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(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

2003-04

(session year)

Assembly

(Assembly, Senate or Joint)

Committee on ... Children and Families (AC-CF)

COMMITTEE NOTICES ...

- Committee Reports ... **CR**
- Executive Sessions ... **ES**
- Public Hearings ... **PH**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

- Appointments ... **Appt** (w/Record of Comm. Proceedings)
- Clearinghouse Rules ... **CRule** (w/Record of Comm. Proceedings)
- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
  (**sb** = Senate Bill) (**sr** = Senate Resolution) (**sjr** = Senate Joint Resolution)
- Miscellaneous ... **Misc**

* Contents organized for archiving by: Stefanie Rose (LRB) (May 2012)

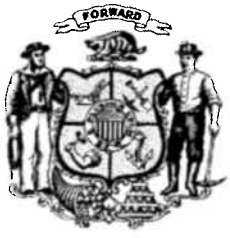
Instructions for Killing Bills Using ComClerk

This document is a set of instructions for Committee Clerks doing the paperwork to return all of the Assembly and Senate Bills, Joint Resolutions and Resolutions jackets out of committee and back to the Chief Clerk's office after the last floorperiod of the biennial session.

1. Start ComClerk as you normally would and open up your committee.
2. Then select **End of Session...** from the **Committee** menu. (If End of Session does not appear under the Committee menu, call Ken Stigler at 6-2406. It means that you did not get the recent update of the program --- possibly because you don't restart your computer every night.) This will open up a window containing a list of active bills, resolutions, and joint resolutions in your committee. Compare the list to the jackets in your possession. Call me if there are any discrepancies.
3. In the **Failed pursuant to** field, "Senate Joint Resolution 1" should appear.
4. In the **Date** field, the date "3/11/2004" should appear.
5. Select the number of copies of the Record of Committee Proceedings (ROCP) you wish to have printed. If you have a large number of bills, consider printing just one copy which you could then sign and xerox. I want 4 copies sent over to me with the jackets.
6. From the list of proposals, select the ones you wish to have adversely disposed. Unless there is some discrepancy, that should be all bills, joint resolutions and resolutions.
7. Ensure that you have enough paper in the printer. If you are unsure which paper tray ComClerk will use to print, consider removing all letterhead from your printer.
8. Click the **Process** button. A message box will appear, requesting you to verify your actions.
9. Click the **OK** button if you wish to continue. ComClerk will then do the following three things: 1) write the appropriate entry in the history "Failed to [pass/concur/adopt] pursuant to Senate Joint Resolution 1", 2) create the ROCP, and 3) print out the specified number of copies for the proposal before moving on to the next selected proposal.
10. ComClerk will return a message stating "Processing complete" when all history entries have been written, all ROCPs created, and all printouts queued to the printer.
11. Send the bill jackets and the signed copies of the ROCPs to the Chief Clerks Office.
12. From now on, all bills, joint resolutions, and resolutions that were adversely disposed of will appear as "Inactive" in ComClerk. All other committee items, such as pending Clearinghouse Rules, will still appear as "Active."

Revised April 19, 2004

WISCONSIN STATE LEGISLATURE

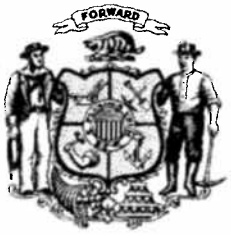


Bill Summary Policy for Bills Receiving Action in One or More Than One Committee

Bills receiving action in only one Assembly standing or joint committee will be completed by the committee clerk of that committee. For example, if a bill only receives action in the Health Committee, then the Health committee clerk would be responsible for drafting the summary. Or if a bill only receives action in the Joint Survey Committee on Tax Exemptions, or only in the Joint Committee on Finance, then the committee clerks for those respective committees would be responsible for drafting the summary.

For bills receiving action in more than one Assembly standing or joint committee, the committee clerk for the committee in which the bill was originally heard would be responsible for drafting the summary. For example, if a bill originally heard in the Joint Survey Committee on Tax Exemptions were to be execed out of the Health Committee, the Tax Exemptions committee clerk would draft the summary. Similarly, if a bill originally heard in the Health Committee were to receive action in the Joint Committee on Finance, the Health committee clerk would draft the summary. All committee clerks are encouraged to immediately forward their records, reports and other relevant material on a calandered bill to the committee clerk for the committee in which the bill was originally heard so he or she can begin drafting the summary.

WISCONSIN STATE LEGISLATURE



2003-04 COMMITTEE HEARING INFORMATION SHEET

Welcome to the 2003-04 biennial session of the Wisconsin Legislature! We have many returning committee clerks as well as a number of individuals who will be a committee clerk for the first time. As a result, for some of you this information is a review, and for others it is new information.

I. WHERE & WHEN TO MEET

Hearing room and meeting day assignments for committees for this session have been established. The Assembly Sergeant-at-Arms memo that was previously distributed to you provides a list of the room and day assignments, the list of "even" and "odd" weeks for the biennium, and an explanation of how the even/odd week system works. If you need another copy, please contact the Assembly Sergeant-at-Arms.

All committees have been assigned a hearing day. Approval by the Speaker is required before a meeting on a non-assigned day is noticed. If for example, your committee has been assigned "Tuesday-even," the committee may only meet on Tuesdays in an even week, unless prior approval by the Speaker is obtained.

How to request permission for a hearing on a non-assigned day
In order to help avoid committee scheduling conflicts for members, please adhere to the following procedures when requesting a hearing for a non-assigned day:

- The committee chair must submit a request to the Speaker at least **two weeks** in advance of a proposed hearing on a non-assigned day. Please allow at least **three business days** for the Speaker to consider the request.
- All requests shall include: (a) the purpose for which the hearing will be held; (b) the reason(s) why it is necessary to hold the hearing in advance of a regularly-scheduled meeting day; and (c) whether an executive session will be held.
- Requests may be sent via e-mail or by letter to Ellen Nowak in the Speaker's office.
- In the event that a request is made in order to expedite legislation for floor action, please contact Bob Karius in Majority Leader Foti's office to coordinate timing regarding scheduling requirements for the Rules Committee and floor scheduling.
- Committee chairs are responsible for determining if committee members will be attending other committee meetings previously scheduled for the date and time in question. This verification process requires the

committee chair to first determine on which other committees the members serve.

- Committee chairs must also contact the committee chairs of potentially affected committees to determine if a committee meeting is scheduled for the date in question. Any potential scheduling conflicts must be included in the written request submitted to the Speaker.

- As a general rule, **holding a committee meeting on a session day is strongly discouraged**. Please verify the floor period schedule with Majority Leader Foti's office if the desired committee date falls within a scheduled floor period. This must be done before submitting the written request to the Speaker. If the committee chair determines it is absolutely necessary to hold a hearing on a scheduled floor session day, the chair must request a hearing time which would conclude before the time that the Assembly is called to the floor or request that the hearing be commenced upon adjournment of the day's floor period.

II. NOTICE FOR PUBLIC HEARINGS

Subject to some exceptions, Wisconsin law requires that government officials conduct hearings that are open to the public and that the public receives advance notice of a meeting. The relevant Wisconsin statutes are sections 19.83-19.85, 19.87-19.88. The following is a summary of the requirements set forth in the law as well as the procedures that the Assembly has established.

What Information Should a Notice Contain?
All notices must provide the date, time, place and agenda for the hearing. When possible, it is best to notice hearings on properly introduced bills. However, if an LRB draft is included on the agenda and it is introduced before the hearing, an amended notice should be sent with the number of the properly introduced bill.

If an executive session may be held on any of the items on the agenda, it should be noted on the notice.

Who Should Be Notified?
Committee chairs are responsible for notifying all committee members and the Legislative Council Attorney assigned to their committee of the hearing. It is also customary for the chair to notify the authors of the bills included on the agenda.

Copies of a hearing notice are required to be posted on the Assembly and Senate Bulleting Boards and filed with the Assembly Chief Clerk for their records and publication in the *Weekly Schedule of Committee Activities*. To be included in the *Weekly Schedule of Committee Activities*, the notice has to be filed with Jody Nussbaum of the Chief Clerk's office before Monday noon for hearings to be held the

following week. It is important for committees to have their hearing notice published in the in the *Weekly Schedule of Committee Activities.*

If a notice cannot be included in the *Weekly Schedule of Committee Activities*, it must be provided at least 24 hours before the committee meets. If the chair determines, with good cause, that the 24 hour notice requirement cannot be met, the law allows shorter notice, but not less than 2 hours under any circumstances. In such cases, the hearing notice is required to be posted as follows:

- If the notice is ready at least 26 hours before the hearing, it is required to be posted on the Assembly and Senate Bulletin Boards and sent to the Chief Clerk. It is also a good idea to send a copy to the media. The Capitol Press Room is located at 235 SW.

- If the notice is ready less than 26 hours before the hearing, it is required to be posted on the Assembly and Senate Bulletin Boards, sent to the Chief Clerk, sent to the official state newspaper, *The Wisconsin State Journal*, and the news media that have specifically requested that they be given such notice (check with the Chief Clerk's office for a list.) Again, it is also a good idea to provide a copy of the notice to the Capitol Press Room.

What if Information Changes After I send a notice?

In general, the same requirements that apply to hearing notices that are described in this memo apply to amended notices. Remember, you must prepare an Amended Notice and post in on the Assembly and Senate Bulletin Boards, send it to the Assembly Chief Clerk and send a copy to committee members. Again, it is a good idea to provide a copy of the amended notice to the Capitol Press Room.

Important Things to Remember

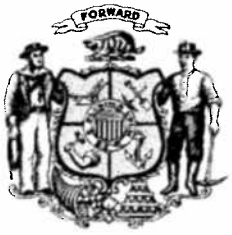
- ❖ Committees should always try to have their public hearing printed in the *Weekly Schedule of Committee Activities.*

- ❖ Committees should meet on their regularly scheduled hearing day. A written request to do otherwise must be approved by the Speaker.

- ❖ Amended Notices should be posted and distributed in the manner explained above.

- ❖ If you have any questions about committee procedures, please contact the Legislative Council Attorney assigned to your committee, the Chief Clerk, or the Speaker's office.

WISCONSIN STATE LEGISLATURE



National Conference of State Legislatures
CHILDREN'S POLICY INITIATIVE
A COLLABORATIVE PROJECT ON CHILDREN AND FAMILY ISSUES

SUBSTANCE-EXPOSED NEWBORNS: NEW FEDERAL LAW RAISES SOME OLD ISSUES

by Steve Christian *September 2004*

In the coming months and years, state legislators will be called upon to enact measures to comply with a new federal law that is intended to protect children who are affected by prenatal exposure to illegal drugs. State implementation of the law is likely to increase the number of children reported to child protective services (CPS) and raises important questions about the child welfare system's role and responsibility in such cases. Implementation also presents an opportunity for policymakers to examine their response to pregnant women who use drugs and alcohol, including prevention of substance-exposed births. This paper describes the new federal law, provides an overview of existing state reporting laws, discusses the role of child protective services and highlights the importance of prevention. An appendix contains the text of state laws that require reporting of substance-exposed newborns.

Background

In the wake of the crack epidemic of the 1980s, most states passed laws to address drug and alcohol use by pregnant women. A 2000 report by the Women's Law Project and National Advocates for Pregnant Women[1] identified the following categories of state laws in response to the this problem:

- Education and Awareness
- Identification, Testing and Reporting
- Treatment Improvement
- Priority Treatment for Pregnant Women
- Third-Party Liability (civil liability for furnishing drugs to pregnant women)
- Criminal Laws (penalties for furnishing drugs to pregnant women)
- Evaluation of Programs
- Funding
- Legislative Mandates, Findings, Declarations
- Oversight Committees, Task Forces, Research
- Civil Child Abuse Statutes
- Services to Children
- Prohibitions on Punitive Sanctions
- Guarantees of Confidentiality or Nondiscrimination
- Public Assistance

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- Adoption Statutes (information, training and support for adoptive parents of children exposed to substances in utero)
- Civil Commitment/Involuntary Detention
- Research

Notwithstanding these laws and a considerable investment of public funds, up to 221,000 children every year are exposed to illicit drugs during gestation, according to estimates by the National Institute on Drug Abuse. When alcohol and tobacco are included, that number climbs to 1.5 million children per year. The overwhelming majority of these newborns are never tested or reported to Child Protective Services.[2] Many of these children are affected by lifetime conditions that require a high level of public spending. Fetal alcohol exposure, for example, is the leading preventable cause of mental retardation, with a cost to society of $4 billion per year.

Keeping Children and Families Safe Act

A new federal law presents an opportunity for states to revisit their approach to this problem. The Keeping Children and Families Safe Act of 2003 added a number of new eligibility requirements for child welfare funding under the Child Abuse Prevention and Treatment Act (CAPTA).[3] Among these is a requirement that states have policies and procedures requiring health care providers to notify CPS of "infants born and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure." States must also develop a "plan of safe care" for such infants.[4] The law does not require reporting of children prenatally exposed to legal substances such as alcohol and tobacco. Nothing in the law, however, prevents states from requiring such reporting.

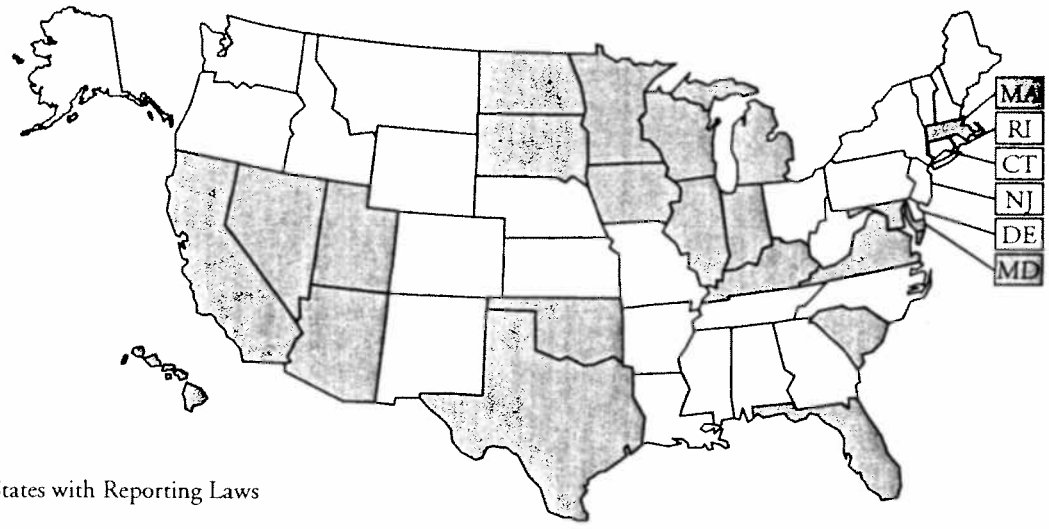
Because the health care system is independent of the child welfare system, implementation of the new CAPTA notification provision will likely require the enactment of legislation in many, if not most, states. A number of states already have statutory provisions that require reporting of substance-exposed newborns to CPS (see appendix). Fifteen states include some type of prenatal substance exposure in their statutory definitions of reportable child abuse and neglect. Some of these states also have requirements pertaining specifically to reporting of substance exposed babies. Another seven states require CPS notification under certain circumstances but do not refer to prenatal substance exposure in their definitions of child abuse and neglect. Two states, Hawaii and North Dakota, have enacted laws since passage of the CAPTA amendment.[5] Figure 1 illustrates the states with reporting laws.

Although the CAPTA amendment does not require states to amend their definitions of abuse and neglect, change their drug testing policies, or prosecute pregnant women who use drugs, it raises anew a number of issues regarding the public response to infants who are prenatally exposed to drugs and alcohol. The National Center on Substance Abuse and Child Welfare has identified four implementation issues for states:

- Identifying infants affected by illegal substance abuse or withdrawal symptoms;
- Implementing the requirement that health care providers involved in the delivery or care of such identified infants notify CPS;
- Addressing the needs of these infants; and
- Developing a plan of safe care.[6]

The first two issues primarily involve the health care system, whereas the last two involve a collaborative response by multiple systems, including CPS. The role of CPS is discussed below.

Figure 1. States with Statutory Provisions Requiring Reporting of Substance-Exposed Newborns to CPS



Source: National Clearinghouse on Child Abuse and Neglect Information, 2004; National Conference of State Legislatures, 2004.

The Role of CPS

Whether and how CPS should be involved in cases of prenatally exposed infants has been a subject of some debate. Some have argued that coercive intervention by CPS and/or the courts is inappropriate because drug addiction is a disease, not a crime, and that the threat of child removal and termination of parental rights will discourage pregnant women from seeking prenatal care. Others have argued for CPS involvement on the grounds that parents are unlikely to enter treatment without a court mandate.[7] As stated above, some states consider prenatal exposure to be child abuse *per se*, mandating a report to and response from CPS.

According to the committee report on H. 14, the House version of the Keeping Children and Families Safe Act, the new notification requirement is intended to "identify infants at risk of child abuse and neglect so appropriate services can be delivered to the infant and mother to provide for the safety of the child." Thus, the law sees the function of CPS as protecting a child who may be at increased risk of maltreatment in the future, regardless of whether the state has determined that such child already has been abused as a result of prenatal exposure to illegal drugs. A related provision in the federal law requires states to have procedures for referral of maltreated children from birth to age 3 to early intervention services under Part C of the Individuals with Disabilities Education Act, known as Early Intervention Programs for Infants and Toddlers with Disabilities.[8] Unlike the reporting requirement, however, this provision relates to children in cases of abuse or neglect that already have been substantiated by CPS.

Although the law's assumption—that children born exposed to illegal drugs in utero are at increased risk of later maltreatment—has been questioned by some observers,[9] maternal alcohol and drug use is clearly associated with numerous risk factors. These include chaotic and dangerous lifestyles, involvement in abusive relationships, and mental health problems that affect parenting.[10] In fact, all children under age 1 are at greater risk of maltreatment—primarily neglect—than any other age group. Such maltreatment can profoundly affect infants' overall development and well-being in addition to their physical safety. Neglect at a very young age, for example, places children at high risk of developmental delays and neurological impairment. Perinatal substance exposure, combined with postnatal risk factors such as unpredictable and inconsistent parenting, increases the risk of poor long-term outcomes, including behavioral problems and cognitive deficits.

The extent to which CPS actually becomes involved in these cases and the extent to which such involvement affects outcomes are unclear. Even though much has been written about the problem of babies born to substance-using women, we know relatively little about the CPS response (or lack thereof) to such babies and their families.[11] It may be that CPS is more likely to follow up on reports in states that have included substance exposure in utero in their definitions of child maltreatment. In other states, babies who are born exposed to drugs or alcohol may not meet the statutory criteria for maltreatment and so may receive less, if any, attention from CPS. A nationwide survey found that 21 percent of counties never file dependency petitions on behalf of substance-exposed newborns, while 46 percent reported filing petitions in at least 41 percent of such cases.[12]

Although little information is available about the CPS response to substance-exposed births, we do know that maltreated infants as a whole are considerably more likely to be placed in foster care than are older maltreated children.[13] Infants also tend to stay in foster care significantly longer than children age 1 and older and experience high rates of foster care re-entry after discharge. Because drug-exposed infants often have more health needs than non-drug-exposed infants, foster caregivers of such children tend to "burn out" more quickly and return the children in their care to CPS.[14] Foster placement itself poses risks to infants' healthy development and formation of healthy attachment relationships.[15]

At present, many child welfare agencies view foster care primarily as a means of protecting children's physical safety and only secondarily as a means of ensuring the healthy social and emotional development of very young children who are removed from home for reasons of abuse and neglect, including children who are prenatally exposed to drugs or alcohol. This attitude about out-of-home placement appears particularly applicable to unlicensed kinship care, which receives less support and is subject to less monitoring than licensed foster care. The limited perception of foster care may be changing because early brain research continues to affect policy and because states are held accountable for assessing and addressing the well-being needs of children under the federal Child and Family Service Reviews. Nevertheless, state performance on these well-being outcomes, particularly children's mental health, lags behind performance in the safety and permanency outcomes.

Questions to Consider Regarding the Role of CPS

Although the requirement to notify CPS of substance-exposed newborns could lead to identification of a greater number of children who are at risk of poor outcomes, the effect of the new law will depend upon a host of factors. One such factor is the capacity of an already

overburdened child welfare system—including foster care providers and dependency courts—to respond to a potentially significant increase in reports. Another is the ability of multiple systems to collaborate in assessing the needs of children and families and in addressing those needs with appropriate services, including developmentally appropriate physical and mental health care, quality early care and learning experiences, and substance abuse treatment and related support services for mothers.[16] Still another is whether the law will result in unintended and undesired consequences, such as an increase in the disproportionate reporting of African-American women for prenatal substance use[17] and overrepresentation of African-American children in foster care, or a chilling effect on the willingness of pregnant women to seek prenatal care or to give birth with the assistance of health care professionals.

In light of the foregoing factors, state legislators may want to ask whether and how their child welfare agencies will respond to reports of substance-exposed babies under the new law.

- Has the agency estimated the effect of the new law on the number of reports it receives?
- Does the agency have the capacity to respond to these new reports?
- How will infants' safety and well-being needs be assessed and addressed?
- What other agencies will be involved?
- Are there interagency protocols in place to ensure a coordinated response?
- What treatment and support services will be provided to the mother to enable her to safely care for her infant?
- If the baby is placed in foster care, what supports and services will be provided to the foster parent and the child?
- What efforts are being made to identify and refer to treatment pregnant women who use drugs or alcohol before they give birth?
- What can be done to ensure that the new reporting requirement does not deter women from involvement with the health care system?

Prevention

Although the new federal law does not address prevention, it may serve to renew a discussion about the efficacy of a state's efforts to reduce the number of substance-exposed births. At the very least, compliance with the new reporting requirement may give states a better idea of the extent of the problem. Many programs address substance abuse prevention, including general education and public awareness campaigns as well as school and community-based programs that target specific age groups.[18] Although few of these programs target pregnant or parenting women, many states require that women of childbearing age be given priority for drug and alcohol treatment. Family drug treatment courts show great promise in helping mothers enter and complete treatment, but only after a child is born and CPS has become involved in the family's life. Although nurse home visitation that begins prior to birth has shown some success in reducing pregnant women's use of tobacco and alcohol, the full potential of this strategy in preventing substance-exposed births has yet to be realized.[19]

Some researchers argue that programs such as drug courts and home visitation may be limited in their ability to reach the larger population of pregnant and parenting women who use drugs and alcohol, primarily because they tend to serve lower income families and often are isolated from the wider community. Substance use among pregnant women is not limited to the poor.[20] These observers argue for broader community-based interventions that involve

partnerships among obstetricians; CPS; the courts; and substance abuse treatment, mental health and other concerned local organizations.

An example of a community-based approach to prevention is the Screening, Assessment, Referral and Treatment (SART) program developed by Dr. Ira Chasnoff and his colleagues at the Children's Research Triangle in Chicago.[21] SART involves raising public awareness about the problem of substance use during pregnancy; creating a team composed of representatives from a variety of disciplines; developing an action plan; building public support; and implementing the core SART intervention, which includes motivating and assisting health care providers to screen pregnant women for substance use. The SART model, which is being implemented in at least 20 communities throughout the country, does not appear to have been rigorously evaluated. A similar community-based intervention program that targeted binge drinking, underage drinking and drunk driving, resulted in significant reductions in self-reported alcohol consumption, alcohol-related traffic accidents, and alcohol-related assault injuries.[22] This intervention involved the combined efforts of a wide array of community members, including the media, alcoholic beverage servers and retailers, law enforcement agencies and zoning authorities.

Why should legislators be interested in community-based prevention initiatives? In addition to enacting laws of statewide application, state legislators can play a leadership role in their districts, mobilizing the community to develop coordinated prevention initiatives. The authority and influence of legislators can help ensure that other participating governmental organizations—such as public health and CPS—are represented in meetings by high-level staff who have the authority to commit resources and shape policy.

Conclusion

State legislators who are called upon to enact legislation to comply with the new CAPTA notification requirement will have an opportunity to re-examine their states' response to drug and alcohol use by pregnant women, including efforts to identify and treat such women as soon as possible after conception and to provide appropriate services to children who are born exposed to substances in utero.

Preparation of this report was supported by a grant from the Freddie Mac Foundation.

Appendix. State Laws on Reporting Substance-Exposed Newborns (SEN) to Child Protective Services			
State/ Jurisdiction	Citation	Circumstances Triggering Reporting Requirement	SEN Included in Abuse/Neglect Definition?
Arizona	13-3620(E)	A health care professional who is regulated pursuant to title 32 and who, after a routine newborn physical assessment of a newborn infant's health status or following notification of positive toxicology screens of a newborn infant, reasonably believes that the newborn infant may be affected by the presence of alcohol or a drug listed in section 13-3401 shall immediately report this information, or cause a report to be made, to child protective services in the department of economic security. For the purposes of this subsection, "newborn infant" means a newborn infant who is under thirty days of age.	No
California	Penal Code 11165.13	For purposes of this article, a positive toxicology screen at the time of the delivery of an infant is not in and of itself a sufficient basis for reporting child abuse or neglect. However, any indication of maternal substance abuse shall lead to an assessment of the needs of the mother and child pursuant to Section 123605 of the Health and Safety Code. If other factors are present that indicate risk to a child, then a report shall be made. However, a report based on risk to a child which relates solely to the inability of the parent to provide the child with regular care due to the parent's substance abuse shall be made only to a county welfare or probation department, and not to a law enforcement agency.	No
Florida	39.01(30)	See definition of abuse/neglect.	"*Harm*" to a child's health or welfare can occur when any person: Exposes a child to a controlled substance or alcohol. Exposure to a controlled substance or alcohol is established by: Use by the mother of a controlled substance or alcohol during pregnancy when the child, at birth, is demonstrably adversely affected by such usage.
Hawaii	SB 2165, Act 210 (2004)	In conformity to the Child Abuse Prevention and Treatment Act . . . as amended by the Keeping Children and Families Safe Act . . . the department of human services shall implement and operate a statewide program relating to child abuse and neglect that includes: (1) policies and procedures, including but not limited to appropriate referrals to child protective services systems and other appropriate services, to address the needs of infants born and identified as being affected by illegal substance abuse or	No

Appendix. State Laws on Reporting Substance-Exposed Newborns (SEN) to Child Protective Services (continued)			
State/ Jurisdiction	Citation	Circumstances Triggering Reporting Requirement	SEN Included in Abuse/Neglect Definition?
Hawaii (continued)		withdrawal symptoms resulting from prenatal drug exposure, including a requirement that health care providers involved in the delivery or care of an affected infant notify child protective services of the occurrence of the condition in the infant; provided that the notification shall not be construed to require criminal prosecution for any illegal action."	
Illinois	325 ILCS 5/3	See definition of abuse/neglect.	"*Neglected child*" means any child who is a newborn infant whose blood, urine, or meconium contains any amount of a controlled substance as defined in subsection (f) of Section 102 of the Illinois Controlled Substances Act or a metabolite thereof, with the exception of a controlled substance or metabolite thereof whose presence in the newborn infant is the result of medical treatment administered to the mother or the newborn infant.
Indiana	31-34-1-10; 31-34-1-11	See definition of abuse/neglect.	Except as provided in sections 12 and 13 of this chapter, a child is a *child in need of services* if: (1) the child is born with: (A) fetal alcohol syndrome; or (B) any amount, including a trace amount, of a controlled substance or a legend drug in the child's body; and (2) the child needs care, treatment, or rehabilitation that: (A) the child is not receiving; or (B) is unlikely to be provided or accepted without the coercive intervention of the court. Except as provided in sections 12 and 13 of this chapter, a child is a *child in need of services* if: (1) the child: C) is at a substantial risk of a life threatening condition; that arises or is substantially aggravated because the child's mother used alcohol, a controlled substance, or a legend drug during pregnancy; and (2) the child needs care, treatment, or rehabilitation that the child: (A) is not receiving; or (B) is unlikely to be provided or accepted without the coercive intervention of the court.

Appendix. State Laws on Reporting Substance-Exposed Newborns (SEN) to Child Protective Services (continued)			
State/ Jurisdiction	Citation	Circumstances Triggering Reporting Requirement	SEN Included in Abuse/Neglect Definition?
Iowa	232.77(2) 232.68(2)	If a health practitioner discovers in a child physical or behavioral symptoms of the effects of exposure to cocaine, heroin, amphetamine, methamphetamine, or other illegal drugs, or combinations or derivatives thereof, which were not prescribed by a health practitioner, or if the health practitioner has determined through examination of the natural mother of the child that the child was exposed in utero, the health practitioner may perform or cause to be performed a medically relevant test, as defined in section 232.73, on the child. The practitioner shall report any positive results of such a test on the child to the department. The department shall begin an assessment pursuant to section 232.71B upon receipt of such a report. A positive test result obtained prior to the birth of a child shall not be used for the criminal prosecution of a parent for acts and omissions resulting in intrauterine exposure of the child to an illegal drug.	*"Child abuse"* or *"abuse"* means: *f.* An illegal drug is present in a child's body as a direct and foreseeable consequence of the acts or omissions of the person responsible for the care of the child.
Kentucky	214.160(3), (4)	A physician or person legally permitted to engage in attendance upon a pregnant woman may administer to each newborn infant born under that person's care a toxicology test to determine whether there is evidence of prenatal exposure to alcohol, a controlled substance, or a substance identified on the list provided by the Cabinet for Health Services, if the attending person has reason to believe, based on a medical assessment of the mother or the infant, that the mother used any such substance for a nonmedical purpose during the pregnancy. The circumstances surrounding any positive toxicology finding shall be evaluated by the attending person to determine if abuse or neglect of the infant, as defined under KRS 600.020(1), has occurred and whether investigation by the Cabinet for Health Services is necessary.	No

Appendix. State Laws on Reporting Substance-Exposed Newborns (SEN) to Child Protective Services (continued)			
State/ Jurisdiction	Citation	Circumstances Triggering Reporting Requirement	SEN Included in Abuse/Neglect Definition?
Maryland	Courts and Judicial Proceedings 3-818	See definition of abuse/neglect.	There is a presumption that a child is *not receiving proper care and attention* from the mother if the child was born exposed to cocaine, heroin, or a derivative of cocaine or heroin as evidenced by any appropriate tests of the mother or child, or upon admission to a hospital for delivery of the child, the mother tested positive for cocaine, heroin, or a derivative of cocaine or heroin as evidenced by any appropriate toxicology test; and drug treatment is made available to the mother and the mother refuses the recommended level of drug treatment, or does not successfully complete the recommended level of drug treatment.
Massachusetts	Ch. 119, sec. 51A	See definition of abuse/neglect.	*Injured, abused, or neglected child* includes a child who is determined to be physically dependent upon an addictive drug at birth.
Michigan	722.623a	In addition to the reporting requirement in section 3, a person who is required to report suspected child abuse or neglect under section 3(1) and who knows, or from the child's symptoms has reasonable cause to suspect, that a newborn infant has any amount of alcohol, a controlled substance, or a metabolite of a controlled substance in his or her body shall report to the department in the same manner as required under section 3. A report is not required under this section if the person knows that the alcohol, controlled substance, or metabolite, or the child's symptoms, are the result of medical treatment administered to the newborn infant or his or her mother.	No
Minnesota	626.5562,Subd.2 626.556, Subd. 2(c)	A physician shall administer to each newborn infant born under the physician's care a toxicology test to determine whether there is evidence of prenatal exposure to a controlled substance, if the physician has reason to believe based on a medical assessment of the mother or the infant that the mother used a controlled substance for a nonmedical purpose during the pregnancy. If the test results are positive, the physician shall report the results as neglect under section 626.556.	*Neglect* means prenatal exposure to a controlled substance, as defined in section 253B.02, subdivision 2, used by the mother for a nonmedical purpose, as evidenced by withdrawal symptoms in the child at birth, results of a toxicology test performed on the mother at delivery or the child at birth, or medical effects or developmental delays during the child's first year of life that medically indicate prenatal exposure to a controlled substance.

Appendix. State Laws on Reporting Substance-Exposed Newborns (SEN) to Child Protective Services (continued)			
State/ Jurisdiction	Citation	Circumstances Triggering Reporting Requirement	SEN Included in Abuse/Neglect Definition?
Nevada	432B.330	See definition of abuse/neglect.	A child is in need of protection if: (b) He is suffering from congenital drug addiction or fetal alcohol syndrome because of the faults or habits of a person responsible for his welfare.
North Dakota	50-25.1-17 27-20-02(8)	If a physician has reason to believe based on a medical assessment of the mother or the infant that the mother used a controlled substance for a nonmedical purpose during the pregnancy, the physician shall administer, without the consent of the child's parents or guardian, to the newborn infant born under the physician's care a toxicology test to determine whether there is evidence of prenatal exposure to a controlled substance. If the test results are positive, the physician shall report the results as neglect under section 50-25.1-03.	*Deprived child* means child who was subject to prenatal exposure to chronic and severe use of alcohol or any controlled substance as defined in chapter 19-03.1 in a manner not lawfully prescribed by a practitioner.
Oklahoma	Title 10, sec. 7103(A)(2)	Every physician or surgeon, including doctors of medicine, licensed osteopathic physicians, residents and interns, or any other health care professional attending the birth of a child who appears to be a child born in a condition of dependence on a controlled dangerous substance shall promptly report the matter to the county office of the Department of Human Services in the county in which such birth occurred.	No
South Carolina	20-7-736(G)	See definition of abuse/neglect.	It is presumed that a newborn child is an *abused or neglected* child as defined in Section 20-7-490 and that the child cannot be protected from further harm without being removed from the custody of the mother upon proof that: (1) a blood or urine test of the child at birth or a blood or urine test of the mother at birth shows the presence of any amount of a controlled substance or a metabolite of a controlled substance unless the presence of the substance or the metabolite is the result of medical treatment administered to the mother of the infant or the infant, or (2) the child has a medical diagnosis of fetal alcohol syndrome; and (3) a blood or urine test of another child of the mother or a blood or urine test of the mother at the birth of another child showed the presence of any amount of a controlled substance or a metabolite of a controlled substance unless the presence of the substance or the metabolite was the result of medical

Appendix. State Laws on Reporting Substance-Exposed Newborns (SEN) to Child Protective Services (continued)			
State/ Jurisdiction	**Citation**	**Circumstances Triggering Reporting Requirement**	**SEN Included in Abuse/Neglect Definition?**
South Carolina (continued)			treatment administered to the mother of the infant or the infant, or (4) another child of the mother has the medical diagnosis of fetal alcohol syndrome.
South Dakota	26-8A-2(9)	See definition of abuse/neglect.	The term, *abused or neglected child*, means a child: Who was subject to prenatal exposure to abusive use of alcohol or any controlled drug or substance not lawfully prescribed by a practitioner as authorized by chapters 22-42 and 34-20B.
Texas	Family Code, 261.001	See definition of abuse/neglect.	"*Born addicted to alcohol or a controlled substance*" means a child: (A) who is born to a mother who during the pregnancy used a controlled substance, as defined by Chapter 481, Health and Safety Code, other than a controlled substance legally obtained by prescription, or alcohol; and (B) who, after birth as a result of the mother's use of the controlled substance or alcohol: experiences observable withdrawal from the alcohol or controlled substance; exhibits observable or harmful effects in the child's physical appearance or functioning; or exhibits the demonstrable presence of alcohol or a controlled substance in the child's bodily fluids.
Utah	62A-4a-404	A determination that a child has fetal alcohol syndrome or fetal drug dependency at the time of birth.	No
Virginia	63.2-1509 (A), (B)	Mandatory reporters must report whenever they have reason to suspect that a child is an abused or neglected child.	"*Reason to suspect that a child is abused or neglected*" shall include (i) a finding made by an attending physician within seven days of a child's birth that the results of a blood or urine test conducted within forty-eight hours of the birth of the child indicate the presence of a controlled substance not prescribed for the mother by a physician; (ii) a finding by an attending physician made within forty-eight hours of a child's birth that the child was born dependent on a controlled substance which was not prescribed by a physician for the mother and has demonstrated withdrawal symptoms; (iii) a diagnosis by an attending physician made within seven days of a child's birth that the child has an illness, disease or condition which, to a reasonable degree of medical certainty, is attributable to in utero exposure to a controlled substance which was

Appendix. State Laws on Reporting Substance-Exposed Newborns (SEN) to Child Protective Services (continued)			
State/ Jurisdiction	Citation	Circumstances Triggering Reporting Requirement	SEN Included in Abuse/Neglect Definition?
Virginia (continued)			not prescribed by a physician for the mother or the child; or (iv) a diagnosis by an attending physician made within seven days of a child's birth that the child has fetal alcohol syndrome attributable to in utero exposure to alcohol
Wisconsin	48.02(1)	See definition of abuse/neglect.	*Abuse* includes physical harm to unborn child and risk of serious physical harm to child when born, caused by habitual lack of self-control of the expectant mother in the use of alcoholic beverages, controlled substances, exhibited to a severe degree.
District of Columbia	16-2301(9)	See definition of abuse/neglect.	The term "*neglected child*" means a child: (viii) who is born addicted or dependent on a controlled substance or has a significant presence of a controlled substance in his or her system at birth; (ix) in whose body there is a controlled substance as a direct and foreseeable consequence of the acts or omissions of the child's parent, guardian, or custodian.
Sources: National Clearinghouse on Child Abuse and Neglect Information, 2004; National Conference of State Legislatures, 2004.			

Notes

1. Lynn Paltrow, David Cohen and Corinne Carey, *Year 2000 Overview: Governmental Responses to Pregnant Women Who Use Alcohol or Other Drugs* (New York: Women's Law Project and National Advocates for Pregnant Women, 2000), available on the web at http://advocatesforpregnantwomen.org/articles/gov_response_review.pdf.

2. Cathleen Otero, et al., "The Child Abuse Prevention and Treatment Act: Substance-Exposed Newborns," presentation at *Putting the Pieces Together: First National Conference on Substance Abuse, Child Welfare and the Dependency Court*, Baltimore, Md., July 14, 2004.

3. Keeping Children and Families Safe Act of 2003, P.L. 108-36.

4. Ibid., section 114.

5. Hawaii S.B. 2165, Act 210 (2004); North Dakota S.B. 2271, Chap. 431 (2003).

6. National Center on Substance Abuse and Child Welfare, "New Child Abuse Prevention and Treatment Act Requirements Concerning Infants Identified as Affected by Illegal Substance Abuse" (Irvine, Calif.: NCSACW, 2004).

7. Steven Ondersma, et al., "Prenatal Drug Exposure and Social Policy: The Search for an Appropriate Response," *Child Maltreatment* 5, no. 2 (May 2000).

8. Section 114, P.L. 108-36.

9. See, e.g., Carol Larson, "Overview of State Legislative and Judicial Responses," in "Drug Exposed Infants," *The Future of Children* 1, no. 1 (Spring 1991).

10. Barry Lester, et al., "Substance Use During Pregnancy: Time for Policy to Catch Up with Reserch," *Harm Reduction Journal* 1, no. 5 (April, 2004).

11. See James MacMahon, "Perinatal Substance Abuse: The Impact of Reporting Infants to Child Protective Services," *Pediatrics* 100, no. 5 (November 1997).

12. Ondersma, note 5.

13. Fred Wulczyn and Kristin Hislop, "Foster Care Dynamics in Urban and Non-Urban Counties," *Issue Papers on Foster Care and Adoption* (Chicago: Chapin Hall Center for Children, 2003).

14. Lester, note 9.

15. See, e.g., Brenda Jones Harden, "Safety and Stability for Foster Children: A Developmental Perspective," in "Children, Families and Foster Care," *The Future of Children* 14, no. 1 (Winter 2004).

16. Sheryl Dicker, Elysa Gordon and Jane Knitzer, *Improving the Odds for the Healthy Development of Young Children in Foster Care* (New York: National Center for Children in Poverty, 2001).

17. Ira Chasnoff et al., "The Prevalence of Illicit-Drug or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida," *New England Journal of Medicine* 322, no. 17 (April 1990).

18. Some of these programs have been reviewed and determined by the Substance Abuse and Mental Health Services Administration to be model programs. See http://modelprograms.samhsa.gov/

.

19. Neil Guterman, *Stopping Child Maltreatment Before it Starts: Emerging Horizons in Early Home Visitation Services* (Thousand Oaks, Calif.: Sage Publications, 2001).

20. Chasnoff, note 7.

21. Richard McGourty and Ira Chasnoff, *Power Beyond Measure* (Chicago: National Training Institute, 2003).

22. Harold Holder, et al., "Effect of Community-Based Interventions on High-Risk Drinking and Alcohol-Related Injuries," *Journal of the American Medical Association* 284, no. 18 (November 18, 2000).

National Conference of State Legislatures
CHILDREN'S POLICY INITIATIVE
A COLLABORATIVE PROJECT ON CHILDREN AND FAMILY ISSUES

TREATING SUBSTANCE ABUSE IN THE CHILD WELFARE SYSTEM

by Michelle Herman *September 2004*

Substance abuse is a prevalent factor in child abuse and neglect and escalates challenges present in the child welfare system. Substance-abusing parents have been found to have compromised parenting practices and an increased risk of child maltreatment. Most child welfare practitioners agree that at least one-third of referrals to the child welfare system and two-thirds of removals from the home involve substance abuse.[1] Once in the system, children of substance-abusing families experience longer stays in foster care and lower rates of family reunification. Substance abuse treatment options are limited and, for those parents who do gain access to treatment, compliance rates are low. State child welfare systems face many challenges in meeting the complex needs of substance-abusing families. In particular, the Adoption of Safe Families Act of 1997, which aims to shorten children's stays in foster care, requires courts to make decisions about children's permanent placement within 12 months after the child enters foster care. Recovery from substance abuse addiction is often a complex, slow process, and time restrictions may not allow parents enough time to overcome their addiction. Comprehensive, effective child welfare and substance abuse programs promote treatment, sustained recovery and self-sufficiency and strive to accomplish two goals: to assist parents to gain access to treatment services to reduce alcohol and drug use, and to keep children safe.

In 1996, the U.S. Department of Health and Human Services, Administration for Children and Families (ACF), announced a new opportunity for states to design and test a wide range of approaches in the delivery and financing of child welfare services. ACF released a proposal for states to apply for waiver demonstration projects using funds from Title IV-E of the Social Security Act, the largest single source of federal funding for child welfare programs. Traditionally, Title IV-E funds pay for room and board for eligible children in foster care and for some administrative costs, but the funds cannot be used for services to prevent placement into foster care or to facilitate family reunification. The Child Welfare Demonstration Projects provide states with greater flexibility in using Title IV-E funds for services that can improve safety, permanency and well-being for children. Since 1996, 17 states have implemented Title IV-E waiver demonstration projects, and three states used waiver funds to develop programs to address the needs of caretakers who have substance abuse problems.[2]

Collectively, the demonstration programs aimed to reduce the number of children and the amount of time spent in foster care, more restrictive and costly placement settings, recurrences of abuse and neglect and re-entry into foster care. The projects were required to be cost-neutral and produce comprehensive evaluation plans with process, outcome and cost-effectiveness measures. This *Policy Matters* brief describes the experiences of Delaware, Illinois and New Hampshire in implementing Child Welfare Demonstration Projects.

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Delaware

In response to a rise in foster care cases involving parental substance abuse—and, consequently, in foster care costs—in 1996 Delaware's Division of Family Services (DFS) applied for and received the first Title IV-E waiver to specifically address child welfare and substance abuse issues. Delaware hoped that, by coordinating substance abuse experts and child welfare staff, the state could lower foster care costs, reduce the number of children removed from their homes, and reduce the length of time spent out-of-home for those children who required such care.

Alcohol and Other Drug Counselors:

- Conduct initial substance abuse assessments.
- Link clients to appropriate substance abuse treatment.
- Work with child welfare treatment units to conduct home visits, develop joint case plans, monitor progress, and plan for services following discharge.
- Provide support services while parents are waiting for admission to a treatment program
- Enter case notes and recommendations into the DFS database.
- Provide on-the-job training for DFS caseworkers on substance abuse issues and indicators.

DFS contracted with community-based substance abuse treatment agencies to hire certified alcohol and other drug (AOD) counselors for the child welfare units involved in the demonstration. The DFS program is based upon multidisciplinary team treatment, which pairs a certified substance abuse counselor with DFS caseworkers to help link parents to effective substance abuse treatment. Although DFS caseworkers had received some substance abuse training, the AOD counselors specialize in connecting clients to substance abuse resources and providing support for clients during treatment.

The DFS case workers, AOD counselors and program managers meet monthly to involve all in case and treatment decisions. Besides assisting in case planning and making service recommendations, the AOD counselors provide support services throughout the treatment continuum and may serve as counselors until spaces open for the parents in other drug and alcohol treatment programs. According to Joann Bruch, treatment program manager, one unexpected benefit of including AOD counselors was their ability to navigate the complicated insurance systems that pay for substance abuse treatment.[3] The AOD counselors' greater knowledge about covered services and time required to complete treatment regimens has made it easier for families to gain access to these services and regimens. Delaware completed its demonstration project in December 2002.

Illinois

The Illinois Department of Children and Family Services (DCFS) applied for a Title IV-E waiver in 1999. The Chicago and suburban Cook County program began in May 2000. Although the other two states designed their programs to co-locate substance abuse and child protective services and focused on the collaboration between those services, the Illinois program works with clients who already have had their children removed from home after the courts established cases of abuse and neglect. DCFS contracts with the Treatment Alternatives for Safe Communities—a private, nonprofit Chicago group—to hire recovery coaches to help identified families whose children have already been removed to obtain and stay engaged in alcohol and other drug abuse (AODA) treatment.

Recovery coaches provide case management for families to spur recovery and to reunify parents with their children. The demonstration redirects Title IV-E money from traditional programs to fund recovery coach teams of substance abuse specialists. Teams are comprised of a supervisor, four recovery coaches and one outreach worker—a "tracker" who specializes in locating difficult-to-reach clients. Recovery coaches, who may have various alcohol and other drug certifications

and at a minimum are certified addiction referral specialists, provide specialized, intensive and therapeutic case management services for involved parents. DCFS presumed that repeated contact with coaches would increase treatment duration and improve treatment completion rates, and parents meet regularly with the recovery coaches.

Recovery Coaches:

- Conduct clinical assessments for substance abuse services, mental and physical health, family support, domestic violence and housing.
- Provide specialized, intensive and therapeutic case management to support parents' changed behavior.
- Assist clients with benefits identification.
- Coordinate service planning from priorities identified in initial assessments.
- Initiate drug testing.
- Provide outreach services, particularly to track difficult-to-find cases.
- Make recommendations for court and treatment decisions.

At or soon after their temporary custody hearing, eligible families may be referred to the project. According to Sam Gillespie, AODA services manager, "Continuous outreach efforts get people into treatment quicker and result in them staying longer. Our early involvement makes a big difference in their success rate."[4] Recovery coaches have regular contact with the AODA treatment agency and child welfare workers and facilitate communication between child welfare, AODA providers and court systems. They provide all involved parties with timely information about parents' treatment progress and other issues relevant to case, reunification and other permanency decisions. The demonstration program will run until June 2005.

New Hampshire

New Hampshire's Division for Children, Youth and Families (DCYF) implemented its Title IV-E Child Welfare Demonstration program, Project First Step, in Nashua and Manchester. This waiver program differs from others because New Hampshire's approach initiates services earlier. While Illinois and Delaware provide coaches or practitioners for parents who already are involved in the courts (and in some cases, after children have been removed from home), New Hampshire provides services to alcohol-or drug-involved families as a preventive effort to deter ongoing child welfare involvement.

When child abuse or neglect is first reported, DCYF has a 60-day investigation period to determine whether to take the case to court. Until a case is confirmed in court, DCYF has limited authority to provide or mandate services for families. In the interim, families may be referred to community-based family resource centers to receive services voluntarily, at which time the department assigns licensed alcohol and drug abuse counselors (LADACs) to child protection investigations for families that need them—before court and official DCYF intervention—in an attempt to prevent or discontinue abuse before the 60-day period ends.

Licensed Alcohol and Drug Abuse Counselors:

- Conduct substance abuse screenings and evaluations.
- Provide intensive substance abuse services for families suspected of child abuse or neglect.
- Make treatment recommendations for DCYF.
- Provide direct counseling for referred family members.
- Develop substance abuse prevention steps for case plans.
- Collaborate with the child protection staff, state and county departments for treatment plans and assessments.
- Train child protection field staff on substance abuse interventions.

The LADACs, who are certified family therapists, act as consultants for the child protection service workers to provide information and treatment recommendations. They work as therapists for the families, providing intervention, treatment and case tracking, and monitoring parents' compliance with treatment recommendations. Bernie Bluhm, DCYF project manager, explained, "Once a child is in foster care, we are reasonably assured that the child is safe. However, what about the children who are still at home—what can be done to ensure their safety? The essence of Project First Step is to provide access in the early stages when the children are at the greatest risk and in need of services."[5] Project First Step received a short-term extension to run through November 2005.

Results

The states assessed improvements in safety, permanency and well-being for children in families that were threatened by substance abuse and experienced encouraging results. All states found that the time children spent in foster care decreased when families were offered substance abuse services; however, due to differences in the number of clients in each program, evaluation criteria and program design, results are difficult to compare.

Delaware calculated the average number of days spent in foster care for those children who were removed from their home. As table 1 shows, on average the children in the demonstration group spent a shorter time in foster care.

Table 1. Comparison of Days Spent in Foster Care in Delaware

Number of Children	Demonstration Group	Control Group
Number of children in each group who entered out-of-home placement	126	106
Average number of foster care days for children who entered out-of-home placement	204	294

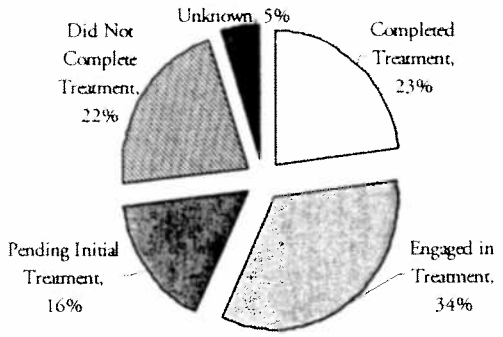
Source: Dorothy Dillard Lockwood. *Delaware Title IV-E Waiver Demonstration Project Report*, 2002.

Delaware examined its program's ability to engage and keep parents engaged in treatment. The state found that it had linked to substance abuse treatment about one third of families served, a nearly 100 percent increase compared to before they implemented multidisciplinary team treatment.[6] Delaware also found that, on average, the control cases remained open for six months longer than the demonstration cases.

To determine how long children spent in foster care, Illinois measured the length of time from case opening to case closing for the 122 children in the demonstration group and the 33 children in the control group who returned home with their parents. The results do not include children who were adopted or who entered guardianship. The children in the demonstration group had an open case for an average of 294 days, while the children in the control group had an open case for an average of 436 days. In addition, Illinois evaluated whether treatment services supported family reunification. The state found a statistically significant difference: as of December 2003, 10 percent of demonstration group children were living with their parents, as compared to 6 percent of the control group.[7]

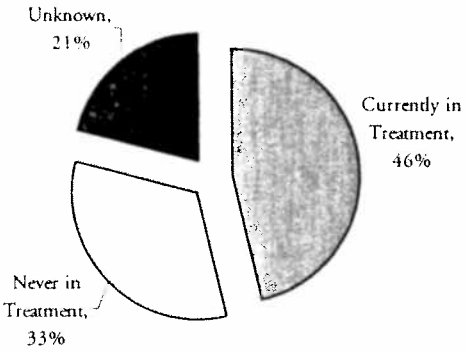
Illinois achieved even greater success with engaging parents in treatment. As illustrated in figures 1 and 2, the demonstration group was more likely to access treatment than the control group. Only 46 percent of the control group was engaged in treatment as of December 2003, while 73 percent of the demonstration group had completed, was engaged in, or was awaiting the start of treatment programs.

Figure 1. Demonstration Group Treatment Records as of December 2003



Source: Bryan Samuels, *Semi-Annual Progress Report: November 2003 - May 2004: Illinois Alcohol and Other Drug Waiver Demonstration*, 2004.

Figure 2. Control Group Treatment Records as of December 2003



Source: Bryan Samuels, *Semi-Annual Progress Report: November 2003 - May 2004: Illinois Alcohol and Other Drug Waiver Demonstration*, 2004.

The demonstration group also accessed treatment more quickly: 40 days after their court assessment, 50 percent of demonstration group caretakers had their first treatment episode and were in contact with recovery coaches, while 100 days passed before 50 percent of the control group completed one treatment episode.[8]

New Hampshire also discovered that the demonstration group experienced shorter stays in foster care (513 days compared to 616 days). However, since New Hampshire provides treatment services earlier than other programs, fewer children had been removed from the home during the evaluation, and the number of children assessed was much smaller than the other programs. The state's results are based on only 17 children in the control group and 15 children in the demonstration group who had been removed from home.[9] New Hampshire also hypothesized that DCYF would receive fewer subsequent referrals for child abuse and neglect investigations for families that accessed LADAC services and this was confirmed. A lower percentage of cases were reopened for investigation for the group that received LADAC services, and a lower percentage of those cases were confirmed in court to be abuse or neglect.[10] In addition, New Hampshire discovered that children ages 4 to 17 in the LADAC group had greater declines the following problem behaviors: anxiety and depression, withdrawn/depressed behavior, somatic problems, attention problems and aggressive behavior.[11] One DCYF attorney affirmed, "This program works so much better at all levels—the court, administrative offices, and child protective services—when the parent's recovery is taken into consideration."[12]

All states experienced some degree of savings. A direct comparison of states' savings is difficult, because each program used different numbers of participants in the control and demonstration groups overall, and each state had dissimilar initial program costs. Delaware found that the demonstration cost almost 38 percent less than costs associated with the control group and saved $655,000.[13] The state acknowledges in its final report that some of the differences in cost are attributed to large sibling groups (three or more children) in foster care and to group home costs. One-fifth (21 percent) of the demonstration foster care costs were spent on large sibling groups and group home costs, while more than half (52 percent) of the control group's foster care costs were expended on large sibling groups and group home costs. As of September 2003, Illinois had a 4.2 percent savings of almost $1 million. Illinois served 1,165 clients

through the first half of fiscal year 2004, with more than twice as many clients in the demonstration group (831) than in the control (334) group.[14] As of August 2004, New Hampshire had a 23 percent savings of almost $300,000. New Hampshire's savings are based on 201 participants, with 101 in the demonstration group.[15]

Although these programs were successful, states confronted some barriers. Most obstacles were related to the time required to complete treatment and to the complexities inherent in chronic substance abuse disorders.

- Delaware's initial proposal estimated that AOD counselors would work with clients for three months; however, the average time required was closer to nine months. In addition, although collaboration was mostly positive, it took a significant amount of time to increase the DFS caseworkers' knowledge of substance abuse and AOD counselors' knowledge of child safety issues. Their experience underscored the need for ongoing education and training for both groups.
- Although family reunification rates increased in Illinois after recovery coaches were hired, the rates were low. One possible explanation is that working toward reunification takes more time; chronic alcohol and drug addiction is a deeply rooted, relapsing disease that requires time, patience and very concentrated resources to address.
- Only a small percentage of child abuse and neglect cases are actually referred to New Hampshire courts. Officials noted that some substance-abusing adults do not realize they need services unless there is court involvement. All interventions depend on parental cooperation. Interventions may be short-term and sporadic and, as a result, may be difficult to track.
- Some federal limitations exist for obtaining a waiver. Previous child welfare regulations required that new waiver proposals be unique; one state waiver application could not duplicate another state's efforts. In the last round of child welfare waivers, however, the Department of Health and Human Services indicated that it would consider proposals that replicated interventions being tested elsewhere.[16] Congressional provisions that would reauthorize the child welfare waivers and would put into statute such flexibility have not yet been acted upon.

Conclusion

The child welfare demonstration programs contribute to a growing pool of effective strategies for serving substance-abusing families in the child welfare system. A recent a survey of all parents involved in Delaware's child protective services discovered that 51 percent of respondents had a substance abuse problem at that point in time. Joann Bruch commented, "This is astronomical. There must be a way to address such a prevalent problem. For us, the answer is co-locating [child welfare and substance abuse services]. This gets clients into treatment faster and we can see that the program benefits both children and parents."[17]

The child welfare demonstration projects reveal better outcomes for children, lower rates of cases reopening, and reduced time in foster care. Incorporating substance abuse treatment into child welfare programs improves services offered to families and, as parents access and complete treatment, may have a lasting effect on the quality of families' lives. Professionally trained substance abuse counselors provide greater insight into parents' complicated substance abuse issues and the level of trauma that children and parents have been exposed to throughout their addiction history, enhancing the system's ability to tailor services to meet families' needs.

Substance abuse specialists' perspective is valuable in the case review process as child welfare agencies and courts increasingly view substance abuse as an important factor in making decisions about foster care placement, treatment plans and case closures.

Moreover, savings were notable. Delaware demonstrated that, with specialized substance abuse services, resistance to treatment is reduced, treatment entry is facilitated, and reliance on foster care is reduced. New positions paid for themselves with saved foster care costs.[18] The programs continue to receive funding; in 2003, the Delaware legislature provided funds to expand the program, and the Administration for Children and Families issued another announcement for states to apply for waivers for fiscal year 2004 demonstrations. The experiences of Delaware, Illinois and New Hampshire provide an incentive for other states to develop strategies to improve the delivery, effectiveness and efficiency of such services for vulnerable families.

For more information about state Child Welfare Demonstration Projects:

•*Delaware Department of Services for Children, Youth and Families, Division of Family Services*
(302) 633-2500
http://www.state.de.us/kids/fs.htm

•*Illinois Department of Children and Family Services*
(217) 785-2509
http://www.state.il.us/dcfs/index.shtml

•*New Hampshire Department of Health and Human Services, Division for Children, Youth and Families*
(603) 271-4451
http://www.dhhs.state.nh.us/DHHS/DCYF/default.htm

Notes

1. Sidney L. Gardner, "A Critical Link: Substance Abuse Issues in Family to Family Efforts" (presentation at the Children and Family Futures, Family to Family California Conference, California, June 2004).

2. Maryland received a waiver as well, but the state terminated the program due to an insufficient number of referrals for alcohol and other drug treatment.

3. Joann Bruch, Delaware treatment program manager, phone conversation with author, July 30, 2004.

4. Sam Gillespie, AODA services manager, phone conversation with author, July 30, 2004.

5. Bernard Bluhm, DCYF program manager, phone conversation with author, July 29, 2004.

6. Dorothy Dillard Lockwood. *Delaware Title IV-E Waiver Demonstration Project Report* (Wilmington: Department of Services for Children, Youth and Families, Division of Family Services, 2002).

7. Bryan Samuels, *Semi-Annual Progress Report: November 2003 – May 2004: Illinois Alcohol and Other Drug Waiver Demonstration* (Chicago: Department of Children and Family Services, 2004).

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9. Bernard Bluhm, Ann Marie Olsen and Glenda Kaufman Kantor, *Project First Step: Title IV-E Child Welfare Demonstration Project Progress Report* (Concord: Department of Health and Human Services, Division for Children, Youth and Families, March 2004).

10. Ibid.

11. Estelle Accalla, Bernard Bluhm and Glenda Kantor, "Parental Substance Abuse and Child Maltreatment: Evaluation Results from Project First Step, New Hampshire IV-E Waiver Project" (presentation at the first National Conference on Substance Abuse, Child Welfare and the Dependency Court, Baltimore, Md., July 2004).

12. Bernard Bluhm, DCYF program manager, phone conversation with author, July 29, 2004.

13. Dorothy Dillard Lockwood. *Delaware Title IV-E Waiver Demonstration Project Report.*

14. Bryan Samuels, *Semi-Annual Progress Report: November 2003 – May 2004: Illinois Alcohol and Other Drug Waiver Demonstration.*

15. Bureau of Administrative Operations, *Project First Step Analysis* (Concord: Department of Health and Human Services, Division for Children, Youth and Families, May 2004).

16. Refer to http://www.acf.hhs.gov/programs/cb/laws/im/im0306all.pdf to access the Department of Health and Human Services memorandum suggesting that increased flexibility would be considered in states' child welfare waiver applications.

17. Joann Bruch, Delaware treatment program manager, phone conversation with author, July 30, 2004.

18. Dorothy Dillard Lockwood. *Delaware Title IV-E Waiver Demonstration Project Report.*

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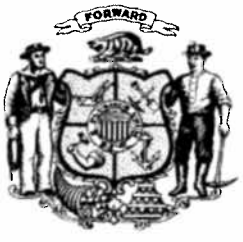
FORWARD

Foster care system to get close look

By JAMAAL ABDUL-ALIM
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Judgment day is drawing near for Wisconsin's foster care system.

Federal officials will be in Milwaukee County and two other Wisconsin counties this week to conduct a Child and Family Services Review that is called for by federal law. Wisconsin is among the dozen or so states that have yet to undergo the reviews by the U.S. Department of Health and Human Services.

As part of the review, teams of federal and state reviewers will pore over case files and interview various "stakeholders" to learn how well the system is doing at ensuring the safety and well-being of the children it serves.

U.S. inspectors to review cases in 3 Wisconsin counties; federal law requires it

Don't be alarmed if the state doesn't pass with flying colors.

Thus far, just about every state that has undergone the review — which is meant to determine whether states are in "substantial conformity" with federal rules that govern foster care — has been found to be deficient in one or several areas, those familiar with the reviews say.

"Nobody fails on all points," said Bill Grimm, a foster care expert and senior attorney at the National Center for Youth Law in Oakland, Calif. "But virtually every state needs improvement in some areas. I don't think Wisconsin will be any different."

Please see RE

MJS 8-18-03

State foster care system to get close look

REVIEW, From 1B

Indeed, a state assessment done to prepare for the federal review found weaknesses in the areas of stability of placements, quality assurance and how long it takes to get children adopted.

However, the assessment indicated that one strength of the system is that it has low re-entry rates, meaning that children who are reunited with their families are not winding up in foster care again.

For this week's federal review, 50 cases will be examined statewide. Of those, 26 will be cases in Milwaukee County, where there are roughly 4,000 children in foster care. The remaining 24 reviewed will be 12 cases each in Outagamie and Kenosha counties.

Despite the relatively small number of cases, the review is thorough enough to provide a good sense of how well foster care systems in Wisconsin are doing, Grimm said. He said federal reviewers are examining paperwork and making sure each child has a plan in place, but they are also asking questions about the child and the family's well-being.

About a month after the Wisconsin review is done, the federal government will issue a report based on its findings. Then the state must submit a "Program Improvement Plan." Once that is approved by the federal government, the state will be asked to submit periodic reports on how well it is doing at implementing the improvement plan.

If the state fails to meet the goals of the plan in the two-year period that follows, the state could face financial penalties in the form of the withholding of federal foster care funds.

State officials say they are more focused on correcting any problems than worried about the penalties.

"We're not focusing on what the penalty aspect of this is," said Kitty Kocol, administrator of the state Division of Children and Family Services.

"We're looking at this process as a way of doing the best we can and the best we know how in terms of making sure the kids are safe and that families are doing well."

Denise Revels Robinson, director of the state-run Bureau of Milwaukee Child Welfare, said she welcomes the review.

"It's an opportunity for us to learn," Revels Robinson said. "It may confirm things we already know. It may also highlight some things we need to see differently."

Feb. 9, 2004

Pressure mounts to get neglected kids back home or adopted

Failure to meet federal timetable could cost the state $1.4 million

By MARY ZAHN
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As a wall clock ticks away, a court commissioner, social workers and attorneys sit around a table at Milwaukee County Children's Court to discuss whether parental ties to abused or neglected children should be severed forever.

On this particular day, court authorities are urgently reviewing the case of David, 4, who was born addicted to cocaine.

Time is of the essence.

Wisconsin was notified last month that it is the 43rd state to fail a federal review of its foster care system that set new, quicker timelines for when children need to be freed for adoption or returned home.

The results, which will be officially released today, could cost the state $1.4 million in penalties if the shortcomings are not corrected.

"It's a very big deal," said Charity Eleson, executive director of the Wisconsin Council on Children and Families. "There are real risks here for kids, but also real risks for the state in terms of funding losses. The feds are not going to be issuing any new dollars to deal with this."

David's case is not unusual. His mother is a longtime addict, and his father has a history of violence. There are no other relatives willing to take him, and David's foster mother is not interested in adoption.

In past decades, thousands of children like David languished in foster care — sometimes being abused and neglected again — as their childhood vanished. The federal law, called the Adoption and Safe Families Act of 1997, was aimed at ending that.

In general, the law requires that abused or neglected children be freed for adoption or returned home within 15 months, unless they have been placed with family members or authorities can document that severing parental ties will not be good for the child.

WHY?

Some factors cited in the state's failure to meet federal rules requiring quicker timelines for freeing foster children to be adopted or returned home:

- A continuing shortage of foster homes and adoptive homes
- A lack of drug, alcohol and mental health services
- High caseloads
- Budget cuts and lack of state funding.

The quicker timelines must be met in 100% of the cases, under federal rules — a standard that Wisconsin and all of the other states reviewed to date have failed to meet. The state has two years to show improvement before facing penalties, authorities said.

"The good part of the review is it is identifying what is needed," said Don Maurer, manager of the intake and support services division of the Waukesha County Department of Health and Human Services. "The downside is are we going to get what we need to get there? The common concerns around counties is — universally — resources, resources, resources."

State and county officials have been meeting for months in anticipation of the bad report card set against a backdrop of budget deficits.

Please see **ADOPTION, 7A**

ADOPTION, From 1A

A continuing shortage of both foster homes and adoptive homes along with a lack of drug, alcohol and mental health services, high caseloads and budget cuts were repeatedly mentioned in an informal survey by the Journal Sentinel of 12 other counties in the state.

The federal review notes a shortage of services to both parents and children tied up in the foster care system and states that a "key concern" by people interviewed was the lack of state funding to address the problems.

■ ■ ■

In Milwaukee County Children's Court, the impact of these costly decisions is clear.

A reporter recently watched as a little girl dressed in all white joyfully hugged her new adoptive parents, grinning broadly as they hugged her back.

Minutes later in the same courtroom, intense sorrow.

Mary, who struggled with drug abuse for years, voluntarily gave up her 11-year-old daughter to a loving foster family. She has one last tearful request: Can she see her child one last time?

"That was a wonderful thing you did," an assistant district attorney whispered to her after the hearing. "It shows how much you love her."

Mary began to sob, grabbed her coat and left the courtroom.

tion is the answer is simply not true."

Cathy Swessel, vice president of out-of-home care for the Children's Service Society, which has handled adoptions for Milwaukee County since September 2001, said her agency has begun a follow-up study to find out how many of these adoptions are failing and why.

"We just want to know," she said. "These are often troubled kids. They are not easy placements. And once the case is finalized, the family no longer has a social worker to help them."

Swessel said about 85% of the foster child adoptions are by the child's foster family or relatives. Nationally, about 10% to 16% of adoptions of foster children fail, she added.

■ ■ ■

The shiny faces of children who are being placed into adoptive families earlier than ever before are evidence that, for some, the child welfare system is succeeding.

Tyrone, 6, is one of them. A frail-looking boy, his feet dangle from the chair as he looks up at Children's Court Judge Joseph Wall. Born with cocaine in his system, Tyrone was detained at 8 months old, after his almost 3-year-old brother was found wandering the streets and Tyrone was found to have suspicious burns on his arms and legs. His brother, Michael, now 8, has been transferred from fos-

ON JSONLINE.COM

Go to **www.jsonline.com/links/child-audit** to read the complete federal review of Wisconsin's child welfare services and to **www.jsonline.com/links/child-state** for the state's summary of the report.

Clock ticking on serving foster children

MILWAUKEE JOURNAL SENTINEL

ter home to foster home because of aggressive behavior and has no one willing to adopt him. As Tyrone's adoption is finalized, he sits between his new parents and looks relieved. His mother's hand never stops stroking his hair.

■ ■ ■

Fewer children like Tyrone are ending up in foster care in recent years, and those who do are returning home quicker, authorities said and records show.

State records show that in 2003, about 8,200 abused or neglected children were living in foster homes or in court-ordered placements with relatives. Of those, about 3,489 were from Milwaukee County. That compares with 11,348 children in those placements statewide in 1999, with about 6,778 from Milwaukee County.

In Milwaukee County Children's Court, parents now receive the final court order listing what they have to do to have their children returned within 68 days of their child's removal, as opposed to 171 days several years ago.

Typically, those orders require things such as parenting classes, a safe and suitable home, psychological evaluations, and drug and alcohol treatment before children can be returned home. These services are often provided to parents by caseworkers within days of their children being removed from the home and before any formal court hearings, officials said.

Concerted efforts are also now being made to find the fathers of the children in the hope they might be placed with other family members, as opposed to strangers, said Chief Children's Court Judge Christopher Foley.

15 months to succeed

Still, serious questions are being raised about whether poor parents can meet the conditions of return within the 15-month window and whether they are being offered adequate services.

"Fifteen months is an incredibly short period of time if you or I have some drug abuse issues," said Milwaukee County Children's Court Commissioner Lindsey Draper. "We tell them, 'OK, we have you on the waiting list. Meta House (treatment facility for women) can take you in 3 months.'

"First off, that is 20% of the 15 months right there before we even get you in treatment," Draper said. He added that it is not uncommon to require six months of drug testing to make sure a parent has not relapsed, leaving little time left to complete other conditions of a child's return before the 15 months is exhausted.

"Unless you can show a compelling reason why a termination of parental rights shouldn't be filed, you may lose your children," he said.

Many poor people do not have telephones and have to make appointments for all kinds of services without a callback number, which also causes delays, he said.

A significant number of women involved in the child welfare system are also involved with the W-2 system, said Tamara Grigsby, program manager for the Wisconsin Council on Children and Families. If all of their children are taken away, they will lose their financial grant and may not be able to pay their rent and maintain a home, which is almost always a condition of return, she added.

"The deficits of the parents we are seeing now are greater," Malmstadt said. "The whole drug thing — how do you rehabilitate or reunite a family when you have a woman who is 20 with five kids and is addicted to crack cocaine and dropped out of school functionally in the sixth grade? A lot of people will say take those children away from those parents, and I understand that as being their first reaction. But what it doesn't take into account is that the children have a strong tie to those parents."

David Titus, director of the Dodge County Human Service and Health Department who also serves on the state child welfare executive steering committee, said almost all of the counties agree philosophically with the federal law but don't know where the additional resources to meet new federal standards will come from.

"In the last couple of budget cycles, we've had to eliminate a supervisor position in child welfare," Titus said. "We've had to discontinue some in-home treatment service programming that focused on keeping families intact once a child was returned home. We've had to discontinue funding to crisis/emergency services — programming used by our child welfare intake staff to get into the family and defuse the crisis. We've seen cost overruns in counseling accounts. Those expenses are made up by cutting other services."

■ ■ ■

Hidden between the budget cuts and legal timelines are people like Joanna, who sat numbly in a Milwaukee courtroom recently. She had a black knit cap pulled over her ears and what looked like an overnight bag next to her. She is a few hearings away from having her parental rights terminated.

Joanna was living from shelter to shelter when her son and daughter were taken away more than two years ago. She has no job skills and little education. Her son, who is now 13, is having behavior problems and was being moved from foster home to foster home. She stopped visiting him last year but has continued to visit her 7-year-old daughter, who is also being moved to another foster home because of behavior problems.

Records show that among the services provided Joanna were counseling and bus tickets. She was also placed on a waiting list for unemployment services.

After the hearing, she quietly asked a caseworker if her son wanted to see her.

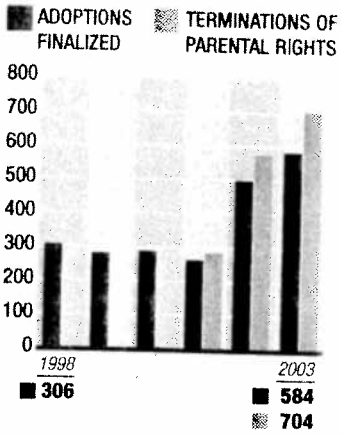
She was told he did not.

MILWAUKEE COUNTY

ADOPTIONS ON THE RISE

After passage of a federal law intended to shorten the time that children spend in foster care, adoptions of children in foster care in Milwaukee County rose from 263 in 2001 to 584 last year. At the same time, terminations of parental rights rose from 286 to 704.

ADOPTION PROGRAM ACTIVITY 1998 THROUGH 2003



Termination data for 1998 through 2000 not available

Source: Milwaukee County district attorney's office and state Bureau of Milwaukee Child Welfare

Journal Sentinel

■ ■ ■

The federal law has had a huge impact. Nationally, foster care adoptions increased 78% from 1996 to 2000, records show. In Milwaukee County, those adoptions have gone from 281 in 1999 to 584 last year. Statewide, the total has gone from 654 to 1,150 in that same period.

There are also financial incentives. States that increase the number of adoptions of kids in foster care over the previous year are paid bonuses from the U.S. Department of Health and Human Services. Last year, Wisconsin received $1,158,000, records show. Nationally, $14.9 million was paid to 25 states and Puerto Rico.

Some adoptions don't work

Meanwhile, court observers in Milwaukee County and others around the state are anecdotally reporting what they believe might be an increase in the number of failed adoptions involving foster children.

"We are being pressured to do more adoptions, and that is a good thing," Milwaukee County Children's Court Judge Michael Malmstadt said. "But is the solution to go out and recruit just about anybody to adopt? Should you have somebody in their mid-60s adopting a 4-year-old kid? Some of these cases are coming back because people who adopt a happy little 6-year-old eight years later have an unhappy little 14-year-old."

There are no hard numbers on failed adoptions because the cases are not tracked once the adoption becomes final.

However, when asked by a reporter, authorities at the Milwaukee County Children's Court Center were able to identify 48 cases in the past two years where permanent adoptive or guardianship placements failed. In those cases, the children bounced back into the foster care system after being abused or neglected or because their adoptive parents no longer wanted them because of escalating behavior problems.

Some of those cases include:

■ Four children who were beaten with belts by their adoptive father.

■ The adoptive parent of a 14-year-old who could no longer handle his violent behavior.

■ An adoptive father who sexually assaulted two of his adoptive sons.

■ The adoptive mother of an 11-year-old girl who wanted her out of the home after the girl began assaulting the woman's birth children.

"Every county in the state can probably point to many adoptions that were failed adoptions," said Robert Haupt, director of Ozaukee County Social Services and secretary of the Wisconsin Counties Human Services Association. "Or where supportive services were pulled out from underneath the parent and it ended up not working, or costing a lot of money anyway. Just to say that permanency via adop-

State to scramble for funds to improve child welfare

By MARY ZAHN
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State and local child welfare authorities will be scrambling to find additional money and will be proposing new initiatives to bolster Wisconsin's child welfare system after a federal review that said the state was doing an inadequate job of protecting and providing services to children in foster care, a top state official said Friday.

"This really matters," said Helene Nelson, secretary of the state Department of Health and Family Services. "Every single case tugs your heartstrings. If it doesn't make you weep, it makes you mad.

"There's no question we are talking about families with very complicated needs and that we are challenged by the federal standards and timelines and our resources. On the other side, we have to welcome the challenge because it's critical for the kids."

Wisconsin was notified last month that it is the 43rd state to fail a federal review of its foster care system that set new, quicker timelines for when children need to be freed for adoption or returned home.

The results, which will be officially released today, could cost the state $1.4 million in penalties if the shortcomings are not corrected.

Nelson said her department would be making recommendations this spring for additional dollars for "targeted programs" to improve the state's child welfare system. In addition, she said, officials will look at ways to better use money they already have and may look at statutory changes to reduce county social worker caseloads.

For example, she said, child protection services are charged with investigating abuse by strangers outside the home.

"Should that be a matter for police to investigate, or should that be a child protective matter?" Nelson said. "So that's the question of statutory definitions."

Additional money needs to be part of the solution, she said. The new federal law provides states with no new dollars to address the shortfalls found in the reviews, she said.

In August, a team of federal reviewers looked at 50 randomly selected cases from Milwaukee, Kenosha and Outagamie counties and reviewed statistical child welfare data submitted by the state. Children, parents, foster parents and all levels of state and local child welfare personnel were also interviewed.

Among the other findings:

■ Services offered were not sufficient to ensure children's safety while they remained in the home. In some cases, children were not being removed where risk of harm was present.

■ Many newly hired caseworkers are assigned caseloads before completion of a training program. The state does not have statewide requirements for staff to participate in ongoing training. In addition, the state requires neither pre-placement nor ongoing training for foster parents and, in some counties, foster parents receive minimal training before having a child placed in their homes.

■ The state does not have an array of services in place to address the needs of children and families to enable children to remain safely with their parents when reasonable and to help children in foster and adoptive homes "achieve permanency."

■ Even when fathers are involved in their children's lives, local agencies do not make concerted efforts to include them in case planning.

■ Children are not receiving mental health assessments even when the family and child's history indicate they are warranted.

■ The state does not have a quality assurance system that "has the capacity to evaluate the quality of services, provide relevant reports, or evaluate the implementation of program improvement measures."