MINUTES

JOINT COMMITTEE ON CHILDREN'S ISSUES

September 23-24, 2003
Room 313-S—Statehouse

Members Present

Representative Brenda Landwehr, Chair
Senator Nick Jordan Vice Chair
Senator David Corbin
Senator Janice Lee
Representative Patricia Barbieri-Lightner
Representative Willa DeCastro
Representative Sue Storm
Representative Roger Toelkes

Member Absent

Senator David Jackson

Round Table Members Present

See attached list.

Staff Present

Hank Avila, Kansas Legislative Research Department
Emalene Correll, Kansas Legislative Research Department
Mike Corrigan, Revisor of Statutes Office
Renae Jefferies, Revisor of Statutes Office
Almira Collier, Committee Secretary

The Chair called the meeting to order and thanked the roundtable members for their willingness to be part of the discussion relative to the foster care system in the State of Kansas. Other roundtable members and committee members introduced themselves (Attachment 1).

Identified Foster Care System Issues

During the discussion, some panel members shared personal stories. A grandmother, who does not know where her adopted grandchildren are, expressed the belief that removal of her grandchildren from their home and the severance of parental rights was unwarranted, that social workers lied to them, and that no one in the system listened to or responded to concerns and

complaints. A foster parent who had cared for 285 children in 18 years stated he was not considered good enough to adopt a grandchild and has left the foster care system because the system that is supposed to work toward reintegrating families seems to be tearing families apart. Nothing was done when children returned to a foster home smelling of meth following an unsupervised home visitation although the children talked of meth being manufactured in the home. The social worker seemed to brush the information aside, saying she had not seen anything. The foster parents tried to talk to a supervisor, and the children tried to call the social worker's supervisor, but all felt they were ignored. A foster parent filed a complaint on a Monday about signs of sexual abuse of a three-year old foster child after a home visit. On the next day, the Department of Social and Rehabilitation Services returned the child and siblings to their parents without an investigation. The first call to the abuse and neglect hot line call was made a week later. During the 11 months the children had been in the foster home, the contractor had not responded to requests for therapy for the children. Ten weeks later the children were brought back into the system, but were not allowed to return to the home of the previous foster parent. Instead they were split up and placed in two different foster homes. The father told the foster parent the contractor and the Department of Social and Rehabilitation Services knew he and the mother were still doing drugs when the children were returned to them. The older children, who were placed with a relative, are showing the same behaviors and are seeing the same social worker as before. A foster parent had two girls for two and a half years before the girls and two brothers were adopted out-of-state. At the time the children were placed in the foster home they had nothing. When the foster parent took the children to the adoptive home, she had misgivings which she tried to share with the Department of Social and Rehabilitation Services and the contractor. After seven months all four children, who showed signs of being abused, were brought to her with none of the special items they had taken with them. The response to the foster parent's complaint was there was insufficient evidence to take action.

According to roundtable members, the shared stories reflect what appears to be lack of response when requests are made for services for foster children; when complaints about the conduct of a social worker or agency are made; or when concerns about what is happening to children during home visits, reintegration into the family, or adoption, especially out-of-state adoption, are expressed. Other accounts reflect the apparent inability of the Department of Social and Rehabilitation Services to hold workers, contractors, and mental health centers accountable for their conduct; the development of policies and outcomes that seem to create an environment in which contractors and social workers are not supported or held to a high standard of conduct; a system that appears to penalize those who complain or express concerns through retaliation or threats; the unresponsiveness of workers, *i.e.*, phone calls not returned or infrequent visits to foster homes; foster parents not given adequate information about children placed with them; the lack of emphasis given to kinship care; contractors who appear to be sweeping things under the rug; and an apparent priority being given to clearing the caseload.

Many roundtable participants shared the feeling that the stories shared are not unusual and represent issues that need to be addressed.

Weaknesses and gaps in the system were brought out in discussion. There is no state entity or at least not one that is functioning adequately, holding contractors, social workers, supervisors, or mental health centers accountable for adopting policies leading to an environment that encourages the types of behaviors and responses that are in the best interests of the children in the system. Although the expressed goals of the system are preservation of families, reintegration into families, services for children, and support of foster families, the behaviors of the responsible entities too often do not appear to support these goals. Respite care has been discontinued in some cases, visitations to foster homes and parental homes are at times infrequent. At times too many social workers are involved in one case, with little or no communication apparent between them. The social worker appearing at a hearing is not necessarily the social worker who has been involved with the child or is a worker who may have seen the child only once for a short time.

There is a need for a well understood, independent complaint mechanism. There appears to be no place to call and feel confident that someone will check to see if there is any validity to the complaint or concern. The response of the Department of Social and Rehabilitation Services is that it is the contractor's responsibility. It seems agencies involved in the foster care system are supervising and overseeing themselves.

The lack of financial accountability in the system was noted. There appears to be an inability to determine how much of the money provided to contractors is utilized for administration and how much for the provision of services. The Department of Social and Rehabilitation Services is not sure if the contractor's accounting for expenditures is considered public information.

Attention was called to the complexity of making decisions relating to children-in-need-of-care and their families. There is a need to look at the criteria followed in making these decisions and at what is considered when deciding the placement or movement of a child. A need for a better method of screening potential out-of-state adoptive parents and for monitoring out-of-state adoptions was also noted.

An advocate for persons with disabilities noted discrimination within the system against persons with disabilities. Children are removed from the home due to misconceptions about the ability of a disabled person to parent. Persons with disabilities feel they are sometimes not given the option of being foster or adoptive parents. (A packet of material, provided for committee members is on file in the Kansas Legislative Research Department.) A panel member who works in a developmental disabilities center briefly explained the center's work with developmentally disabled foster children and the agencies who serve them. According to this individual, approximately 90 percent of the children in foster homes have developmental disabilities resulting from genetic factors, behaviors of the mother during pregnancy, the trauma of being removed from the home, and multiple placements, which impact the child for life. Foster parents, professionals in the child welfare and judicial systems and physicians are beginning to focus on this issue but do not seem to connect with each other.

A panel member associated with the Kansas Department on Aging distributed literature on a program called "Grandparents and Relatives as Parents" implemented by the Department (Attachment 2). The number of grandparents and relatives raising children is increasing for many reasons. Ms. Williams noted that over 3,600 children in Kansas live in households headed by grandparents or other relatives. While the value of such placements is continuity of the family, a need for providing relatives with more information about financial, medical, and legal support has been created. She called attention to the fact that every child kept out of foster care saves the state $25,000 a year.

Specific Issues

Contract System: A central issue throughout discussion was the discontinuity for a child and the other problems created by separating the adoption contract and the foster care contract. It was noted the child may remain in foster care for an additional time since the case must be transferred from one contractor to another; often the child is moved from one foster family to another and from one part of the state to another; any counseling or mental health service is disrupted because of a move; social workers change, with the new worker being one who has had no previous contact with the child; records are delayed; the court that has a history with the child may not be the court that handles any eventual adoption or other permanency action; and the adoption contractor may replicate home studies previously done. All of this comes at a time when the child is particularly vulnerable because parental rights have been severed and he or she is facing extreme life change.

Medical Records: In 1986 the Child Welfare League of America and the American Academy of Pediatrics developed and published medical care standards for entities in the foster care system, but few within the system know they exist. These standards include such things as knowing where the child' s medical records are; what the diagnosis, if any, is; doing a screening within 24 hours; and completing a multi-disciplinary evaluation within 30 days. A comprehensive assessment and medical plan are significant factors in resolving systemic issues, enabling entities in the system to know what each is doing and fostering cooperation and coordination. An issue is the person bringing the child in, if not the parent, frequently has very little information about the child's medical history. Records are fragmented, and social workers often feel they cannot share information they have. An important issue in providing services for foster children is the centralization of medical records. Kansas City, Missouri has established a model that utilizes a unit of nurses dedicated to collecting and monitoring the medical records of foster children. The records have been centralized due to a court mandate resulting from a lawsuit. A model program in Arkansas uses a roaming multi-disciplinary team to develop records. Initial screening and comprehensive evaluations are completed within a specified amount of time and a medical record is developed which is shared with the foster parents. Reference was also made to the model developed by KVC to provide a medical home for each foster child. The latter program will be discussed on the second day of the meeting.

Outcomes: During discussion it was pointed out the outcomes established in the contracts are essentially performance measures for the contractors. There is a need to determine what outcomes for the child should be measured. The Adoption and Safe Families Act affirms the outcomes of child safety, permanency, and well-being. The Foster Care Independence Act identifies such things as educational attainment, homelessness, high-risk behaviors, and incarceration as areas in which to develop outcomes.

Suggestions

A representative of the Department of Social and Rehabilitation Services stated allegations and complaints are taken seriously by the Department and asked that information relative to specific incidents such as those shared by roundtable participants, including names of the social worker or others involved and a time line of events, be submitted to her. Ms. Farrell emphasized the system is designed to protect children, make families stronger, and reunite families. The Department, like others at the roundtable, wants what is best for the children. However, at a given point in time, this is not always easy to determine.

It was suggested there be an independent board with a broad representation, including average citizens, to insure social workers are complying with the laws, rules and regulations, and professional ethics and that entities within the system are held accountable. Establishing an independent board to report to the legislature on how the system is doing in carrying out its mandate was also suggested. Reference was made to two models, The Children and Family Research Center in Illinois, and the State Institute for Public Policy in the State of Washington.

Other suggestions included narrowing the definition of child-in-need-of-care to encompass only cases of abuse and neglect; changing the law governing state contracts to make line item budgets of contractors public documents; establishing as a state policy that child welfare services utilize practices that have the strongest evidence for producing desired outcomes or evidence-based practices; acknowledging as myth the assumption that a person who is disabled is unable to parent or of becoming a foster or adoptive parent; and providing services, if needed, to families in order that the child can be maintained in the home.

Additional suggestions included training for social workers relative to developmental disorders; better communication about standards relative to foster care established by reputable groups; better use of programs and services that are available in the state to assist persons involved

with a foster child; centralization and monitoring of medical records, *i.e.*, a medical home for each foster child; and clarifying for all parties the provisions of statutes pertaining to confidentiality.

It was suggested attention should not be focused exclusively on the Department of Social and Rehabilitation Services and contractors. Other players in the system are judges and county and district attorneys who make decisions relative to children and families and *guardians ad litem*. The role of legislators is also significant because the legislature is responsible for policy directions and funds.

Behavioral changes within a system do not just happen it was pointed out. There must be a change in thinking first.

Questions for Further Consideration

Two questions raised during discussion were: What would be the impact if family preservation were the first priority and foster care the last resort? How can the system be redesigned to provide for empowerment of the family as a unit rather than focusing only on the child? It was noted family preservation as originally designed does not exist. To have a good family preservation program funding must be a priority. Benefits of the family preservation approach are providing authority to remove the child from the home if needed, giving the social worker time to identify the basic changes needed in the family for the child to be maintained in the home, and providing a way to determine if the family can make progress within the system. There needs to be a clarification of what is meant by family preservation because different groups define it differently. Reference was made to a family resource center and integrated intake system involving 15 agencies in one building developed in Topeka as a pilot project. Persons who can sign or speak Spanish are available. The goal is to meet the needs of parents, keep children out of the system if they do not belong there, and get appropriate services to families so they can keep their children at home. An assessment is made and appropriate referrals made to services usually located within the building. This project has provided opportunity for easy interchange of information, collaboration, and understanding among the agencies involved.

The meeting was recessed until 1:30 p.m.

Afternoon Session

A former foster care client currently working on a Master's Degree in Social Work, stated she entered foster care in 1994 at age 13 prior to privatization. Factors which contributed to her success in the foster care system were: she had only one foster family who treated her like a normal teen and who was and continues to be very supportive; she had two social workers who saw her as an individual rather than as another foster youth and asked her what she wanted; and she received a lot of therapy. She entered an independent living program and was involved with the former Kansas Youth Advisory Council, one of the voices of Kansas foster youth. She noted the need for more mentoring for foster youth, for asking foster youth what they want, helping biological and foster parents work together, and more opportunities for foster youth that will empower them to be leaders. In response to a question, she stated she was the exception in the foster care system.

Referring to earlier discussion of open courts and families having access to records, a panel member stated too often everyone but the family knows what the allegations are. In response to a question, it was stated opening the courts would not jeopardize federal funding. Families need support in the court room, and people who care need to be there. Reference was made to two pilot

projects, one in an urban area and one in a rural area, created to address this issue. Concern was expressed over how comfortable families would be without some restrictions on who could be in the courtroom since the details of their lives are being shared. Also noted was the reluctance of some judges to have additional persons in the court room. Hopefully the pilot projects will help alleviate those concerns.

The Chair referred to copies of a form "Authorization for Release of Information" supplied by the Department of Social and Rehabilitation Services and asked any parents present who would like a committee member to look into a case to fill out one of the forms and give it to her or a staff member. Persons present were invited to take a form to other families they knew of who might like to have their case looked into.

System Issues Continued

A panel member noted the child welfare system is a highly crisis oriented system dealing with traumatized people. A question that needs to be addressed is, "Within this system are we looking at the safety of the child and the sanctity of the family?" There needs to be a balance between the two.

Reference was made to a communication from the Department of Social and Rehabilitation Services asking for feedback regarding the foster care system. Interest was expressed in the results and what impact the feedback will have on changes, if any.

A foster parent shared a good experience, but noted the two contractors they work with in the community have difficulty communicating with each other let alone with foster parents. Another case in which the foster parent was threatened by a social worker was resolved by the worker's supervisor. However, threats are a reality which affect biological and foster parent willingness to report incidents and concerns.

A individual who is an adoptive parent shared the story of a teen-age adoptive daughter who, after running away multiple times, ended up in the foster care system which does not listen to the parents and which has put an additional financial burden on the family. It seems adoptive parents who take children with multiple problems are penalized by the system. The daughter was placed in a Level IV facility in spite of the fact the parents asked that she be placed in a 24-hour secure facility because her pattern was to run again within 19 to 21 days. She ran on the 19th day. She has now been in detention 90 days, and a psychological report has been filed with the court, but there appears to be no forward movement. An assault charge has added another player to the picture, and it appears there is no communication between the entities involved. For example, the adoptive parents were notified by the district attorney's office that if the child in custody did not appear at a court hearing, she would be taken into custody and the parents might be required to pay child support. She is already in custody, and child support is already being paid.

It was noted families across the state need and are asking for services that should be in place and are not. The lack of services adversely affects a family's ability to maintain a foster or adoptive child in the home. For example, very few services are available for children with attachment disorders who cannot be treated by conventional therapy methods. A foster parent noted a request to go to Colorado for treatment not available in Kansas was denied; another foster parent noted requests for family therapy were denied; and another family moved out-of-state in order to get the help the child needed.

The lack of appropriate facilities for young children with major mental illnesses was noted. If facilities are available, they are not being used in a way that results in a more positive intervention. Three days in a psychiatric hospital is not very effective in helping a child.

A member of the state agency staff stated there is a recognition that children not only need to be safe they also need a family connection. When separation from the biological family is necessary, ways to support a connection with the substitute family are important. Training is provided to both public and private agency staff on how to change the way we think and how we do business so everyone recognizes this need to maintain connections for children.

It was noted having foster care and adoption under different contractors has had unintended consequences for children in the system, including duplication of costs and services, disruption in services, and lack of continuity in services. All can adversely affect the child and add to the length of stay in foster care. When a child is placed for adoption, even if already in the adoptive home, it is an agency, not just a paper, transfer. A single provider contract, a concept strongly supported by panel members, would improve performance and provide cost savings that could be used to further improve services for children and support innovative programs such as a tiered system of incentives for taking children who are difficult to adopt. The goal should be to improve services, shorten the time children are in foster care, and give children permanency. Reference was made to a Kansas Action for Children paper dealing with this issue.

A foster parent stated their experience was it took 7 or 8 months after parental rights were terminated for children in their care to make it into the applicant pool for adoption. At this point the children got a new social worker who did not know them and who had only one or two contacts with the children in contrast to a social worker who had worked with the children over a period of time, knew what type of adoptive home they needed, and recognized the viability of a kinship adoption.

Another roundtable member stated the guiding principle for the system should be to protect the child and empower the family which does not seem to be the way it is functioning now. The system needs to be redone to get to that end. Placing a child in foster care, which carries a financial cost for the system and an emotional cost to the persons involved, should not be done as lightly as it is now. Referring families and children for an assessment several months after the child has been placed in foster care should not be happening. A good assessment, up front, involving multiple entities, would allow a good plan to be developed before the child comes into the system. If a child is put in foster care, it should be with the intent of reintegration in the family. If reintegration is not possible, adoption procedures should be started. Creating three contracts, family preservation, foster care, and adoption has divided the system, and, at times created an adversarial rather than a coordinated model. There is also divisiveness between the contractors and the mental health providers.

Suggestions

Suggestions voiced during the afternoon session of the roundtable included: development of a better definition of permanency and some alternatives for reintegration and adoption; recognition that some children and youth, at least at a certain time in their life, may not be suitable for family placement and providing suitable alternatives for them; full disclosure to foster and adoptive parents prior to placement to help them make informed decisions and avoid preventable surprises; development of a statewide organization partially funded with state dollars to serve as a liaison between foster and adoptive parents, contractors, and the Department of Social and Rehabilitation Services to arbitrate disputes before they reach a crisis point and to provide an educational resource for families; parenting classes in schools; education and training for foster parents beyond MAPP, especially in the areas of attachment disorders and behaviors resulting from sexual abuse; training for professionals in the area of attachment disorders, including research findings and proven modalities of treatment; an advocate for parents to tell them what questions to ask in court and how to handle the adjudication process; time for foster parents to strengthen their relationship so they can maintain a strong environment for foster children; and utilization of out-of-state services needed but not available in Kansas;

Amending the kinship care statute was suggested as one way the legislature could help. Relatives are preventing the system from being overwhelmed. One thing Kansas Legal Services hears on its statewide toll free foster care helpline is that many times willing relatives are kept out of the system until it is too late. Mandating a kinship conference prior to disposition as an alternative to adjudication and including notification of all relatives similar to the current notification of grandparents was suggested. This would require the Secretary of the Department of Social and Rehabilitation Services and court services officers to locate all relatives who might be a kinship placement. By requiring a child be placed with a relative unless good cause is shown to do otherwise provides a fact driven practice based on recommendations from professionals. If a relative objected, there would be a record showing the basis for the decision.

A grandmother approved to be a foster parent for her granddaughter stated when she wanted to adopt the child, she had to educate the social worker on how it could be done. It is important to inform both relatives and social workers about what is required for a relative adoption. It was noted a significant barrier to grandparents adopting, even if it would be in the best interest of the child, is financial. Approximately 17 percent of the grandparents in Kansas providing custodial care of grandchildren fall below the federal poverty levels. Finding ways to address this issue was suggested. A representative of the Department of Health and Environment stated special exceptions not relating to the health and safety of a child may be granted to persons caring for a child related to them so they can meet the licensing standards. Licensing gives the relative the option of receiving financial assistance.

It was suggested that ways for money to follow a child is needed. The foster care contractor receives $2,750 per month per child, but if the child is placed with a relative the relative may not see any of this money although it stretches the family finances when an additional child becomes a part of the family. Reference was made to a program in Douglas County, Friends of Children in Foster Care, which collects money from persons involved with foster children and others in the community which is used to provide, in confidence, extras for foster children in Douglas County such as choir trips, basketball shoes, prom dresses, and senior pictures.

Other suggestions included the need for a critical analysis of what the vision and goals of privatization were at its inception and where the system is now; better mentoring, supervision, professional development, and support for those working within the system; looking at those aspects of the system that place contractors in competition with each other; taking steps to encourage team work that includes biological and foster parents; building more consistency within the system; listening to biological, foster, and adoptive parents; putting more emphasis on family preservation, backed up with adequate funding; and taking steps to address the fear of retribution expressed by biological and foster parents such as a community board that those with grievances or complaints could access.

Comments From The Floor

The Chair opened the meeting for comments from anyone in the audience. A disabled parent, whose three children are in the foster care system, stated she has met all the court orders, but is now being asked to assume full time employment which is not feasible. Noting she is 39, but feels she has been treated as though she is 10, she asked where she could turn to find help to right an injustice and help her bring her children home.

A father noted he and his sister had been taken away from disabled parents. Both his and his sister's children have been put in the foster care system. His baby was removed in spite of the fact he did what the doctor said and took the baby to the emergency room after it fell and hit its head during a seizure. One week later the emergency room doctor notified the Department of Social and

Rehabilitation Services that no action needed to be taken, but the baby was removed from the home. Everything requested by the judge has been done, but the baby is still in custody.

Ms. Farrell stated a judge usually has to approve the removal of a custody order based on information from multiple sources. Parents can talk to the social worker, district attorney, or *guardian ad litem* but need to have an attorney to represent them.

A story was shared about a ten year old child who was denied an opportunity to tell her side of the story. It was noted that a *guardian ad litem* or an attorney appointed for the child could represent the child's wishes in court, and no one can interfere with that process.

A representative of an independent living resource center stated the center has found when working with parents with disabilities the stories previously related are not the exception. Disabled parents are held to a higher standard than other parents. At times children are removed from the home because of the misconception that parents with disabilities cannot care for their children. Steps need to be taken to eliminate this perception or taking action based on the perception alone.

A panel member shared that she was a child of a very abusive parent, but no one wanted to believe her or her siblings because the parent was a very prominent person in the community. The perception that a parent is incapable of being abusive just because he or she is "Mr. or Mrs. So and So" needs to be dispelled.

A social worker noted a disservice is done to a family if the social worker does not let them know what their choices are and the consequences of choices they make. Parents need to be faced with the fact there are certain behaviors that put the child at risk and exhibiting these behaviors means losing the child. Parents have choices which need to be respected, but they also need to be told what the consequences of certain behaviors are. A social worker does a family a disservice if facts are withheld at a case meeting.

A program administrator stated that he, and he was sure other administrators, would be concerned if a member of his staff were using measures of retaliation or retribution or acting in unethical or unprofessional ways. His agency takes allegations seriously, staff are dealt with, and staff have been terminated as a result of an investigation. He encouraged those with concerns to report them to the contractor by going to the CEO if necessary. A representative of another contractor expressed the same sentiments.

An administrator stated the contractor is trying to recruit additional foster homes for special needs youth and difficult youth with multiple problems so these youth will not have to be sent to homes in western Kansas willing to take them. Noting that children with special needs seem to bounce between entities in the system, including the courts, he stated there is a need to get all the system together to work in the best interest of these children. Referring to the stories shared during the day about things that do happen, the administrator stated he is amazed on a daily basis with the dedication of very young social workers and the work they do when they are faced with difficult situations and decisions on a daily basis. Noting there are success stories, the administrator shared the story of a boy who was left at an emergency shelter and placed in foster care. The boy was in and out of hospitals and the state hospital, adoptive parents decided not to take him shortly before the adoption was to be finalized, he came back into the foster care system, had several placements, finally was put in a home where there could be a one-on-one relationship, has been in this home for several months, and is doing remarkably well although originally it was thought this placement could not work.

Another issue raised was the difficulty of getting foster children's medical needs met. Getting a primary physician can take six to eight weeks. Finding a dentist willing to take Medicaid is extremely difficult. The amount of time a foster parent needs to take off work, which is usually

charged to sick or vacation time, to take the children to appointments needs to acknowledged and addressed. One foster parent noted relatives have taken vacation time to help. Cases were noted in which a school district refused to provide speech therapy during the summer for a child of three who could say only "Ma, Da, etc," and it was difficult to find a speech therapist who would accept Medicaid. A foster parent employed by the State of Kansas asked for consideration of ways the state could support employees who opted to be foster parents and set an example for the private sector.

Ms. Farrell, Department of Social and Rehabilitation Services, noted there is a way for Medicaid providers to find out why a claim was denied. If the provider does not want to pursue it or cannot find out why the claim was denied, a foster parent should contact the contractor's or the state agency social worker and explain the situation.

The Chair asked that anyone having suggestions for persons or the types of persons that should be considered for an oversight-investigative committee; suggested definitions for abuse and neglect; or questions to be addressed by persons from the judicial system to send the suggestions to Emalene Correll in the Legislative Research Department.

Progress With Mental Health Services Issues

Sue McKenna, Department of Social and Rehabilitation Services, presented written answers to the issues raised at the 2002 committee meeting on mental health services (Attachment 3). Addressing the first question relating to gaps in services available through the community mental health centers, Ms. McKenna stated gaps in service delivery did occur early on in the partnership. As the partnership has developed, this issue has largely been resolved by the centers although staff turnover may result sometimes in service delays.

Ms. McKenna, referring to the indications that mental health centers will not contract with private providers experienced in dealing with the most difficult children, noted part of the contractor's rate is for the provision of behavior management mental health services for foster children in their care. These services are delivered by licensed master's level social workers or other master's level licensed professionals, not by the community mental health centers. The centers are responsible for providing certain required services, but are not required to contract or affiliate with a particular provider for such services. The centers need the discretion to contract or not contract for services.

In response to the second question relating to what seem to be differing goals of the community mental health system and the contractors and differing obligations of the two entities, Ms. McKenna stated, although the specific outcomes are not the same, the overall goal for both entities is to assure the safety, permanency, and well being of the children. The philosophy of the community mental health system is to incorporate all significant parties in the treatment planning process. The purpose of the contractor-mental health partnership is to ensure that children have access to in-home and community based services through the community mental health centers. Including all significant parties is difficult when the child is placed in a foster home some distance from the biological family. Contractors are working to recruit and maintain more foster homes, and the partnership continues to meet to resolve this and other issues.

Ms. McKenna, responding to a question, stated a contractor may elect to place a child in a foster home it supervises that is further away rather than utilize the foster home supervised by another contractor that is closer due to the benefit of not having an additional agency involved. Concern was expressed that children are being moved unnecessarily when the only reasons for moving should be permanency, a placement closer to home, or a problem in the foster home. A case was shared in which a child was placed in another contractor's foster home, resulting in the child being visited monthly by two people from one contractor, one person from the other contractor, and the *guardian ad litem*. This appears to represent a costly duplication of effort. It was suggested a

system in which a foster child has only one social worker, even though more than one contractor may be involved, needs to be explored. Ms. McKenna stated reducing the number of moves for a child is a high priority of the Department because each move is costly for the child. A team is working on developing healthy competition between agencies that would improve services to children, families, and foster families, and increase cost efficiency for the state. It was suggested this is an area contractors and subcontractors need to address.

Reference was made to the fact that a contractor is at financial risk when reintegration fails, but the mental health center is not. Ms. McKenna stated this is not a statement she would make, and she sees this as a false conflict. Both the contractors and the centers want children to be safe with their own families whenever possible.

The third question, Ms. McKenna noted, related to the issue of unacceptable time lags between referral of a child for an evaluation or services and the time an initial visit is scheduled or services are initiated. The community mental centers are required to maintain specific access standards based on the urgency of the situation for all persons in their catchment area. The Department monitors the center's performance relative to the established access standards. There is 100 percent compliance with the standard in emergency situations, and the Department is not aware of any waiting lists in this area of the delivery system. In response to a question, Ms. McKenna stated in order for centers to respond to emergency needs, meeting routine mental health care needs takes longer. Centers are utilizing evening hours in response to families' needs. A question was raised as to whether more evening hours are needed.

Ms. McKenna, noting concerns expressed about interruptions in treatment resulting from a child being moved within the system or moving from the private sector to the child welfare system, stated this issue is of concern to those working in the system. Efforts are made to minimize the number of placements a child has. A main purpose of the partnership is to improve continuity of care for a child receiving mental health services. The partnership can review current issues that may need to be resolved.

Addressing the fifth question, relating to the failure to develop and support therapeutic foster families willing to accept children with multiple and difficult problems, Ms. McKenna stated contractors continue efforts to recruit and maintain therapeutic foster care homes. The Department's standards for therapeutic foster care homes and the monitoring of child placing agencies providing this service has been centralized in the Division of Children and Family Policy to provide more service consistency and better program compliance monitoring. The standards are high, and the agencies are paid to provide respite care, therapy, and support for therapeutic foster families.

The contractor's need to reduce qualified in-house mental health staff with the transfer of responsibility for severely emotionally disturbed (SED) children and youth to the medical card and community mental health center system, which in some cases did not have the same level of professional personnel, was the sixth issue. Ms. McKenna stated community mental health centers are required to provide an array of certain services and employ staff from specific disciplines. All services provided must be done by or under the immediate supervision of a licensed professional and under the direction of a physician. The contractor may provide mental health services for children who are not SED or may refer them to the center for services. The contractors were not required to reduce staff when the partnership was created.

Addressing the seventh issue which related to utilizing appropriate outcome measurements and appropriate evaluators, Ms. McKenna noted the federal government has outcomes the Department must meet for children in foster care that are monitored by the Department and the federal Department of Health and Human Services. The Department has established outcomes for foster care contractors and the community mental health centers are monitored by the Department. Outlining the areas in which outcomes and performance measures are monitored, Ms. McKenna

asked the committee members to submit suggestions for additional outcomes that should be established and suggestions as to who should monitor the outcomes to Sandra Hazlett, Director of Children and Family Policy, Department of Social and Rehabilitation Services.

Children Leaving Foster Care Due to Emancipation

Robena Farrell, Department of Social and Rehabilitation Services, presented written testimony (Attachment 4), noting in FY 2002, 186 children left the Department's care due to emancipation; in 2003, the number was 215. An age breakdown for these children will be presented as soon as possible. In response to a question, Ms. Farrell stated aging out and emancipation are the same thing. Youth age out at 21, but can ask to be emancipated before then if they have completed high school or a GED. The decision in these cases is made by the court. One reason youth stay in after 18 is to maintain the medical card.

Mariam Hysten, Resource Center for Independent Living, which has a contract with the Kansas Children's Service League, stated emancipation can occur before the age of 18 if the youth has proof of completing the educational requirement, has a job, and is capable of making his or her own decisions. Youth making the decision to age out at age 18 without completing a high school education are strongly encouraged to wait until their education is completed. A youth going on to college may elect to stay in a foster family.

Followup Information on State Children's Health Insurance Program

In written testimony (Attachment 5) from the Department of Social and Rehabilitation Services in response to questions raised at the August meeting it was noted, although variance in data makes it difficult to draw conclusions, it appears the percentage of uninsured Kansas children has declined since the initiation of the State Children's Health Insurance Program (SCHIP). The estimated number of uninsured children has fallen from a high estimate of 74,000 in 1997-1998 to a low estimate of 50,000 in 2001. The effect of repealing the statutory provision requiring a six-month waiting period for persons who had been covered by private insurance coverage has been negligible. Prior to the repeal, approximately 35 children were denied coverage each month by the HealthWave program because they had been covered by employer-sponsored health insurance at some point in the prior six-month period. Since the law was amended, there has continued to be a small number of applications for children covered by some form of private health insurance in the prior six months.

In response to a question relative to administrative costs, the testimony was administration costs for the Children's Health Insurance Program include the costs of processing applications at the centralized clearinghouse, benefit management, consumer and provider relations, and outreach and marketing. A table showing the percentage administrative costs are of total program costs since SCHIP began is included in the testimony. The percentage in federal fiscal year 1999 was 13.58 percent which reflected start-up costs; in the first two quarters of federal fiscal year 2003, the percentage was 8.60 percent

The meeting was recessed until 9:00 a.m., Wednesday, September 24.

September 24 Morning Session

The meeting was reconvened by the Chair.

Innovations in Child Welfare Services

Families Kan: Sarah Robinson, Wichita Children's Home, presented statistics relative to the children placed in the Home (Attachment 6). Ms. Robinson then introduced Walter Thiessen, Executive Director, Wichita Child Guidance Center and Coordinator of the Families Kan Program who presented written testimony (Attachment 7). The Families Kan Program was started in October 2000, as a partnership between four non-profit agencies, including the Wichita Children's Home. The goal of the program is to reduce the number of children and adolescents placed in the custody of the Secretary of Social and Rehabilitation Services. Most children referred to the program are identified as non-abuse and neglect cases. Case managers respond immediately, appropriate assessments of both the child and the family are made, referrals are made, and a plan of care is developed with the child and the family. Assessments are funded by a grant. Since the beginning of the program, 1,075 youth and their families have been served. Approximately 60 percent were in police protective custody at the time of referral. Only about 10 percent of youth served were later placed in the custody of the Secretary or the Juvenile Justice Authority. The overall number of children and youth entering the foster care system decreased by 26 percent. The conferee noted the importance of having a good working relationship with other entities in the community, of engaging with the youth and family at the time of crisis, of having qualified mental health professionals and substance abuse counselors available to assist in the assessment of the child and family so the family has a clear sense of the issues and how to address them, and providing parents with information about how different systems work in order that they know what to expect. Most parents want to help their children and are cooperative when faced with the consequences of not doing what they are asked to do.

In answer to a question, Mr. Thiessen stated the program will respond anytime a family is in crisis or a child is at risk. When a child comes to them, the Department of Social and Rehabilitation Services is called to see if they have any information on the child. An agency worker has to review the case within 72 hours to determine if returning the child to the home or some other alternative is in the best interest of the child. The Families Kan Program can become involved before the expiration of the 72 hours if it is clearly not an abuse and neglect case. Children who come to this program are not yet in state custody and, if the parents do what they are asked to do, the child may not end up as a ward of the state.

Responding to a question, the conferree stated if there is a therapist already involved with the family, the program works with that therapist. If no therapist is involved, the child and family are referred as appropriate. A case is kept open until the child is really connected with someone else.

Mr. Thiessen responded to a series of questions by stating the average age of children entering the program is 12½ and most have not been in custody before. Some children served are adopted. Some families have been in the system before or are currently receiving services so a full assessment is not always necessary. At the point the program is contacted, the family has not been to court. Emphasis is given to kinship conferencing, and, if the child wants to go somewhere other than home and it is agreeable with the parents, the court does not have to be involved. While there is a need to help the child, there is also a need to focus on parents. Most parents want to do well by their child. If they are not, it is necessary to find out why and address these issues. Cooperation among agencies is essential the conferree stated in response to a question. A good case manager is familiar with community resources and their services and how to access them. The Families Kan Program has access to some flexible funds for emergency help, such as paying bills. Other agencies that become involved use their own funds to provide assistance.

Responding to a question, Mr. Thiessen stated it would be difficult to replicate this program outside a metropolitan area because there are fewer 24 hour, seven days a week services available. However, it would be possible to assess the situation up front before automatically saying the state is the best parent for the child. As communities get together and say it is our kids in trouble and ask what can be done, resources can be mobilized in amazing ways.

Child Advocacy Centers: Ron Paschal, Chief Juvenile District Attorney, Wichita, distributed a blueprint of the Child Advocacy Center concept being discussed in Wichita (Attachment 8) and a paper from the 2003 Crimes Against Children Conference, "Dallas Children's Advocacy Center Information Packet" and national statistics relating to the impact of domestic violence on children (Attachment 9). Mr. Paschal stated a child advocacy center is a centralized location using a multi-disciplinary approach to resolve cases involving child abuse or neglect successfully, while at the same time providing services to the victim and non-offending family members. The primary goals are to minimize re-victimization of child victims and supportive family members and to facilitate prosecution of perpetrators through effective fact-finding and strong case development. It provides a faster and more efficient case investigation which will be occurring simultaneously with the initial risk assessment. The conferee referred to the diagram on the first page of the handout, noting this is a proposed model for a center in Sedgwick County. This model would create the child advocacy center in the Wichita Children's Home. The Home is a good physical facility which provides a safe place for a child. Some of the Home's staff could be involved in the Center operation which would favorably impact the learning curve for staff. The diagram shows how children would enter the center and the tasks that would take place.

Mr. Paschal stated the large number of cases coming into the system demands a more efficient way for all entities involved to coordinate efforts and develop and implement appropriate plans for the child and the family. The child advocacy center concept addresses this need in a productive way. The concept provides for starting the forensic and criminal investigation processes in a centralized location where people can communicate. Some centers do forensic and medical exams. In other centers, these exams are done through agreements with university medical centers or other hospitals. A triage process can take place, and assessments and plans for disposition can be made. The conferee discussed various types of cases that could be handled through the center, how they are handled now, and how they could be handled with the child advocacy center approach. This could result in less time in police custody and a more coordinated and simultaneous approach to the needs of the child and the family.

Noting there are two child advocacy centers in Kansas, Mr. Paschal stated Kansas is only one of 13 states that does not have a statewide policy for the operation of child advocacy centers. Referring to the Texas child advocacy center legislation included in the written material presented to the committee, the conferee stated legislation, while not necessary, is a good idea because it provides for uniformity in the operation of centers and is helpful in procuring funding. In Texas, the state procures funds and doles them out to the centers based on the size of the community. Attention was drawn to two provisions of the Texas legislation. First, it provides for a board of directors composed of certain agency heads which is probably a good idea since these people understand the scope and functioning of their agency. Mr. Paschal recommended adding two at-large members from the community who have children in the community to provide additional perspective and insight. The Texas legislation also requires that the child advocacy center not be located on the site of another public agency which speaks to the issue of intimidation. The center is to look like a non-profit entity to serve victims and appropriate family members.

The conferee, in answer to a question, stated when law enforcement picks up a child they are operating under two governing rules. One is the state statute which gives them some direction as to when they can and should take a child into protective custody which triggers the 72 hour time limitation. The other is their own departmental policy which in Sedgwick County is more restrictive that the state statute. If it is a child abuse or neglect case, Social and Rehabilitation Services

becomes involved. If it is a criminal investigation, law enforcement stays involved. Utilizing a child advocacy center protocol, it is not necessary to keep the child where he or she is initially taken. Other alternatives, such as the Children's Home, a relative, a non-offending parent, or short-term emergency foster care, can be utilized as appropriate. Mr. Paschal stated JIAC is in the diagram because, while it deals with children and youth who are suspected of being or are alleged to be juvenile offenders, it also sends children, with some degree of frequency, to the Children's Home. The JJA is not included because that aspect has not been thought through yet. Except for those who are juvenile offenders, the children would be screened by JIAC before entering the center. In answer to a question, the conferee stated foster care contractors and family preservation personnel have participated in the service provider meetings in Sedgwick County. Mr. Thiessen stated he had attended these meetings and one of the difficulties is that participants talk different languages. Programs get set up to do certain things with a specific emphasis. The challenge is to pull specific programs and emphases together to provide a good service for children. The difficulty of developing a center in rural areas was noted. Mr. Paschal stated in Texas several counties have combined and contracted with a center to provide services. For example, a law enforcement officer can bring an abuse and neglect case to the center where the children are interviewed and a case is worked up.

Sunflower Family Services: Teresa Witthuhn, Executive Director of Sunflower Family Services and Vice-President of the Kansas Chapter of the Association of Treatment and Training of Attachmental Children (ATTAC), stated ATTAC addresses the education of therapists and others working with children who have attachment issues, many of whom have come through the foster care system and have been adopted after living through some very chaotic situations or multiple placements. Ms. Witthuhn, a biological parent of two girls; an adoptive parent of one boy with attachment and bipolar disorders and ADA and another with brain injury inflicted by an abusive father; and foster parent of two foster children remaining in the home, one with attachment disorder, started Sunflower Family Services, a non-profit agency licensed by Kansas in 1995 as a private child service agency in response to problems she and others encountered in trying to get continuing services for children they had adopted. The conferee noted she gave up her foster care license a year ago because of the lack of support and help from the contractor. Initially doing infant adoption, Sunflower served as a subcontractor for special needs adoptions from 1996 through 1999 and then moved into the area of court ordered custody limitation services.

Ms. Witthuhn provided an outline of the written testimony (Attachment 10), stating the state has not kept pace with the need for post-adoption services and support to newly formed adoptive families. Many adoptive parents nurturing children who present on-going, chronic behavior problems state they are not receiving the support, training and other services they feel they need in order to maintain these children in their home. In response to this need, Sunflower Family Services in Hays has provided support, advocacy, and training to families adopting special needs children with disruptive behaviors. A recently launched program, Prairie Families' Resource Project, seeks to educate adoptive families about attachment and its importance in all areas of child development as well as in the adoptive relationship. Some families come with a lot of anger because they were not given adequate information before taking a child or weren't provided adequate training and support to raise a child with severe difficulties. Some families are afraid for the safety of their own children or themselves.

Sunflower Family Services also provides training in therapeutic parenting and attachment parenting techniques, advocates for both birth and adoptive families, acts as a support and resource center, and provides crisis intervention services which have empowered parents to maintain their children in the home. Other services are currently being developed, including education and training throughout the state on attachment disorder for professionals, respite resources, and support groups. Traditional therapy does not work for some children, especially those with attachment disorder. If they communicate with the therapist, they will probably say only what they think the therapist wants to hear. Plans also include adding a page to their website (www.sunflowerfamily.org) which would allow families to post questions and concerns.

The conferee stated Sunflower is often approached by families whose child is in the custody of the Department of Social and Rehabilitation Services who need help in working on or completing the requirements for getting their children back. Parents may prefer to come to Sunflower because they find it difficult to work with a social worker they feel has stigmatized them or blames them. Responding to a question, Ms. Witthuhn stated parents go to other states to get services because there is a lack of persons in Kansas trained in providing post adoptive services and attachment issues therapy.

Sunflower House: Brenda Sharp, President and CEO of Sunflower House, a Child Advocacy Center serving Johnson and Wyandotte Counties and also representing the Kansas Association of Children's Advocacy Centers, stated there are currently six centers in Kansas in various stages of development and recognized Kelly Stevens director of the Prairie Advocacy Center in Topeka, a center the committee might visit. Ms Sharp distributed a list of the Child Advocacy Centers in Kansas (Attachment 11), an outline of her testimony (Attachment 12) and an article, "Children's Advocacy Centers: One Philosophy, Many Models" (Attachment 13) noting it is exciting to see movement beyond emotions into problem solving strategies.

The child advocacy center (CAC) movement, Ms. Sharp stated, was started by a Congressman who took to heart that the system trying to help children after an accusation of abuse was made was in fact re-traumatizing them to a great extent. His goal was to create a child friendly environment to which the child could be taken and bring the professionals to the child. Today there are about 300 children's advocacy centers that are full members of the National Children's Advocacy Center Alliance which has a rigorous application and accreditation process. Sunflower House and Meadowlark House in Dodge City are full members of the Alliance; the center in Topeka will probably get full membership soon; the Child Advocacy Center in Pittsburg serving several counties is an associate member; and there are two developing programs, Heart to Heart-Harvey County Child Advocacy Center in Newton, and SOS Child Advocacy Center in Emporia. The conferee discussed the ten standards, each with a multitude of criteria, for child advocacy centers. The partners in a center must include law enforcement, child protective services, the state social services agency, prosecutors, mental health services, medical services, victim advocacy, and center staff so that joint decisions involving multiple people can be made at the front end. A center may exist under the leadership of varied entities, but the administrative home chosen by the community must have the organizational capacity to administer the program. It is also important that advocacy centers take into consideration and plan for the various cultural entities they serve. Forensic interviews are the key component next to the multi-disciplinary team review component of a center. Since there is wide variance in the quality and level of forensic interviewing in our state, the goal is to centralize this interviewing to a core group of people with specific training. Responding to a question, the conferee stated forensic means a legally defensible argument. Forensic for the police means what is needed to determine whether or not a crime has occurred; for child protection it is to determine whether or not the child is going to be safe; for the medical person it is to determine whether the child has an injury or illness related to abuse; for prosecution it is to determine if this child can handle going through a criminal trial; the victim's advocate wants to be sure the best interests of the child are protected; the mental health people want to insure the child is not further traumatized. Forensic in its basic form is a legally defensible interview. Advocacy centers anticipate every conceivable question from the defense attorney and test the child's adjustability, credibility, and other things. In Kansas, advocacy centers videotape the forensic interviews to reduce such things as asking leading questions or planting an idea in the child's head. Judges, attorneys, and prosecutors appreciate these tapes, and plea rates have increased dramatically since their inception. Provision is made for the detective and state agency social worker assigned to the case to observe the interview from outside the interview room and to feed additional questions to the interviewer.

Ms. Sharp stated the medical examination, which may be the first complete examination the child has received, may discover evidence of abuse or medical neglect, such as head lice or untreated sexually transmitted diseases. In Kansas there are only about five people considered

nationally to be experts in forensic medical evaluations of children. Some communities utilize the hospital, and work is being done to train specific nurse groups. Victim advocacy includes making sure the children and families understand that the criminal justice process is separate from the child protection process with varying outcomes. Families are much more cooperative and particpatory in planning and follow through when they understand what to expect.

The first year Sunflower House did 180 case reviews, some of which were found under a pile of folders on a detective's desk and some of which had not been transferred to another case worker when a social worker left Social and Rehabilitation Services. Now there is a sophisticated system for tracking a case from the time a report is made through final disposition of the case. The system includes whether or not there was a criminal trial or a conviction, how long the perpetrator will be incarcerated, and any probation provisions. Case review is an opportunity for all the people involved in an investigation to sit down regularly, usually once a month, and review all the cases to determine what is breaking down and what is going well. Addressing the benefits of the advocacy center approach, Ms. Sharp noted that bringing a team of players together is better than having just one person or persons who are not working together. This approach dramatically reduces the number of repeat interviews of children which reduces the likelihood they are going to recant. Also, the time the child may stay in the care of an abuser is shortened from as long as three months to usually one or two days. There are interviewers with specific training and experience and prosecutors get a single report rather than reports from four or more entities. There is much better agency collaboration and information sharing supported by legislation that allows the sharing of information related to child abuse and neglect cases. This approach places the primary focus on the child victim within the family. One of the most unique things is the ability of the child advocacy center to provide a mutual and neutral ground for all the players in the child welfare system to develop trust and understanding of each other, provide support and cross-training for each other, and constructively confront one another to make system changes. Another benefit is that family cooperation and commitment to protecting the child is dramatically increased because they were treated with respect and dignity. The child is more often protected and less traumatized by the process. Children who should not be removed from the family are not because the investigating officers are looking at family placement. Children who should be removed are because multiple people bring multiple pieces of information to the case. Family and child health are improved, and other issues, including medical, developmental, and psychological, are identified through the process. There is an increased rate of successful prosecutions in cases coming through the center. Data is being collected which provides educational and research opportunities.

Development of a child advocacy center, Ms Sharp stated, requires a great deal of collaboration, some redirection of funding, and empowering the community to do things differently. Kansas has some multi-disciplinary team legislation in place that is a starting point for building a statewide infrastructure, but funding is minuscule. Oklahoma has a tiered funding system through the Department of Human Services based on the criteria of the National Children's Alliance (NCA) plus a designated amount for multi-disciplinary teams. Certain amounts of funding for rural, midline, and urban communities is designated in each tier. Missouri designated a significant amount to be divided among the first four centers. However, the amount remained the same when the number of centers increased to 16. Arkansas tied funding to NCA accreditation but did not provide for re-accreditation. In Texas, sex offenders who produce the clients of the advocacy centers are assessed a $50 contribution to the child advocacy center in that jurisdiction as part of the restitution or probation plan. The centers in Kansas get some United Way support, apply for competitive grants, and are compatible with several federal sources of funding. Responding to comments, Ms. Sharp stated care needs to be taken that where funding comes from does not negatively impact the flexibility of the center.

Ms. Sharp emphasized that any legislation or appropriations must meet the needs of all the state, not just rural or urban. Meeting the challenge of adapting the concept to rural areas is possible. Currently mobile forensic interview units are being developed. Video conferencing is being

considered. Responding to comments about time frames, the conferee stated it takes three to five years to develop a center due to turf issues and getting people to see things a different way. Responding to a question, Ms. Sharp stated Sunflower House is a classic child advocacy center model. A child abuse prevention coalition, that had been doing educational programs for about 25 years, merged with a group starting a center in 1996. The core service is the child assessment piece which is the forensic interview, case review, and education, with medical review now being added. Other services such as temporary lodging for children are provided by other entities in the community. Some models have consolidated all the services into one organization. Sunflower House has a family advocacy follow-up program. Each family is contacted one month and three months after the interview to get the family's assessment of each entity with which they came in contact. The data collected is distributed to each team member. A protocol has been developed to determine what should happen after a report has been made. Sunflower staff are participants in the discussion of whether or not a child should be removed from his home, but Social and Rehabilitation Services and law enforcement ultimately make the decision which is their legal mandate. About 50 to 60 percent of initial reports come from school based reporting authorities. After a report has been made, the family is told the child will be interviewed and is given the option of bringing the child to Sunflower House or having the police pick up the child. Most children are transported to Sunflower House by a non-offending parent or guardian and are not in state or police protective custody. About 3 to 5 percent of the cases coming to Sunflower House are determined to be false accusations. In these cases other issues may surface and the child, whether or not in custody, can be referred for help. In any given year, between 5 and 15 percent of children interviewed at Sunflower House will be taken into either state or police protective custody. In many cases, the parent is in a protective mode and just needs to know resources are available at the crisis point and throughout the process.

A committee member expressed the hope this committee could work toward legislation that would assist the development and continuation of child advocacy centers. Staff noted that one piece is funding, but there also needs to be a clarification of what is meant by a child advocacy center and the establishment of what constitutes best practices in these centers.

KVC: Maureen Mahoney, General Counsel, KVC Behavioral Health Care, distributed a packet of material relating to KVC and its programs (Attachment 14). Ms. Mahoney stated KVC is looking at how to improve the system based on empirically valid information, *i.e.,* evidence based treatment. Currently there are approximately 250 research projects focused on the mental health of children in foster care. The discouraging aspect is that it may take 15 years for a service based on research findings to get to line staff. Kay Hodges has developed a tool to use with children as they come into the system and has developed a tool for KVC to use when working with parents. A number of approaches for working with parents are being looked at, but a common thread is providing parent management training. There is a list that indicates what works with a child with certain diagnoses. The problem is that only 50 percent of the children entering the system have a diagnosis. The remaining children have behavioral issues. In either case, individual therapy or help for the child is not productive for reintegration unless a family structure is developed.

The conferee stated that KVC now has a computer which allows immediate access to information about KVC licensed foster homes, including how far they are from the child's home. Information entered relative to the child and the child's needs can be matched to the foster homes. The goal is to keep the child within 36 miles of home and within the same school district. When necessary, a subcontractor's foster home is used. Ms. Mahoney introduced Ann Roberts, KVC CEO to discuss two new developments, a medical records program and a pediatric services clinic.

Ms. Roberts presented written testimony (Attachment 15). Ms. Roberts referred to a sheet showing a comparison of outcomes between May 1997 (pre-public-private partnership) and May 2003, noting significant improvements and stating KVC is still not where it wants to be on outcomes. Realizing the importance of physical health, a staff nurse was hired 14 years ago and a physician a year later. Reducing the number of children in residential care, has allowed the full-time physician

to spend more time working with the children in foster homes, and a nurse practitioner has been added to the staff. The conferee stated, according to the American Medical Association, "the unhealthiest children in the U.S. are children in foster care." Their health problems are chronic and have a long lasting affect on their lives. In 1997, pediatric staff from the University of Kansas Medical Center initiated forums for community stakeholders to discuss obstacles to the delivery of high quality medical care for foster care children. To address the issues identified in these forums, KVC opened a pediatric services clinic in its east facility. Case managers, psychiatrists, and therapists are also located at this facility, and parenting and support groups meet here. This builds on the multi-disciplinary team approach, allows families to combine multiple visits, and fosters better coordination of services and better communications between professionals. Another issue being addressed is the fragmentation of medical records for foster children. Efforts are being made by KVC to establish a medical home model for children in its care. Much of last year was spent developing a computerized medical data base for each child. The first step was to find out where such records might exist and gather all the past information available, including physical health, medication, mental health, and diagnotic information and enter it in the data base. This information can be accessed by the staff physician at home via a computer which enables medical staff to respond more adequately and appropriately to crisis situations. The benefits to the child of the practitioner having this information readily available is obvious. A more detailed explanation of these two initiatives was given in the written testimony.

The Chair thanked all of the conferees, noting Kathy Jo Ledbetter-Williams' testimony has been postponed until the October committee meeting.

The meeting was recessed until 1:30 p.m.

Afternoon Session

The meeting was reconvened by the Chair, Representative Brenda Landwehr.

Status of Proposed After-School Child Care Regulations and Issues

It was noted that when some community agencies in the Kansas City area wanted to develop after-school programs several years ago, rules and regulations relating specifically to child care facilities and day care did not fit the proposed programs. There was an agreement that the Department of Health and Environment would develop some rules and regulations specific to after-school programs. The Department held a series of forums bringing together groups that operate this type program and prepared draft regulations that were presented to the Health Care Reform Legislative Oversight Committee. Interested parties appeared, stating the regulations as drafted addressed their concerns. Later, issues were raised by a Boys Club and changes were made in the proposed regulations which were adopted by the Secretary of Health and Environment at the beginning of 2003. Since Boys and Girls Clubs and several other types of programs continued to have problems with the regulations, a proviso prohibiting the Department from using any appropriated funds for enforcement was added to an appropriations bill during the 2003 Legislative Session and the parties were again asked to work out a compromise. However, entities choosing to be licensed under the rules and regulations have been licensed.

Bridgitt Mitchell, Assistant to the Secretary, Kansas Department of Health and Environment, presented written testimony (Attachment 16) stating the Department continues discussion with

interested parties. The Department, due to the uniqueness, diversity, and mission of the programs, is interested in exploring exempting programs that are affiliated with counties, municipalities, school districts, and not-for-profit organizations meeting organization or other standards as noted in the written testimony, providing the well being of the children served is insured. The Department would respond to complaints regarding these programs and encourage appropriate resolution of any such complaints.

Laura Kelly, Kansas Recreation and Parks Association, presented written testimony with a copy of 2003 HB 2376 and the Association's testimony before the House Committee on Local Government as well as a proposed amended regulation to address the concerns of the Kansas Recreation and Parks Association, the Boys and Girls Clubs of Kansas, and the Salvation Army (Attachment 17). Ms. Kelly's testimony explained the Association's reluctant support of HB 2376 and the concern that the rules and regulations were too inclusive. She spoke to the fiscal impact licensing might have on programs and the increased cost of adding regulators to enforce the regulations. She indicated rules designed to provide childcare for school age children were desirable but the licensing of playground and drop-in programs is not acceptable. The meeting concluded with the expectation that new language addressing the areas of consensus would be drafted by the provider agencies (see the Proposed Amended Regulation attached to the testimony) and the areas of disagreement would be addressed later. Ms. Kelly asked the committee to recommend to the Legislature that a law similar to the proposed amended regulation be enacted into law during the 2004 Legislative Session.

Joyce Glasscock, Kansas Alliance of Boys and Girls Clubs, presented a written outline of the Club's testimony (Attachment 18) giving background information about Boys and Girls Clubs and the impact enforcing the current rules and regulations would have on youth served by the Clubs. Ms. Glasscock stated the need for after-school programs is substantiated by the National Census Bureau' estimate of the number of children going home to an empty house after school. According to the National Center for Juvenile Justice, it is during the hours right after school that children perpetrate crimes, engage in illegal activities, or are victims of crimes. Many families served by the Clubs can afford the $10 to $50 annual membership fee, but cannot afford alternative after school childcare. If enforced, Kansas would be the first state to apply mandatory school age program licensing regulations to drop- in or open-door membership based programs of Boys and Girls Clubs of America. The conferee stated she appreciated the Kansas Department of Health and Environment's effort to find a compromise, but she does not have the authority on behalf of the Alliance to accept the offer presented earlier by the Department. The Alliance requested that the Committee endorse the modifications referred to by Ms. Kelly.

Leadell Ediger, Executive Director, Kansas Association of Child Care Resources and Referral Agencies (KACCRRA), presented written testimony in support of after-school child care regulations as adopted by the Kansas Department of Health and Environment (Attachment 19). This past year, 6,442 families asked agencies for help in locating care for their children over the age of five. Since the rules and regulations under which the resource and referral agencies operate states that referrals can be made only to child care facilities which have a temporary permit, license, or certificate of registration issued by the Secretary of Health and Environment, exempting certain after-school child care would inhibit referring parents to these programs. The Association believes licensing school age programs improves the quality of out-of-school time for children by addressing the appropriateness of staff and environmental and safety issues.

In response to a question, an individual from the Department of Health and Environment noted those asking to be exempted from the current rules and regulations are technically subject to the regulations even if they cannot be enforced at this time. Therefore, the resource and referral agencies could continue to refer parents to them. Any entities exempted by the proviso may apply for licensure and be subject to the current rules and regulations.

Cindy D'Ercole, Kansas Action for Children, presented written testimony (Attachment 20) stating there is clear evidence that after-school programs not only keep children safe and off the streets, but are also associated with positive outcomes for the child. Licensing not only ensures that programs meet basic health and safety standards, but also impacts the quality of care. It is the hope that the parties represented today can reach a compromise that will provide assurances to the community and parents that their children are in a safe and qualified after-school program that provides a valuable service. In response to a question, Ms. D'Ercole stated there is probably not a definition of a safe place. However, based on her knowledge and experience, it would include complying with health and safety codes, personnel who have passed a background check and are trained in first aid, and records that contain appropriate information. Because of the uniqueness of drop-in programs, additional consideration probably needs to be given to developing regulations appropriate to this type program.

Bob Ecklund, Chief Operating Officer, YMCA of Greater Kansas City, presented written testimony (Attachment 21) opposing exemptions and the development of regulations specific to after-school drop-in programs stating that regulations are about the safety of children and not about fairness to providers. Mr. Ecklund presented information relative to the YMCA of Greater Kansas City and the process leading up to the drafting of the current regulations. The YMCAs, along with other providers and advocacy groups, feel the school age program requirements are achievable for any agency operating 12 or more hours per week during non-school hours. Under the new regulations, the YMCA's operation costs have decreased significantly and revenues have increased primarily because of the new regulations pertaining to staff-child ratio, unit size, elimination of five foot dividers, reduction of license renewal fees, changes in amendment fees, and allowing in-service training within the organization. In response to a question, it was noted that Missouri has more strict qualifications for staff of these programs, but exempts faith-based organizations. Mr. Ecklund stated Missouri's regulations are similar to those adopted by the Department of Health and Environment.

Emily Lies, Greater Wichita YMCA, presented written testimony (Attachment 22) giving statistics pertaining to the Greater Wichita YMCA and focusing on two issues–minimum health and safety standards for all children and youth and consistency and equality in program regulation.

Adrienne Woolley, Mid-America Regional Council's Metropolitan Council on Early Learning, presented written testimony (Attachment 23) in opposition to exempting certain school age programs from meeting the state's licensing requirements, stating that meeting these requirements helps to ensure the programs are meeting basic health and safety standards which helps ensure the children attending the programs are safe. Through the process initiated by Health and Environment, rules and regulations were developed to accommodate the unique needs of all school age after-school programs. Experience shows that children are put at risk when programs are exempted from licensing.

Kerry Scott, Vice President of Partnership with Children, presented written testimony (Attachment 24) in support of the current rules and regulations, stating the regulations provide assurance that minimal standards of health and safety are being met when children are participating in the programs. There are far too many examples of what can happen when basic safety and health procedures are not followed. The Partnership asserts that all children and their families deserve assurances that every precaution has been taken to ensure their safety, irrespective of the ability to pay. While there is a cost to providing services, it is less costly under the new rules and regulations than before. Provision has already been made to address after-school programs that do not function as child care.

Diane Purcell, Kansas Association for the Education of Young Children, presented written testimony prepared by Marlene Glasscock, President of the Association (Attachment 25) in support of the current rules and regulations and in opposition to exempting select organizations from

regulatory oversight or adopting weaker standards than those endorsed by the Department and a majority of school-age providers.

Committee members were referred to written statements sent to the Committee. The statement from the Salvation Army (Attachment 26) asks the committee to exempt drop-in centers through the new proposed language or through appropriate legislation. The Salvation Army is committed to licensing traditional child care centers, but is concerned about the impact of the school age regulations on drop-in programs which are not promoted as alternative child care. Efforts have been made to resolve this issue, but the state agency has communicated to the organization its intension to license every program a child is a part of.

The statement from Rogers Brazier, Director, Parks and Recreation of Topeka (Attachment 27) provided statistics about the organization's programs, including programs impacted by the new rules and regulations and expressed opposition to the expansion of regulatory control over drop-in youth programs operated and overseen by municipalities, Boys and Girls Clubs, the Salvation Army and similar organizations. The statement noted drop-in programs, which provide a safe haven and structured program for children, are not day care and the negative impact the rules and regulations will have on these programs. The statement noted qualifications required of staff and staffing ratios for these programs and the oversight provided.

In answer to a question, Ms. Mitchell stated the Department has had several meetings with the involved parties, the last being July 13, 2003.

Ms. Glasscock, responding to the availability of a definition of basic health and safety, referred the committee to the guidelines set out by the Boys and Girls Clubs of America which are similar to those recommended by the YMCA. One reason the Boys and Girls Clubs are opposed to the new rules and regulations is the cost to comply. Ms. Glasscock stated typically only about 20 to 40 percent of the 700 to 850 members in her program show up on any given day. However, if more than the number the Club is licensed for show up, some would have to be turned away. Meeting the licensure requirements for the potential number who could attend would require expanding the current facility three or four times. Ms. Purcell stated that licensed capacity deals with the maximum number of children who are ever going to attend on any one day, not the total membership.

A representative of the Salvation Army stated meeting the staff educational requirements proposed in the rules and regulations would have an impact on staffing costs. The requirements seem high for someone to supervise children at play. Also the square footage requirements are higher than those in the fire code which means changing the number of children who can play in the gym at any given time even though fire code regulations are being met. Another example is the requirement that a snack be provided if a child is there for a specified amount of time.

In response to a question relating to after-school programs in schools, Mr. Doll stated that many YMCA programs are operated in school buildings. He noted it was his understanding that approximately 91 percent of the programs have elected to use the new regulations which seems to be an overwhelming vote of confidence in them. Answering another question, Mr. Doll stated the fee for the before and after-school program in $55.00, with a lesser fee for participation in only one of the programs. Some families receive reimbursement from Social and Rehabilitation Services and scholarships are available. Accommodating significantly increased numbers would depend on the income of the families and availability of funding. Another YMCA representative, addressing cost issues raised previously, stated it would be difficult to know the impact on operating costs unless the program were operating under the new rules and regulations. The YMCA of Greater Kansas City has realized a cost saving of about $2,000 per year, per site due primarily to reduced fees, new staff to child ratio which affects unit size, elimination of 5 foot dividers, and the change allowing in-service training. It was noted groups not under the earlier regulations would not necessarily realize these savings since they would not have met requirements under earlier rules and regulations.

Laura Kelly spoke to the process the Department used to develop the new rules and regulations, noting that the Kansas Recreation and Parks Association became involved in the process in 1991. The Association was not asked to be involved when the process was initiated again in 1998, although a few of the Association's members who had licensed programs participated and agreed the proposed rules and regulations were better for those programs already licensed. Apparently they did not notice that programs not previously licensed were included. When the Recreation and Parks agency in Lawrence notified the Association in 2002 of what was happening, the Association, along with the Boys and Girls Clubs, and Salvation Army made recommendations relative to the needs of after-school programs that were not included in the final rules and regulations. Statements that these groups are unwilling to have their programs licensed is not true. The Association continues to support licensure of programs for which licensure is appropriate. However, there are certain types of programs for which licensure is not appropriate.

Staff was instructed to provide the committee with a list of points on which all parties agree and a list of points on which there is still disagreement, an unbiased report on the laws and rules and regulations pertaining to licensure of after-school programs in the surrounding states, and any statistics starting with 1991 pertaining to deaths or injuries occurring in after-school programs.

Two questions raised by Committee members but not answered were: What makes 12 hours a magic number and what happens if the agencies in opposition to licensure of certain programs do not get a license?

The Committee asked that the concerned parties continue meeting and reach an agreement.

The following materials were submitted to the Committee:

- Attachment 28—"Every Child Deserves A Medical Home" describing the CHERISH Program of the Developmental Disabilities Center at the Kansas University Medical Center and a summary of medical home issues and benefits for children;
- Attachment 29—"A case for Contract Reform: Improving the Kansas Child Welfare System" pertaining to the case made by the Kansas Action for Children for a single regional contract for foster care and adoption services;
- Attachment 30—"Foster Care Helpline Report: Issues and Policy Recommendations" a report dated March 15, 2003;
- Attachment 31—"2002 Foster Care Helpline Report: Issues and Policy Recommendations" a report dated July 18, 2003;
- Attachment 32—Issues and recommendations submitted by John Poertner; and
- Attachment 33 – Comments submitted by Shirley Norris relative to proposed after school child care regulations.

The meeting was adjourned by the Chair.

Prepared by Almira Collier
Edited by Emalene Correll

Approved by Committee on:

October 30, 2003