for all injury categories in the study.

Shaken Baby Syndrome has been noted as an abusive cause of traumatic brain injury in babies. Shaking is at times used as a method of discipline for babies. The whiplash effect of shaking an infant can result in subdural hematoma. Babies are vulnerable to traumatic intracranial bleeding because of their heavy head and weak neck muscles (Chaffey, 1972) and many of these children will be disabled for life. Shaking is not always the mechanism which causes head and/or traumatic brain injury. A 1983 study examined the injuries of children who had been confirmed as victims of child abuse. About 12% of the children in the study suffered head injuries. An analysis of the mechanism of these head injuries showed that 35% were caused by dropping, throwing or falling. Direct blows to the face, head or another body part caused 54% of the head injuries. An additional 8% were due to shaking (Hahn, 1983).

Children with developmental delays or deviations are particularly vulnerable to abusive injuries. Also at risk for physical abuse are children of premature births or with neonatal illnesses which caused lengthy separation of the baby and parents during the newborn period. Other risk categories for abuse related injury include children who are often ill, those with chronic illnesses, and children with behavior characterized as hyperactive, aggressive or stubborn (ReKate et al, 1983.)

The state of Kansas averages about 23,000 reports and 5,250 confirmations of child abuse and neglect annually. The rate of confirmations of abuse and neglect reached an eight year high in 1984 with 12 confirmed cases for every 1,000 children. Rates appear to be decreasing. In 1989 there were 4 confirmations of abuse or neglect for every 1,000 children (Portner, 1989). Since this rate is based upon 1980 census data, it may not be a true reflection of the rate of abuse/neglect confirmations. The decline may also be impacted by changes in the SRS abuse/neglect reporting procedures. Because child abuse injury data are kept by SRS in broad categories, e.g. moderate and major injury, it is virtually impossible to calculate the number of Kansas children who sustain severe head injuries due to child abuse. Such information could be obtained through a proposed state-wide injury information retrieval system.

Personnel shortages and overall inadequate funding for the Department of Social and Rehabilitation Services, as well as reductions in community services for children, have had a negative impact on child protection services. Additional factors, such as the introduction of due process into the investigation

of abuse/neglect reports, impact upon the number of confirmed cases. These combine to account for lower than expected rates of reports and confirmations. Last year Pediatric News reported on a national telephone survey of public health officials which obtained information from states about current child abuse prevalence and prevention programs. Thirty-six states reported an overall 5% increase from 1987-1988 in child abuse fatalities and a 35% increase between 1985-1988. In spite of these disturbing figures only 12 states in the survey reported an increase in their child abuse prevention budgets ("Cases of Child Abuse", 1989). Enforcement, which plays an important role in the prevention of unintentional injury, is also a critical element in prevention of intentional injury or child abuse. Inadequate personnel to enforce the state child abuse reporting statues, creates situations where children are not protected, and families may not receive needed support services.

Enforcement is only one element of child abuse prevention. Parent support groups such as Parents Anonymous and Parents As Teachers provide important peer support and education for mothers and fathers. Respite care has also proved helpful to parents experiencing high levels of stress.

Effective parent education and support programs combined with adequate enforcement of child protection statutes will make a major impact in helping to reduce overall rates of child abuse. These supportive programs result in mothers and fathers who have an increased ability to raise physically and mentally healthy children.

Objective: By the year 2000 reverse to less than 45 the annual number of confirmed cases of child abuse which result in a major injury requiring hospitalization and to less than 4 the annual number of confirmed cases resulting in permanent injury.

Performance Indicator: The number of confirmed cases of physical child abuse resulting in a major injury requiring hospitalization and the number of confirmed cases of abuse which result in permanent injury as reported by SRS.

Baseline Data: During fiscal years 1987-1990, a major physical abuse injuries requiring hospitalization averaged 45.5 per year and the average number of children permanently injured was 4 per year.

Objective Source: The Kansas Prevention Task Force

Agency Planning Responsibility:

Lead Agency - SRS/Youth Services; KDHE, KSDE.

Other Key Players:

Kansas Assn. of Chiefs of Police; Kansas Sheriffs Assn.; Kansas Peace Officers Assn.; Kansas Medical Society; Board of Emergency Medical Services; Kansas Public Health Assn.; Alcohol and Drug Abuse Services; Kansas Chapter of the American Academy of Family Practice; Local School Districts; Kansas Chapter of the American Academy of Pediatrics; Kansas Hospital Assn.; Kansas School Nurses Organization; Kansas Nurses Assn.; Developmental Disabilities Planning Council; Kansas-National Assn. of Social Workers; Kansas Congress of Parents and Teachers; Kansas Home Economics Assn.; United School Administrators of Kansas; Local Health Departments; Office of Child Care Licensing; Kansas Federation of Teachers; Kansas Assn. of School Health; Court Appointed Special Advocate; Kansas Assn. for the Education of Young Children; Kansas Cooperative Extension Services; Kansas Children's Service League; Kansas Child Abuse Prevention Council; Kansas Assn. of School Boards; Assn. for Retarded Citizens; Kansas Action for Children; Kansas Assn. of School Social Workers.

Recommendations:

I. Improve available services to schools, social service providers and parents which impact the issue of child abuse.

   * Expand the development of local multidisciplinary child protection teams to assist in the investigation of reported cases to child abuse/neglect.

   * Expand the Parents As Teachers program to all Kansas school districts.

   * Expand the Healthy Start Home visitor program to all Kansas Counties.

   * Actively encourage the development of local community child abuse prevention coalitions and Parents Anonymous chapters.

II. Develop and/or increase funding for parent education.

III. Expand consumer and public awareness on the causes, identification, reporting of and intervention in child abuse.

* Expand public awareness programs and information on stressors and circumstances that lead to child abuse.

* Expand public awareness of the rights of victims of physical abuse.

* Expand public awareness about the need for foster homes, adoptive homes, licensed child care providers, and alternative placements for children who have been abused and neglected.

IV. Expand pre- and in-service training to health care professionals, educators, and social service providers on the prevention and identification of child abuse and intervention for children in abusive situations.

* Increase the number of school districts which include the identification, referral and prevention of physical and sexual abuse and child neglect as a part of their local district in-service program.

* Increase the number of school districts which include training on positive classroom management, motivation of children and positive parent involvement as a part of their local district in-service program.

V. Maintain data on the prevalence of child abuse and evaluate the effectiveness of child abuse prevention strategies.

PARENTING AND COGNITIVE DISABILITIES

GOAL 11: EXPAND TRAINING AND SUPPORT SERVICES IN FAMILY LIFE FOR ADOLESCENTS AND ADULTS WITH COGNITIVE DISABILITIES

There is an urgent need to improve the parenting skills of people with cognitive disabilities. Increasing numbers of persons with mild and mental retardation are now living independently in the community (cited in Feldman, et al 1986). This development is resulting in more persons with cognitive disabilities bearing and raising children.

Historically, many of these people demonstrate difficulty dealing with the complicated responsibilities and skills associated with parenting. There have been several studies showing that their children are at increased risk for maltreatment, neglect and developmental delay (Feldman, et al 1986). A significant portion of children who come to the attention of Early Intervention Programs are children of parents who themselves have cognitive disabilities and came from environmentally deprived homes. Many of the delays or disabilities these children exhibit could be prevented by providing their parents with basic training in parenting-skills and ongoing family support. Typically, parenting courses are wasted because they are too short term (6 weeks verses 6 years) or are geared for individuals with average and above I.Q.s. In addition, these courses do not provide transportation or childcare.

This training and support must be ongoing throughout the child bearing years. People with mental retardation often have low self-esteem, general distrust of people, a lack of money or reliable transportation and the inability to read and understand written materials. These parents lack experience or understanding to help them cope with these issues.

As an example of the training needs, high school students enrolled in special education classes rarely receive any type of training, whether general or specifically tailored, in the areas of human sexuality, health, and family life education. During the 89-90 school year only 19% of special education students in Kansas were receiving human sexuality and HIV education which was mandated for all students in 1988 (Wilson, personal communication, February 18, 1991).

The goal addressed here is to provide people who have cognitive disabilities with specialized training in the areas of human sexuality, health and family life education before they ever consider becoming parents, and to provide parents with cognitive disabilities ongoing parent education and support.

Objective

By year 2000 the number of appropriate parent training and ongoing support services for students and parents with cognitive disabilities will increase by 60%.

Performance Indicator: The numbers of secondary special education students receiving family life education, human sexuality and HIV Education and the number of parents with cognitive disabilities receiving specialized support services and training.

Baseline Data: In the 89-90 school year 19% of the special education students were receiving human sexuality/HIV education The Task Force knows of only one parent education program in Kansas for adults with mental retardation which is operated by the Topeka Assn. for Retarded Citizens. (Human sexuality/HIV education information based on information tabulated from the school principal's building report submitted to State Department of Education October 10, 1989).

Objective Source: The Kansas Prevention Task Force

Agency Planning Responsibility:

Lead Agency - Kansas State Department of Education; SRS/Mental Health and Mental Retardation Services.

Other Key Players:

Developmental Disabilities Planning Council; United School Administrators of Kansas; Kansas Congress of Parents and Teachers; Kansas Medical Society; Kansas Chapter of the American Academy of Pediatrics; Kansas Chapter of the American College of Obstetricians and Gynecologists; Local School Districts; Kansas Assn. for Children with Learning Disabilities; Assn. for Retarded Citizens; Kansas Assn. of Rehabilitation Facilities; Kansas Assn. of School Boards; Kansas Assn. of Special Education Administrators; Kansas National Education Assn.; Local Health Departments; Kansas Chapter of the American Academy of Family Practice; Kansas-National Assn. of Social Workers; Kansas Assn. of School Social Workers; Families Together, Kansas Assn. for the Education of Young Children; Kansas Children's Service League.

Recommendations:

I. Expand availability of services for training and support in sexuality, health, and family life for adolescents and adults of this population.

   * Advocate for expansion of school curricula in sexuality and family life education for special education students.

   * Expand Human Sexuality and AIDS training for use with special education students in integrated and non-integrated classrooms.

   * Develop special education Family Life Education curriculum for use in integrated and non-integrated classrooms, covering topics such as normal growth and development of infants and children, nutrition, appropriate play, stimulation and discipline, cleanliness, safety, routine medical care, harmful effects of substance abuse during pregnancy, nurturing skills and birth control.

- Encourage inclusion of objectives related to family life education and support services as a part of Individualized Transition Plans.

- Expand available training and support services for adults with cognitive disabilities.

- Encourage development and replication of model training programs for parents with cognitive disabilities.

- Provide family-centered support services for parents with cognitive disabilities who utilize adult programs providing: residential, independent living, respite care and case management services.

II. Obtain and/or increase funding for the development and implementation of specialized family life and parenting skills curricula for special student populations.

III. Increase consumer and public awareness of the need for programs and services for parents with cognitive disabilities and their children who could be at risk for developmental delays.

- Develop and present information to parents of special education students and adults with disabilities concerning the needs for sexuality, family life, and parenting skills education.

IV. Expand pre- and in-service training to educators, school administrators, school social workers and school nurses on the implementation of specialized health, sex education and family life curricula for students with mental retardation and related developmental disabilities.

- Develop and present information to professional, consumer and provider associations about the issues and service needs of parents who have cognitive disabilities.

V. Identify and maintain data on families in which parents have cognitive disabilities.

- Administer a confidential survey of local disability organizations (e.g. local ARC chapters, child abuse coalitions), health care programs (M&I, Healthy Start, Head Start), Unified School Districts, SRS, local health departments, Department of Education etc., to identify numbers of children who are at risk for developmental disability who have been born to parents with cognitive disabilities.

- Develop a system for interagency collaboration to identify families who could benefit from specialized services.

The KANSAS Prevention of Developmental Disabilities Plan - Agency Overview
Prevention Project - Children's Rehabilitation Unit - University of Kansas Medical Center - 913-588-5900

1/91

Prevention Goal	Lead Agency: The agency with primary responsibility for service delivery.	Agencies with supplementary planning responsibilities
Goal 1 - Prepregnancy Risk-Factor Identification	Kansas Department of Health-Environment (KDHE)	SRS/Income Support & Medical Svcs.
Goal 2 - Comprehensive School Health Programs	Kansas Department of Education (KSDE)	SRS/Alcohol & Drug Abuse Svcs. (ADAS)
Goal 3 - Prenatal Care	KDHE	SRS/Income Support & Medical Svcs.
Goal 4 - Nutrition	KDHE	KSDE; SRS/Income Support & Medical Svcs.
Goal 5 - Drug Use & Pregnancy	SRS/ADAS	KDHE, KSDE, SRS/Youth Services
Goal 6 - Adolescent Pregnancy	KDHE	SRS/Income Support & Medical Svcs. SRS/Youth Svcs. KSDE,
Goal 7 - Primary Health Care for Children	KDHE	SRS/Income Support & Medical Svcs.
Goal 8 - Child Safety	KDHE	Kansas Department of Transportation (KDOT), KSDE, SRS/Youth Services, SRS/Vocational Rehabilitation Svcs.
Goal 9 - Identification & Intervention	KDHE	SRS/MHRS, Coordinating Council for Early Childhood Development, KSDE, SRS/Youth Services, SRS/Income Support & Medical Svcs.
Goal 10 - Child Abuse	SRS/Youth Svcs.	KDHE, KSDE
Goal 11 - Training and Support Services For Adolescents and Adults with & Mental Retardation with Cognitive Disabilities	KSDE	KSDE, KDHE, SRS/Vocational Rehabilitation Svcs., SRS/Mental Health & Retardation Svcs.

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Children's Services Testimony

John Poertner

The large number of proposals for reform of the Kansas child welfare system attests to the acknowledgment that something must be done. There is agreement on many points including:

-The Kansas child welfare system is inadequately funded. You need to find increased resources for children.

-When the budget battles heat up children do not have a large and effective constituency. You have to provide the leadership for Kansas children.

-Most Kansas resources for children are devoted to expensive out of home placements resulting in a system which lacks creativity and flexibility.

-No state has an "ideal" child welfare system to serve as a model for Kansas. However we do have knowledge and must use what we know.

Given this situation how does the legislature respond. The following case example illustrates the type of system we have and the type we need.

A family adopts a child who needs a family. The family notices almost immediately that the child does things that are difficult to control. The family goes to a variety of local service agencies to obtain assistance in caring for their child and is told that this agency cannot help them. From some agencies they receive services that do not help. Finally the family finds a program 60 miles away that makes a difference. The program is able to help the child during the school day and the parents are able to care for the child during the remained of the time. The program costs $1,500 per month which is difficult for the family and they use their savings to pay for the service. The family continues to seek help because they know that their savings will not last. They appeal for an adoption subsidy. They are refused. They continue to approach the state for help. They even suggest that they continue to pay half of the costs and the state pay half. They

HOUSE FEDERAL AND STATE AFFAIRS
March 20, 1991
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are met by an inflexible system that say's this is not possible. Finally they relinquish custody of their child to the state. They are no longer involved in decisions about their child and the child is placed in a residential placement costing $150 per day or $4,500 per month.

How might it work differently. The same family goes to the single local entity responsible for children in out of home placement and children at risk of out of home placement. This local agency requires all of the professionals involved in the child's case to meet and determine what this child needs to be safely cared for within a family. The local entity uses family and public funds as creatively and flexibly as possible to "wrap " services around the child and maintain the child safely at home. When and if this is not possible the local entity pays for out of home placement out of their residential placement allocation. The personal and fiscal implications are clear to the family, community and state. If the families needs are not met they have administrative, political and legal recourse. It is clear which agency is responsible for the outcome for this child and family.

How do you proceed to create a flexible and accountable system? There are parts of all of the proposals before you which will take Kansas in the desired direction. The essential elements include:

1. You, the legislature defines the outcomes you want for children and families in Kansas.

2. You require a strong state child welfare agency that:

   - maximizing claims on federal funds that are compatible with your defined outcomes for children.

   - holds local communities accountable for funds and your defined outcomes for children and families.

- provides training and technical assistance to local communities to accomplish your mandate.

- reports annually to you on outcomes for children and families in Kansas.

- develops structures, policies and funding mechanisms that maximize creativity and flexibility in meeting the needs of Kansas families.

3. You create strong community entities that:

- are responsible for the outcomes you define for all children in out of home placement or at risk of out of home placement.

- are responsible for all funds currently expended on these children.

- establishes a single point where all professionals involved in each of these child's situation meet to decide on how to meet the child's needs within the most family like environment possible.

The Local Children,s Authority has all of these required elements. It is my belief that this is the best way to create the type of child welfare system we want for Kansas. Through careful pilot testing we can answer critical questions about implementation and build a community based child welfare system in Kansas.

A Child Welfare Outcome System for Kansas

The Department of Social and Rehabilitation Services will report annually to the legislature on the outcomes of all children's programs including but not limited to:

-achievement of permanent placements

-reunification with original caretaker

-adoptions

-adoption disruptions

-child abuse or neglect recidivism

-child abuse or neglect after case is closed

-abuse or neglect while active protective service case

-school attendance and academic performance of children in the care and custody of the secretary

Keys For Networking, Inc.

700 S.W. Jackson
Jayhawk Tower Suite 100-A
Topeka, Ks. 66603

March 20. 1991

Representative Kathleen Sebelius
State Capitol Building
Topeka. Kansas 66603

Dear Representative Sebelius and Members of the Committee on Federal and State Affairs:

Keys For Networking, Inc. supports HB 2553 based on the need for flexible funds in order for families to have access to programs and services that will allow them to keep their children at home and in their communities.

Thank you for your continued support in the area of children services.

Sincerely,

Barbara Huff
Executive Director

Keys For Networking, Inc.

700 S.W. Jackson
Jayhawk Tower Suite 100-A
Topeka, Ks. 66603

Since 1985, families in Kansas have been involved in identifying their needs and defining the services they need to keep their children in their homes and communities. Through the Family Input Project and the subsequent follow up to the Families As Allies meetings, families have consistently stated what they have needed and have articulated the services and family supports which would enable them to keep their children and adolescents at home. This has been reiterated by parents involved in the Kansas CASSP Advisory Board, the formation and implementation of Keys for Networking, and the numerous support networks now available to family members in Kansas.

It has been estimated that there are approximately 10,000 children and adolescents in Kansas who have a severe emotional disturbance. Another 60,000 children and adolescents are reported to be in need of mental health services and are at risk of developing a severe emotional disturbance.

There is broad agreement among Kansas families and families across the country that a comprehensive, coordinated system of care must be developed and funded for children and adolescents with emotional disturbances. Such a system should include a wide array of services and family supports in order to meet the multiple needs of these children and their families. The concept of a system of care represents more than individual service components. Rather, it embodies a philosophy about the way in which services and family supports should be delivered to children and their families. Two core values and ten principles have been developed by the National Institute of Mental Health's Children and Adolescent Service System Program (CASSP), to provide this philosophical framework for the system of care. Families in Kansas support these values and principles in their entirety.

The two core values are:

1. The system must be driven by the needs of the child and his or her family, and must be child and family centered.

2. The system of care should be community based.

The ten principles are:

1. Children and adolescents with serious emotional disturbances and their families should have access to a comprehensive array of services and supports that address the child's and family's physical, emotional, social, and educational needs.

2. Children and adolescents with serious emotional disturbances and their families should receive individualized services and supports in accordance with the unique needs and strengths of each child and family.

3. Children and adolescents with serious emotional disturbances and their families should receive services and supports within the most normative environments.

4. Families of children and adolescents with emotional disturbances should be full participants in all aspects of planning and delivery of services and supports.

5. Children and adolescents with emotional disturbances and their families should receive services and supports that are integrated, with linkages between child-care serving agencies and programs and mechanisms for planning, developing and coordinating services and supports.

6. Children and adolescents with serious emotional disturbances and their families should be provided with case management to ensure that the multiple services and supports are delivered in a coordinated manner, and that they can move through the system of services and supports in accordance with their changing needs.

7. Early identification and intervention for children with serious emotional disturbances should be promoted by the system of care in order to enhance the likelihood of positive outcomes.

8. Adolescents with serious emotional disturbances and their families should be ensured smooth transitions to the adult service system as the adolescent reachs maturity.

9. The rights of children and adolescents with serious emotional disturbances and their families should be protected, and effective advocacy efforts should be promoted.

10. Children and adolescents with serious emotional disturbances and their families should receive services and supports without regard to race, religion, national origin, sex, physical disability or other characteristics; and services and supports should be sensitive and responsive to cultural differences and special needs.

The services and family supports Kansas families of children and adolescents with serious emotional disturbances have identified include, but are not limited to, the following:

SERVICES
- Central point of entry
- Early identification and intervention
- Assessment and diagnosis
- Case management
- Education/mental health liaison
- Outpatient treatment
- Name-based family services
- Family-based crisis services and other emergency services
- Day treatment
- Short-term inpatient care
- Therapeutic foster care
- Therapeutic group homes that are community-based
- Vocational assessment and training

Services to enable adolescents to transition into adult services and/or to transition into independent living:

FAMILY SUPPORT SERVICES

FORMAL SUPPORTS
- Respite care
- After-school programs
- Summer programs
- Recreational activities
- Home aide

INFORMAL SUPPORTS
- Information
- Support networks and groups
- Training (advocacy and parent education)
- Volunteer programs
- Transportation
- Any other supports necessary for the family to maintain the child in their home

STATE OF KANSAS

OFFICE OF THE ATTORNEY GENERAL

2ND FLOOR, KANSAS JUDICIAL CENTER, TOPEKA 66612-1597

ROBERT T. STEPHAN
ATTORNEY GENERAL

MAIN PHONE: (913) 296-2215
CONSUMER PROTECTION: 296-3751
TELECOPIER: 296-6296

Testimony of
Juliene Maska
Statewide Victims' Rights Coordinator
Before the House Federal and State Affairs Committee
RE: House Bills 2010, 2542, and 2555
March 20, 1991

On behalf of Attorney General Bob Stephan I ask for your support of House Bill 2010. Attorney General Stephan is a member of the Criminal Justice Coordinating Council. Last year they requested Senate Bill 521 and House Bill 2667 which set up a master planning commission for juvenile affairs. After interim study, it is my understanding that House Bill 2010 was recommended.

Attorney General Stephan believes there is a need for a coordinated system of programs and policies to address the needs of children's services. The legislature must recognize that this is a concern of great importance that will require extensive research and planning over a period of time before the issues to be addressed can be resolved.

House Bill 2010 permits professionals to review and make recommendations on services that will make a difference in the way assistance is provided to children in our state.

I would recommend an amendment to this bill to include the attorney general or his designee as part of the planning

commission. You might want to consider adding the secretary of corrections also. In last year's original bill they were included as members.

I believe it is important to have the attorney general on such a commission because he is the chief law enforcement officer of the state responsible for interpreting laws that effect children. Also, he has been actively involved in such areas as missing and exploited children, substance abuse, investigation of child abuse cases, and as an advocate for children's issues.

Attorney General Stephan also supports the concepts in House Bills 2542 and 2555. I would also recommend the addition of the attorney general to the governor's commission on children, youth and families which is addressed in House Bill 2542. Again, it is appropriate the attorney general or his designee be included on these important children's planning commissions.

These bills are a sound approach to a known concern. I ask for your support.

KANSAS CHILDREN'S SERVICE LEAGUE

...to protect and promote the well-being of children ...to strengthen the quality of family life —since 1893

Wichita District & Central Office
1365 N. Custer
P.O. Box 517
Wichita, KS 67201
(316) 942-4261

Kansas City District Office
Gateway Center Tower II
Suite 921
4th & State Ave.
P.O. Box 17-1273
Kansas City, KS 66117
(913) 621-2016

Topeka District Office
2053 Kansas Ave.
P.O. Box 5314
Topeka, KS 66605
(913) 232-0543

Western Kansas District Office
705 Ballinger
Garden City, KS 67846
(316) 276-3232

FIELD OFFICES

Flint Hills
227 Southwind Place
Manhattan, KS 66502
(913) 539-3193

Emporia
417 Commercial
P.O. Box 724
Emporia, KS 66801
(316) 342-8429

United Way

Member Child Welfare League of America

Accredited by The Council on Accreditation of Services for Families & Children

TESTIMONY BEFORE THE HOUSE FEDERAL AND STATE AFFAIRS COMMITTEE

RE: HB 2010, HB 2542, HB 2555
RELATING TO POLICY DEVELOPMENT, PLANNING AND SERVICE DELIVERY SYSTEMS FOR CHILDREN AND FAMILIES

Kansas Children's Service League is a statewide not for profit child welfare agency. Our mission is to promote the well-being of children and to strengthen the quality of family life.

The services we deliver are dependent on community need and range from respite care, Head Start services, foster care, family preservation, adoption, teen pregnancy prevention, parent/adolescent mediation services, pregnancy counseling and family counseling.

One of the League's top recommendations for 1991 is that Kansas define a statewide policy for children and families. The combination of broad based state policy for children and families and quality service delivery are at the heart proposals before this committee.

WHY CONSIDER THESE PROPOSALS?

>Our human service delivery system is problem driven and crisis oriented.
>Our system has outlived its ability to respond in the way it once could.
>Our system does not allow the opportunities needed by our children and families to stay together, to become self-sufficient or independent of our governmental support systems.
>Consequently, priorities for human services are based on resource availability and not clear policy choices.

TWO KEY QUESTIONS

In order to gain adequate support for these proposals two key questions must be answered:

1. Will this proposal move us from a resource driven to policy driven system?
2. Will this proposal assist in making services developmental, preventive and child centered in nature versus problem and crisis centered?

We believe all proposals meet that threshold test. Policy makers, the SRS task force and other citizen participants are to be commended on their effort to date.

The bigger question therefore is not do we change our response but rather how and in what manner?

In addition to defining the intent behind and the outcomes hoped for in each of these proposals, we have also used the following five elements of any new system in our continuing analysis of them:

1. Are comprehensive policies included in this proposal or does it support the development of them? Are these policies supported through legislative and legal action?

2. Are there competent organizational structures to deliver services or does this proposal create the opportunity for this to happen?

3. Are there adequate financial resources which can ensure sufficient service amount and quality, including competent staffing for the particular proposal?

4. Is there a provision for or is there in fact effective community linkages to ensure coordination and prevent fragmentation of effort?

5. Is there effective service or program evaluation models included in this proposal which identify the outcomes desired by this proposal?

RECOMMENDATIONS:

>Establish a special or interim committee which will further refine the proposal. We are not asking for further study.
>Combine the concepts and proposals specifically in HB 2542 and HB 2555. HB 2542 begins with a policy and planning concept and works down.
>Establish a policy framework that outlines obligations, commitments and outcomes relevant to children and families. Until we have a well defined policy, for families and children we are going to be unable to develop responsive systems and programs.
>Identify other state entities particularly other state commissions which attempt to set state policy as it relates to children and families. This will be critical in our ability to coordinate policy and set clear planning parameters for the state and local communities.

SUMMARY

We believe the search for the perfect model is over. In these proposals, you have the basis for positive change in the child services delivery system. The danger now is devoting too little time or inadequate resources to truly refine a solid proposal.

We ask the committee to take the information from this hearing and deliver it to a special interim or select committee. The charge of that committee would be to refine and develop an integrated proposal which includes:
>a policy framework for children and families,
>a planning mechanism for the state and communities, and
>support for new service delivery systems proposals as outlined in their final report.

COMMENTS RE: PROPOSALS HB 2543, 2555
FROM PEOPLE PROVIDING SERVICES TO CHILDREN IN OUT OF HOME CARE

HB 2542
GENERAL COMMENTS AND CONCERNS

>May make some policy decisions less political.
>This is very similar to the intent behind the development of the Commission on Developmental Disabilities.
>This gives us a good run at developing a statewide plan.
>Need to be clearer about the service delivery aspect.

BENEFITS
>Elevates the visibility of children and families and gives a mandate for better planning and coordinating services.
>I like the policy development approach.
>The role for the local community is a good one; one I think the community to be a true part.

HB 2555
GENERAL COMMENTS AND CONCERNS

>Let's remember why we moved away from the county system when designing a local service delivery system? Why would judicial districts be any better than designating geographical areas? Should take a closer look at using judicial districts as the service delivery point.
>At the local level, who makes the decisions about the type and level of service provided? On what basis are they made, by what standards and within what parameters?
>How will the priorities be set at the local level?
>The relationship with SRS, the judicial system, and the school system etc. is unclear.
>The plan seems to missing critical implementation details ie. how the money will really flow
>Concerned it may lead to more fragmentation of services if for example someone in one judicial district needs a service that is not offered and is forced to go to another county or area in order to acess services.
>Concerned there will be a lack of community support or energy needed to make the local commissions/authorities work.
>Organizational structure is unclear.

BENEFITS:

>Gets us on the right track regarding innovative ideas and changing to a system that is more person oriented.
>Forces the community to be a part of supporting and resolving problems faced by children and families.
>It is needs driven v. agency or budget driven.
>Has real potential for the development of comprehensive services to children and families.

over

FOR GENERAL CONSIDERATION

>If we are going to do this we need to devote a solid amount of planning time.
>We don't need more studies. We should take the information we have and move ahead.
>There needs to be a good balance between state policy and control with local policy and control.
>Adequate funding! We know all to well what happens without it.
>The system must be "child" friendly.
>The policy mandates and timelines for implementation must be strong. We can look to how long and how we finally were able to start removing juveniles from adult jails as an example of what has to happen before something gets done.
>There is a critical balance between "responsibility " and authority.
>How will this be integrated with mental health reform?
>Do we really have community support to make it happen. We will need people available to participate on local committees. In smaller communities many of the same people serve on a variety of boards. Is this a problem?

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[Note: These comments do not represent one organization's position or point of view and should be used as discussion points only.]

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Robert C. Harder, Acting Secretary
March 20, 1991

Testimony on House Bills 2010, 2542, and 2555

Acts establishing the Kansas Children's Planning Commission; concerning children, youth and families and providing for the establishment of the Governor's Commission and local commissions on children, youth and families; and establishing local children's authorities pilot studies.

Madame Chairperson, Members of the Committee, I appear before you today regarding House Bills 2010, 2542, and 2555.

The statutes being proposed in these bills and in Senate Bill 227 call for the development of both state and local level groups charged with studying, planning, and implementing services to children, youth, and families. Priority is placed on interagency collaboration at both the state and local levels with varying emphases, including prevention and early intervention, outcome measurement, flexible funding, public-private partnership, and elimination of duplication.

We support the development of more effective collaborative efforts at the state and local levels and believe these bills and Senate Bill 227 should be consolidated.

Leadership should be provided at the state level for the development of integrated state policy on children and families. Priority should be placed on strategies which enable families to carry out their responsibillities to their children and to function independently. Expectations should be tied to the resources allocated, with emphasis placed on outcomes to be achieved. Consumer involvement in planning should be ensured. State level agencies should model the kind of collaboration necessary and expected at the local level to carry out mutual expectations.

Additional studies should not be undertaken without a thorough review of studies which have recently been completed. Conclusions reached by the Department of Education's study of at-risk students, the Children and Youth Advisory Committee's Ten-Year Plan, the Juvenile Offender Policy Conference, the University of Kansas Analysis of the System of Care for Emotionally Disturbed Children, Legislative Performance Audit Reports, and Governor Hayden's Task Force on Children and Families provide strong policy guidance without further study.

State level efforts should provide support, encouragement, and incentives to local level collaboration without being proscriptive. Communities should be encouraged to build on the considerable collaborative efforts which already exist. They should be empowered to develop strategies and design programs which meet the unique needs of their children, families, and communities. Examples of existing efforts include the Court/Education/SRS Liaison Committees at the state and local levels, foster care review boards, mental health planning coalitions, child protective service multi-disciplinary teams, and early childhood coordinating councils.

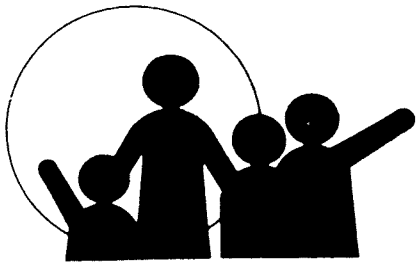
We have the following additional comments regarding House Bill 2555 on local children's authorities pilot studies. Discussions regarding local children's authorities have centered on replicating funding decategorization studies in Iowa with the belief that federal funds were being decategorized. In checking with Iowa, we learned that they are only decategorizing state funds. Federal staff at the regional Health and Human Service Office also indicated that they are not aware of any state attempting to decategorize federal funds.

We believe that considerable latitude already exists with both state and federal funds to accomplish many of the outcomes sought in this bill. Our recent expansion of the use of Medicaid funding for alternatives to hospitalization has enhanced our ability to serve eligible children without families losing custody. We believe Medicaid funding can be further enhanced by matching child welfare funds. We are initiating planning in this area, as well as expanded eligibility under SSI. If new funds generated by these efforts remain available to SRS to serve children and families, we can meet many of the expectations of this bill.

Finally, we do not support any plan which leaves the responsibility for the outcomes achieved with SRS, but grants the authority to carry out the program to other entities such as the local children's authorities.

I appreciate this opportunity to appear before you today.

Carolyn Risley Hill
Acting Commissioner
Youth and Adult Services
Department of Social and
Rehabilitation Services
(913) 296-3284



KALPCCA

KANSAS ASSOCIATION OF LICENSED PRIVATE CHILD CARE AGENCIES

EXECUTIVE DIRECTOR
Bruce Linhos
Box 3658
Lawrence, Kansas 66046
913-749-2775

Testimony
Federal and State Affairs
H.B. 2010, 2542, 2555

March 20, 1991

I appreciate the opportunity to appear here before you today on these three bills. I am the Executive Director of KALPCCA, which is the state association of group homes and residential centers. Each member of our association are private, not-for-profit, community based child welfare agencies.

The Child Welfare system in Kansas, as in all other states, experiencing record demands being put on it. These three bills are responses to the fact that we must do something.

In studying the three bills before you I find myself unsure of what to recommend to you. Each of the bills is an honest attempt to address a particular aspect of either planning or service delivery.

Perhaps I can be most helpful to the committee if I share with you the questions I have as I study these three bills.

1. I recognize that the child welfare system is ineffective partially because it is always in a crisis response mode, and as a result it bandages the hemorrhage rather looking at the system as a whole. The child welfare system needs careful and thoughtful study of this very complicated and entwined system. Is a commission the best way to study this system?

2. The previous administration appointed a Commission of Children and Families. The result of this groups work included several recommendations few of which were implemented. More over this commission like so many others, seem overwhelmed by the enormity and complexity of the problem. How can we best insure that the study and planning

required does not result in just another report?

3. The SRS system currently has many structures in place similar to many of the functions described in these bills. For example; The Children and Youth Committee, The Juvenile Offender Advisory Committee, local advisory committees in each SRS region, as well as judicial coordinating groups, and SRS, Education, Courts coordinating groups . How will these existing groups interface with these proposals so we are not creating duplicate structures? Can existing groups be re-tooled to serve the purposes described in these bills?

4. SRS was appropriated money last year to employ a consultant to study our child welfare services and make recommendations. Currently a contract has been developed with Michael Petit to conduct this study. How can the various efforts proposed and underway be coordinated to insure a full systems approach to our child welfare system?

5. SRS is currently under the direction of an interim Secretary. We are promised a permanent Secretary by July 1. Would it not be useful if the new person in charge of SRS was a part of directing and coordinating the revamping of the states child welfare system?

6. Specifically pertaining to the Youth Authority idea, the goal of making local communities responsible for the needs of their children is certainly a positive one. How this would work practically seems to leave many questions. SRS would contribute money to the local Youth Authority. Would other departments of government, most notably Education, also be expected to contribute funding? The Youth Authorities are developed on the basis of judicial districts, the SRS regions overlap several judicial districts. How would service coordination between these overlaying districts be insured? Decatagorization of funding for services to children and their families is a critical piece of

the Youth Authority proposal. Decatagorization of funding as developed in the model project in Iowa deals only with the decatagorization of SGF dollars. The HHS representative for this region said that she knows of no state that has, to date, been successful at decatagorizing federal dollars. What implication does this proposal have for Kansas being able to draw down maximum federal dollars?

We support the need for reform of the child welfare system. The reform however must be a true reform that first carefully studies the existing system. What we do not need is piece meal approaches to reform.

I would encourage you to consider referring these proposals to an interim. I believe that the thoughtful preparation prior to a study, and prior to developing a body responsible for that study, is absolutely essential if the resulting recommendations are not simply going to fill a volume on someone book shelf.

As we face this crisis we also face an opportunity to make significant improvements in the way children and their families are served. We hope that we all can contribute to a careful, thoughtful analysis of the child welfare system in Kansas.

Bruce Linhos
Executive Director

State of Kansas
Joan Finney, Governor
Department of Health and Environment
Division of Health
Landon State Office Bldg., Topeka, KS 66612-1290
Reply to: _____
FAX (913) 296-6231

Acting
Stanley C. Grant, Ph.D., Secretary

Testimony presented to

House Federal and State Affairs Committee

by

Kansas Department of Health and Environment

House Bill 2010
House Bill 2542
House Bill 2555

The Advisory Committee on Juvenile Offenders, the Children and Youth Advisory Committee, the SRS Task Force, and other groups have looked at the present status of services for children and found it flawed. There are critical gaps where needed services are not available because of these boundaries.

KDHE shares the concern about the need to coordinate services to children across geographic, categorical, agency and "system" boundaries. There is not a focal point in the state for drawing together the many interests in childrens' issues to forge a comprehensive policy plan and determine priorities for action and resources. At present there are not only multiple state agencies and interest groups seeking to influence policy, there are multiple committees and commissions established to focus on a particular problem or sub-population of children.

The population of "children" ranges from age 0-20, presenting both common and disparate needs and problems for the agencies and programs seeking to serve parts of the overall group. Though the issues relating to teenage juvenile offenders have little to do with the problems of assuring screening, nutrition and basic health services for infants and toddlers, we now recognize the value of "prevention" and must struggle with difficult questions of relative priority for scarce resources. We need the capability to coordinate policy and program activities both for specific issues and populations and to set policy priorities comprehensively from a "bird's eye" view.

There is strong interest in decentralizing control of services to the local level to improve coordination and have policy and resource allocation decisions made by those closest to the problem. Unfortunately, the maze of legal and organizational obstacles to even trying out the idea is formidable and the problem of linking separate service delivery systems is no less difficult at the local level.

Charles Konigsberg, Jr., M.D., M.P.H.
Director of Health
(913) 296-1343

James Power, P.E.
Director of Environment
(913) 296-1535

Lorne Phillips, Ph.D.
Director of Information Systems
(913) 296-1415

Roger Carlson, Ph.D.
Director of the Kansas Health and Environment Laboratory
(913) 296-1619

Unfortunately, all of the proposals before you address some but not all of the major issues. Should we have one entity responsible for coordination of all children and youth policy issues? Should we add such a body without removing any of the existing committees and commissions? Should we create an "umbrella" commission with direct links to other entities dealing with particular populations? Can we realistically decentralize and "decategorize" control of program funds? How will state programs and policies be effectively linked with local authorities? These and other questions need more analysis and specific alternatives before a trial and error approach is started.

The Department recommends that a time limited commission such as that proposed in House Bill 2010 should be charged to complete a more detailed analysis of the policy issues and recommend legislation for the 1992 Legislative Session. KDHE will participate in and fully support such an effort.

Testimony presented by: Richard J. Morrissey
Deputy Director of Health
Division of Health
March 20, 1991

Observations and Recommendations on Children and Mental Health

Testimony to the Committee on Federal and State Affairs of the
Kansas House of Representatives
March 19, 1990

by

Michael B. Lubbers, Ph.D.
Co-chair of the Joint Children and Youth Work Study Group
of the Kansas Psychological Association and the
Kansas Association of Professional Psychologists

While officially representing many of the psychologists that practice within the State of Kansas, I have also spent the recent weeks and months sharing ideas with colleagues from other mental health disciplines, consumers, advocates, and governmental servants. Such is an important process because despite my strong, and at times passionate, positions, I am regularly reminded and humbled that the most good always comes from the crossing of minds and the collective expression of human energy. I also trust that in speaking with you today, I represent the needs and wishes of Kansas children struggling with the pain of abuse and abandonment, the fear of family conflict and divorce, and the uncertainty of a world changing faster than their young psyches can develop. Were I not fairly certain of what they need and wish, I would be less bold before you now.

Since 1984, I have been working with children in psychiatric hospitals - public and private - and outside of hospitals. Some are helped, some change little, and some continue to be damaged, a reexperience of the neglect and abuse within their natural families. I have been part of the mental health delivery system working well, and working very badly. For the most part, it is staffed by dedicated and caring people who are only limited in their capacity to help children by the mandates and fiscal restrictions of the settings within which they practice.

All parties concerned with children's health issues agree that for too long the mental health needs of Kansas children have been ignored, or at best minimized, within the current State system. The reasons for the lack of attention are many, and better discussed in some other forum. But strides have been made within mental health and education to better help parents attend to the needs of their children, as exemplified by the increased attention to life span education and family therapy. However, in most cases, children at risk and in need of services are cared for within the existing mental health model - that being the **Medical-Institutional Model.** During the 1990 Legislative session, a reference to children's services was entered into the Mental Health Reform Bill. Without any funding attached to

develop services in the communities, it is upon the shoulders of the mental health centers to divert some of their minimal resources into children's services. Urban centers are in a better position than rural centers to develop some programs. In reality, little has changed for children with the implementation of Mental Health Reform because it is not truly a **reform of the model** that the systems uses. It does not articulate the State's mission regarding children, and it continues to rely most often on medical treatment.

Over the past several years, consumer and advocacy groups have eloquently and passionately delivered the message that unless we better attend to the needs of our troubled children, our society is headed further down the road of devolution. The rest of us - legislators, professionals, and administrators - have heard the message. 1991 is at least informally the year of children. There is pressure for something to happen. A variety of legislation has been proposed. Before you are the fruits of these efforts.

Each of the bills being discussed have good intentions and procedures toward better understanding and caring for distressed Kansas children. However, the two main proposals - HB 2542 and HB 2555 - have a subtle differences in philosophy. The former works toward the establishment of a strong, central office of children, from which would radiate into the community the mechanisms for the delivery of services. The latter bill focuses on local control and design of services with the explicit goal that more children be served in their homes. I emphasize these are subtle differences because the designers of these bills would readily agree that in the end there must be cooperation between the State and local authorities if any plan is to work. It must be clearly said, however, that at present we are not unified in our philosophy and mission about the best way to care for children. There exists two camps - one wanting to increase and improve institutional services and the other wanting to transfer most of our limited funds to community-based treatment.

There is another division between the service needs of children in the urban and rural communities. Examples abound within the history of this State of difficulty applying programs designed for one upon the other.

Therefore, I do not believe the children of the State of Kansas would be well served by adopting either of the major legislative proposals at this time - although they both have much merit and have been carefully thought through by their authors. Most of my colleagues agree that what is needed is a time-limited, but authoritative and comprehensive commission, essentially an expansion of HB 2010: 1) to develop our mission for children,

2) to design and conduct experimental research and systems analyses, and 3) to write the legislation needed to implement the best plan. Many people are legitimately leery of another commission. To often, they are created as a way to avoid necessary action. So the emphasis is on an **authoritative** commission - one populated by 15-20 innovative experts and advocates in the field of children's health, welfare and education - who are given the resources and legitimacy to do a comprehensive study. Some of the qualifications for membership should include: people with vision, people intimate with other state programs that are working well for children, and people with the experience needed to design and conduct research - the results of which will chart our future direction. Both HB 2542 and 2555 propose pilot studies. However, these studies have a community focus and would benefit from expansion. Our research must study treatment processes and outcomes from community programs (e.g., Medicaid option pilot studies) compared to state-of-the-art institutional programs, in both rural and urban settings. In the end, we will discover what many already know: the only delivery system that works is one offering an array of quality services that can be called upon based on the unique needs of the child. If we do the research, analyses, and development the right way, we are more likely to attract alternative funding sources, as well as add to the body of literature that will help children across the country.

A final point regarding the membership of the commission: some believe it needs to include the heads of the various agencies currently involved with the care and education of children. Both HB 2542 and 2555 do not allow for a designee by the particular secretary or commissioner. While it is important for the top people to mentor, and in some cases serve on, the commission, we would want the membership to consist of people who are in the best position to use creative ideas to solve difficult problems. Certainly members should have direct and open communication with the head administrators of current agencies.

Children are in crisis, money is elusive, and time is short. Let us take bold new action, even though the plan that may only be fully implemented by the turn of the century. Let a commission on children digest the goals and recommendations of The Children and Youth Advisory Committee (Toward the Year 2000: A Plan for Kansas Children, December 1990), and then adopt their working mission and models. Let a commission struggle with how to create and solicit new funds from businesses and foundations. Let a commission design ways of cooperating instead of competing with the private sector. **(Note the attached Broder editorial.)** Let a commission do all the important things discussed in HB 2010, 2542, 2555, and let it also design an advertising campaign to rally the support of the citizens of the State of Kansas. The

reports in the press speculate people are only interested in taxes, specifically in how to be relieved from them. This does not fit with my experience in talking with people. They worry about children. They want the best for children. They are willing to help out if they are asked and emotionally supported.

Most importantly, let us not get in the way of a commission with our personal/political agendas. Let them work for three years, report on a yearly basis, and propose interim legislation as needed. In the mean time, let us all work to cultivate a climate that will readily accept and implement their important conclusions. (An excellent example of something to begin right away is SB 227, also included in HB 2542, calling for a children's planning group in each judicial district. I have had the privilege of serving on the Wyandotte County Children's Services Coordinating Council. It exemplifies the spirit and letter of SB 227, and it has done good work toward dealing with interagency conflicts and increasing cooperation in that county.

It can be argued that many communities have all the services necessary to care for the health and welfare of its citizens. Were the homes, churches, schools, hospitals, mental health centers, and private providers and agencies genuinely to work together - fortified by the wealth of resources within this State and nation - we could effectively care for just about all us, regardless of our need. However, if the public and private sectors continue to oppose and distrust each other, if we fail to develop an agreed upon and coordinated mission for the care of our troubled citizens, and if we continue our dependence on outdated models and underfunded programs, our only solution will be to fund and then build more prisons and hospitals for our increasingly disturbed population.

May this testimony never be viewed as the final word. I have much to learn about how this process works and of what my colleagues are thinking. But the best interest of children is always served by honestly sharing thoughts and visions with each other, and then collectively working toward the greater good.

In conclusion, I strongly recommend this Committee find a way to integrate the best from each of these proposals, and then to establish a Children's Commission - populated by visionaries and leading-edge program planners within the government, the private sector, and general public - that is given a three year mission to study and recommend the implementation of the comprehensive plan for children's services that will carry us into the next century.

Thank you for the opportunity to speak before you today. Please contact me if I may be of further assistance.

The nation's children also need saving

Washington Post Writers Group

WASHINGTON — With near perfect timing, the Committee for Economic Development, a policy and advocacy group made up of 250 leading business executives, chose the morning after President Bush's speech ending the Persian Gulf War to remind Americans of "the unfinished agenda." In language that would be suspect if it came from a liberal band of do-gooders, but actually carried the imprimatur of bosses of Aetna, Arco, Ciba-Geigy, Texas Instruments and the like, the report said:

"Unless we act swiftly and decisively to improve the way we

DAVID S. BRODER

invest in our most important resource — our nation's children — we are jeopardizing America's survival as a free and prosperous society and condemning much of a new generation to lives of poverty and despair."

Bold words, but not as surprising from this group of executives as they first seem.

Twice before, in 1985 and in 1987, the CED's research and policy committee has addressed the topics of school reform and early childhood programs. Those reports spurred local and state efforts to see that children start off life with adequate health care and nutrition and that they have a chance to develop their skills, from age 3 through to graduation.

The reason this new report is called "The Unfinished Agenda — a New Vision for Child Development and Education" is that the business executives, like the governors and others grappling with this challenge, have come to understand the complexity of the task. They now realize that piecemeal efforts to remove one or another roadblock from a child's path to adult citizenship and economic self-reliance will not succeed.

"Many people are trying to do the right thing," said James J. Renier, chairman of Honeywell Inc. and head of the task force that wrote the report. "But the system is not designed" to permit the kind of "comprehensive and coordinated human-investment strategy for child development and education" that he and his colleagues think is needed.

turned over part of company headquarters to house a school for teen-age mothers, Renier found himself battling bureaucracies and rigid federal and state regulations.

Even more than additional money, he and his colleagues concluded, the system must be redesigned to do two things.

First, it has to reach out into the community to enable parents, especially those with meager educations of their own, to avail themselves of the services their children need. And, second, it must deliver continuing social services at school to help youngsters become active, eager students while allowing teachers to concentrate on their real job of education.

The social service agencies already exist in most communities, but too often are not readily available at school sites.

Paying for such an effort is financially possible, they say. The annual additional federal spending that would be required to provide prenatal care, diet supplements to pregnant women and infants, immunizations, infant and toddler care and pre-school Head Start programs to all the nation's poor children is about $10 billion. That's about what two weeks of Operation Desert Storm cost us.

The real question the report raises is whether a nation which coordinated brilliantly an international military rescue mission for Kuwait can coordinate a similar mission to rescue its own children.

Rescue them from what? From a situation where a rising percentage of them (one of four under age six in 1989) live in poverty, where one in four drop out of school before the 12th grade, and where far too many graduates lack the language, math and critical thinking skills needed for productive work in the new economy.

The good news, say these business executives, is that over the past decade, enough experiments have been conducted in enough places so that "we know what works in education and child development."

The CED report is filled with brief descriptions of local and state models that have achieved significant results. Many of the smaller-scale experiments have been foundation-financed. The common feature of those that are large enough to require tax support is that they have been developed through a consensus process, involving political leaders, business and professional officials and the broad mass of voters.

A similar effort, led by the president, could save a generation — and secure the nation's future.

TOWARD THE YEAR 2000

A PLAN FOR KANSAS CHILDREN

by

The Children and Youth Advisory Committee

December 1990