

TESTIMONY OF  
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*before the*

COMMITTEE ON WAYS AND MEANS  
SUBCOMMITTEE ON HUMAN RESOURCES  
US HOUSE OF REPRESENTATIVES

“Improving Programs Designed to Protect At-Risk Youth”

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Good morning, Chairman Davis, Ranking Member Doggett and Members of the Subcommittee. My name is Patricia Wilson. I am the Commissioner of the Kentucky Department for Community Based Services – the agency that administers the child protection, foster care and adoption, adult protection, child care assistance, Temporary Assistance for Needy Families, Supplemental Food and Nutrition Program and Medicaid eligibility for the Commonwealth. Collectively, the programs the Department administers in each of Kentucky’s 120 counties touches the lives of approximately 1 million individuals annually; nearly 20% of the state’s population.

I am most honored to have the privilege of speaking to you about two key aspects of the child welfare system, the Child Welfare Services program and the Promoting Safe and Stable Families program. Each of these programs is instrumental to the safety and well-being of our nation’s children. In Kentucky, approximately 50,000 children and their families are touched by these two programs annually. While the specific instances I will share with you are drawn from Kentucky’s experience, the themes reflect perspectives shared by colleagues across the country.

Child Welfare Services and Promoting Safe and Stable Families, in concert with the other programs under the rubric of Title IV-B, along with Title IV-E, Foster Care and Adoptions, form the nucleus of our approach to families experiencing child abuse and neglect. Particularly since the inception of Promoting Safe and Stable Families in 1993, the acts of Congress to reauthorize and expand these two programs, along with the Court Improvement Program, have provided a sustained focus on children and families by enabling services that assist in assessing, developing and enhancing the protective capacity of families, promote the child and family’s engagement in case planning and set clear expectations about the achievement of permanency for children who are removed to foster care . The reasons for abuse and neglect are varied, ranging from a knowledge deficit, parental inattention and poor parenting skills through acts of harm fueled by the substance abuse of the parent/caregiver. Regardless of the underlying cause of the abuse or neglect, the children in those families deserve and must be afforded the opportunity for

safety and stability. It is that opportunity that the programs we speak about today seek to enable.

While both programs target the issue of child abuse and neglect and are often seen as synonymous in purpose, it is important to recognize a distinction permitted by legislation. Child Welfare Services encompasses a wider range of activities than are permitted under Promoting Safe and Stable Families (PSSF). PSSF is specific to interventions targeting four broad categories of child and family service, while a prime use of Child Welfare Services funds is for the salaries of child welfare workers engaged in the investigation of reports of abuse and neglect as well as the provision of protective services.

Any of the four broad categories – community-based services to increase the strength and stability of families; in-home services to improve parenting skills in order to prevent removal; time-limited reunification services to facilitate the safe return of children who have recently been removed from the home; and, services and activities to promote and support adoption of children experiencing foster care – are worthy of testimony; however, my comments today will focus on three aspects that were new to the last reauthorization (monthly caseworker visits, regional partnerships related to substance abusing parents, coordination of medical care) as well as offering suggestions for program improvement.

**First, monthly caseworker visits.** As a former front-line worker and supervisor, I applaud Congress and the Administration for setting the benchmark for acceptable practice being a monthly caseworker visit to the child in foster care. Children removed from their home deserve to know about efforts being made to remedy the circumstances that resulted in their removal, to have their care monitored and to have the opportunity to voice their concerns and worries. Who better to listen and provide information than the person working the case? Monthly visits are critical to improving permanency outcomes for children in foster care.

It is not the intent of the legislation that is concerning, rather it is the method of calculating performance that is troubling. The current calculation is child-based, meaning that the number of months a child is in care a full month in a twelve month period counts as one unit. If the caseworker fails to visit in any one of those months, the child's case is deemed out of compliance for the entire 12 month period. For example, a child meriting 11 visits in a 12 month period was seen 10 times, but according to the current methodology, the child's case is out of compliance for the full 12 month period.

Being out of compliance has financial repercussions for the agency and a personal impact on the caseworker. For the agency, if compliance falls below an established threshold, the state must spend more its own funds under the program in order to receive its full federal allotment. States should be held accountable for performance and if progress toward the goal does not occur, sanction is an acceptable consequence of poor performance; however, it is equally important that the measure of performance be one that gives credit for all work that is done. For the worker, it is demoralizing to know that

missing one visit discredits all other visits that may be made – and that one missed visit could cost the agency financially.

There are often valid reasons for missing monthly visits. While the issue of available and accessible resources is one that child welfare agencies are ever striving to address, the fact is that a number of children in foster care must be placed some distance away from their home communities in order to receive the care and treatment they need. Particularly in rural states such as mine, inclement weather including ice and snow storms and flooding can make driving treacherous, which necessitates planned visits being cancelled, without sufficient time to reschedule within the month. Other acts of nature, whether tornadoes, hurricanes or wildfires, also contribute to missed visits.

Additionally, during these fiscally constrained times, many jurisdictions have to contend with a reduced work effort, either due to hiring freezes, layoffs or furloughs. In a child welfare agency, no responsibility weighs heavier than that of timely response to reports of child abuse and neglect. Caseworkers and supervisors often face the dilemma of juggling monthly visits with conducting protective service investigations. When that happens, the decision is to err on the side of child safety and give the investigation precedence.

A proposed alternative methodology is to make the calculation event-based. Every required visit would count as one unit. In the above example, the case meriting 11 visits would be credited with the 10 visits that were received.

To further illustrate, I use my agency as an example. Under the current methodology, there were 9,828 children in foster care at least a full calendar month over the 12 month period; 6,449 of those children were visited each of the required months for a rate of 65.6%. Under the proposed alternative of calculating the number of visits that those 9,828 children merited, in that same 12 month period, 72,379 visits were required; 64,662 of those visits were made for a rate of 89.3%. I'm quite certain this disparity is not unique to Kentucky.

Continued funding to help support the caseworker visits is much needed. As agencies raise personal vehicle mileage reimbursement rates to defray the rising cost of gasoline, we find ourselves falling further behind in our efforts to balance the expense of service with available revenue.

The second aspect I will comment on is that of **improving outcomes for children affected by their parent/caretaker's abuse of methamphetamine or another substance**. Kentucky, like many other states, finds that substance use/abuse by parents/caretakers is a predominant characteristic in the majority of its child abuse and neglect reports. Substance abuse is found to be a risk factor in the majority of the almost 40,000 investigations we conduct annually. Among children in substantiated reports of abuse and/or neglect, 60% were found to have families exhibiting substance abuse; the younger the child the higher the rate of parental substance abuse. Sadly, though, the

opportunities for treatment, especially intensive out-patient and long-term residential, are quite lacking.

Beginning in FY 2007, through a competitive grant process, 53 regional partnerships involving child welfare and other impacted agencies, such as substance abuse, mental health, local law enforcement, juvenile justice, judiciary and education, were formed to address this issue. Two of those 53 partnerships were granted in eastern Kentucky, a region that leads the nation in the illicit use of diverted prescription drugs according to two studies conducted by the University of Kentucky (Leukefeld et al., 2005) and the Carsey Institute of the University of New Hampshire (Van Gundy 2006). These studies also show that substance abuse directly or indirectly affects nearly every individual in the region, yet treatment is rarely available. Additionally, in 2008 the Office of National Drug Control Policy included a number of Kentucky counties in the High Intensity Drug Trafficking Area, with a primary emphasis on marijuana.

While there is not time to detail both programs, I would like to highlight the positive outcomes of the partnership in tiny Martin County. This county of just over 12,000 residents in rural Appalachia led Kentucky in the percent of the child population in substantiated reports of abuse or neglect in 2010 with 6.6 of every 100 children in the county having substantiated abuse compared to 1.5 in the state. Half of those children with substantiated reports were age 6 or younger. With an average family income of \$23,000, 37% of the children live in poverty.

Prior to the regional partnership, there was one substance abuse counselor who provided one day of outpatient service per week for all the clients in the county. There were 65 women waiting for services, with a 4 month wait to receive a maximum of one hour service per week. There were no support groups, such as AA, NA or faith-based. There was little hope of helping these families and addiction seemed to affect every person in the county, either directly or indirectly.

The Regional Partnership Grant enabled the child welfare agency and the state substance abuse agency to work collaboratively with county officials and residents to implement the START (Sobriety Treatment and Recovery Teams) program in Martin County. The child welfare and substance abuse agencies had successfully implemented START in three other counties across the state, but limited funding dictated the scope of the program.

START pairs highly trained family mentors with specially trained child protective service workers; partners with substance abuse treatment professionals to ensure quick access to treatment, retention in treatment, and joint decision making with the family; and, partners with the court to identify options for child safety and permanency and to promote parental capacity to care for children. In the two plus years the program has been operational (establishing the infrastructure takes time), the county now has

- Intensive out-patient services for both mothers and fathers within the county four days per week and several nights per week;
- Nine weekly 12-step meetings and a Families Anonymous meeting;

- A faith-based support group, regular town hall meetings and community partnership groups that build community supports for people in recovery;
- Transportation to services as needed. Transportation support includes accompanying the client to the first four out-patient sessions as this has been demonstrated to be important to participation retention.

Fifty-one families (98 parents), mostly married couples in their mid-20s, with 112 children, have been served. Another 61 families were referred but had to be turned away due to caseload limitations. Of those 98 parents served, 75% received treatment within 10 days of the referral (immediacy being a key to participation) and 40% have been able to achieve sobriety and maintain their children safely at home. The results from the Martin County program are not yet equal to those in the more established counties where 67% of the families have been successful, however, as the program matures, the rate of success is expected to improve. Moreover, as the county Family Court judge recently commented, “we now have hope in the community and real support for that hope”.

The Regional Partnership Grants supports rigorous program evaluation at the state and national level so that solutions to this difficult problem of parental substance abuse and child maltreatment can be clearly identified and disseminated nationally. To ensure program fidelity, the same data collected for the START program in Martin County is collected and analyzed for all of Kentucky’s START sites. Collectively, the evaluation of the four START sites in Kentucky evidences that children in families served by START are 50% less likely to enter foster care when compared to similar children. It costs \$20,000 per family to provide the treatment, family mentor services, specialized child protective service intervention, wrap around supports, program administration and evaluation.

The third aspect on which I will comment is **consultation with medical professionals and physicians in assessing the health and well-being of children in foster care, as well as determining appropriate medical treatment** for them. The first of my comments draw solely upon Kentucky’s experience. Having registered nurses on staff in central administration as well as having 10 registered nurses deployed across the state through a cooperative agreement with The Commission on Children with Special Health Care Needs provides consultation and support to frontline child welfare staff regarding medical issues of children in foster care, assessment of injuries identified during investigation, coordination of appropriate medical follow up, and insuring access to all health services including prevention and wellness programs, in addition to making face to face visits with medically fragile children in foster care. This collaboration has made consultation around children’s health issues more readily available. The primary obstacle we have experienced in obtaining routine health care for children in foster care has been children living in areas underserved by medical professionals. While this has not been a widespread issue for physical health, dental care is a much more troublesome issue as there are far fewer practitioners available. For those children needing the most intensive mental health services, the child welfare agency and the state Medicaid agency work collegially on securing the most appropriate placement.

The issue that looms large for Kentucky, and perhaps other states based on anecdotal reports, is oversight of prescription medicines, particularly psychotropics, for children in foster care. While not all abused or neglected children manifest mental or behavioral health issues, those who do may exhibit depression, aggression, anxiety, and/or self-injurious behaviors. As Kentucky approached its 2008 Child and Family Service Review, a convening of stakeholders elicited the following concerns with regard to psychotropic medications for children in foster care:

- Children who take multiple psychotropic medications should have regular psychiatric consultation;
- Psychotropic medications are often prescribed by pediatricians when child psychiatrists are not available prior to the child entering foster care; and,
- Psychotropic medications are being prescribed (possibly inappropriately) when other alternatives for behavior management have not been fully explored and used.

Kentucky is attempting to address these issues through its multi-disciplinary State Interagency Council (SIAC) composed of child welfare, behavioral health, education, juvenile justice, public health and the courts. For child welfare in general, the oversight of prescription medicines may be one of the most complex issues confronting practice. It is an area that requires thoughtful planning and collaboration among all the partner agencies. As has come to the attention of Congress and the Administration, this issue merits careful study as future policy decisions are considered.

In closing, I offer a general comment about the interpretation that a state must spend 20% of its **Promoting Safe and Stable Families allotment** on each of the four service categories. As has been documented via numerous reports, the four categories of PSSF - community-based services to increase the strength and stability of families; in-home services to improve parenting skills in order to prevent removal; time-limited reunification services to facilitate the safe return of children who have recently been removed from the home; and, services and activities to promote and support adoption of children experiencing foster care – are similar, and in some cases identical, in their purpose. While each has a different target population, such as any family in a community benefitting from the community-based services as compared to those families receiving time-limited reunification services because their child has been removed, the overarching goals are related – promoting the safety and stability/well-being of children within the context of family, whether that family is biological, foster or adoptive.

When Promoting Safe and Stable Families was authorized in 1993, there was understandably much concern from Congress and the Administration that states give equal consideration and resources to each of the four goals. Targeted funding provides direction that most generally drives results. That drive to results is perhaps no better demonstrated than in the growth of adoptions from foster care due to the promotion and support undergirded by PSSF. However, with fifteen plus years of experience and data to support the assertion, states are finding there is a need to rebalance the funding of PSSF across the service categories. For example, activities promoting adoption and adoption support have become so embedded in agency practice that the positive results can be

sustained without as much targeted funding. On the other hand, states are grasping for additional resources to prevent removals and enhance reunification.

Allowing states more latitude in determining the distribution of its PSSF allotment would provide a much needed opportunity to rebalance the funding with the service need in order to fully actualize the goals of Promoting Safe and Stable Families.

Chairman Davis, Ranking Member Doggett and Members of the Subcommittee, your attention to and concern for the welfare of abused and neglected children is most sincerely appreciated by child welfare agencies, community partners, foster and adoptive parents, advocates and most importantly, the children and families whose lives are impacted.

Thank you for the opportunity to share my views.