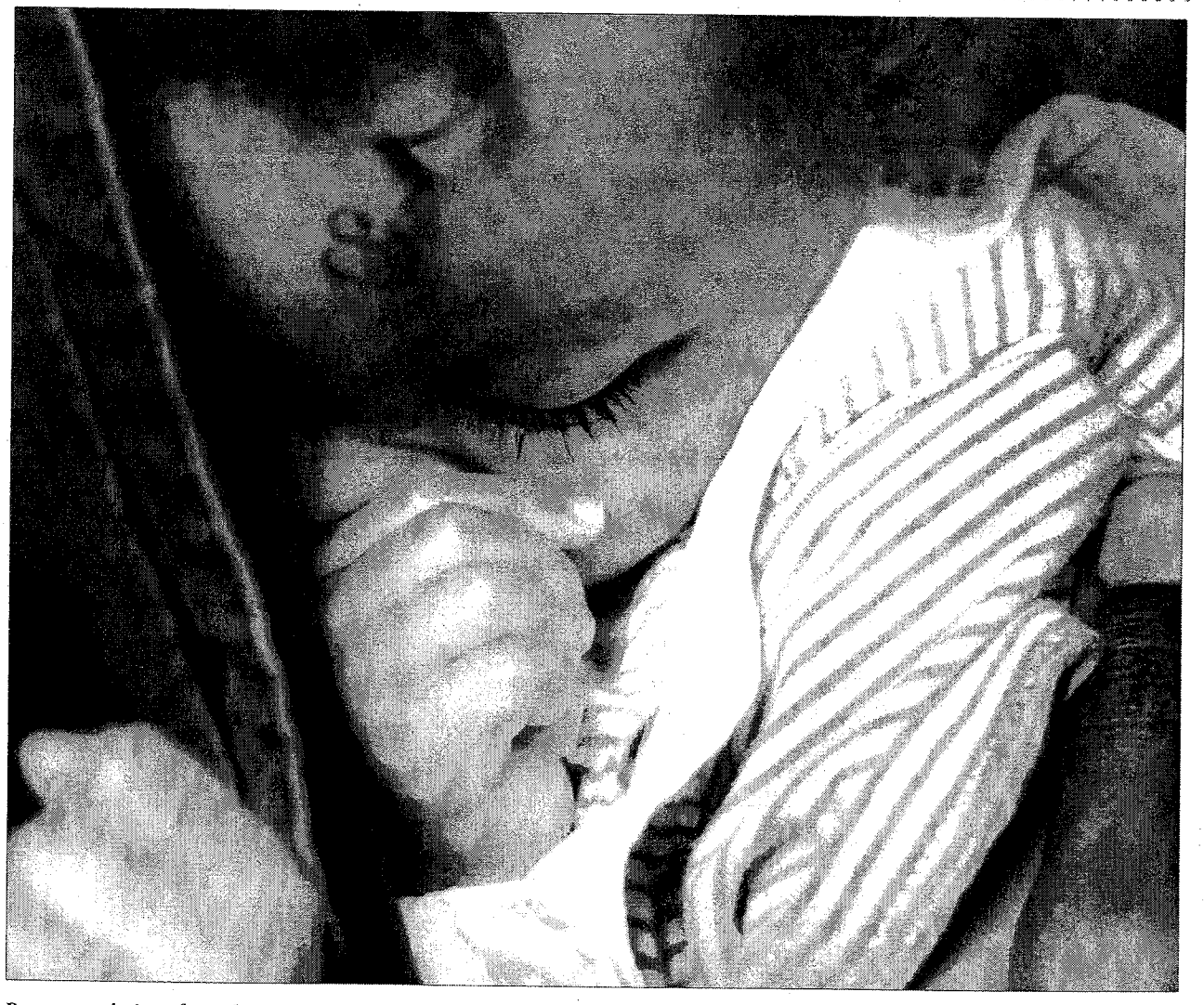
2006

WISCONSIN'S STATE PLAN TO PREVENT CHILD MALTREATMENT



Recommendations from the State Call to Action Workgroups and Governor Jim Doyle's Summit to Prevent Child Abuse and Neglect

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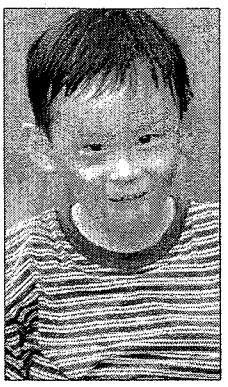


A STATE CALL TO ACTION

Working Together to End Child Abuse and Neglect in Wisconsin

ACKNOWLEDGEMENTS

Hundreds of professionals have made room in their busy schedules to contribute to this initiative.

Wisconsin's State Call to Action to Prevent Child Abuse and Neglect would not be possible without the time, energy, and commitment of individuals and organizations throughout the state. Hundreds of professionals have made room in their busy schedules during the past 2 years to contribute to this initiative—whether helping to plan Governor Jim Doyle's Summit to Prevent Child Abuse and Neglect, serving on a workgroup to develop the recommendations that appear in *Wisconsin's State Plan to Prevent Child Maltreatment*, or forging new partnerships to better serve children and families in Wisconsin communities. With the publication of the *State Plan*, we hope the groups of contributors and partners at the state and local level will continue to grow.

For the past year, a smaller group of individuals have focused on organizing the work done on the State Call to Action into the *Wisconsin State Plan to Prevent Child Maltreatment*. More than 120 committed workgroup members lent their time and energy to formulate the diverse and exciting recommendations that make up the body of the *State Plan*. The co-chairs of all six workgroups, each of whose daily work is dedicated to improving conditions for the children of Wisconsin, made an extraordinary commitment to convene, facilitate, and report on the efforts of their respective workgroups. We are grateful to the workgroup members and co-chairs for their commitment and are inspired by the vision they helped shape.

Supporting the workgroups and compiling their results into this *State Plan to Prevent Child Maltreatment* was the task of the sponsoring agencies. We and our staff colleagues attended workgroup meetings, provided in-kind and financial support when needed, convened meetings, and provided training for the co-chairs. A special thanks to Cailin O'Connor of the Children's Trust Fund, who spent countless hours compiling the workgroup reports into a *State Plan* with a common vision and voice. Credit is also due Norma Sampson, Children's Trust Fund, for designing this report. We extend our appreciation to our boards of directors for their support of our efforts to improve children's lives by preventing child maltreatment.

As the Steering Committee for the State Call to Action to Prevent Child Abuse and Neglect, we will promote, monitor, and support the implementation of the *State Plan's* recommendations, and seek new partners and champions for the various initiatives outlined here. Please join us in making Wisconsin a safe place for children to grow and thrive.

Mary Anne Snyder
Executive Director
Children's Trust Fund

Jennifer Hammel
Director
Child Abuse Prevention Fund
of Children's Hospital
and Health System

Patti Herman
Executive Director
Prevent Child Abuse Wisconsin

EXECUTIVE SUMMARY

Unless someone like you cares a whole awful lot,

Nothing is going to get better. It's not.

***The Lorax* by Dr. Seuss**

A STATE CALL TO ACTION

Working Together to End Child Abuse and Neglect in Wisconsin

Child maltreatment—encompassing physical, emotional, and sexual abuse as well as physical and emotional neglect—is an everyday tragedy for thousands of children in Wisconsin. In addition to the devastating immediate effects of abuse and neglect on a child's physical and emotional health, maltreatment has effects that are long-term and far-reaching, not only for children and their families, but also for society. It is time for all of us who care about children's well being to rethink how we work with children and families. This means making a commitment to invest in prevention, expand proven strategies, and implement new approaches to the prevention of child maltreatment.

In recent years, at the national level and in several states, coalitions of government agencies, nonprofit organizations, advocates, and families have come together to formulate a new approach to child maltreatment prevention. Initiated in 2004, the Wisconsin State Call to Action is spearheaded by a public-private partnership of the Wisconsin's Child Abuse and Neglect Prevention Board (also known as Children's Trust Fund), the Child Abuse Prevention Fund of Children's Hospital and Health System, and Prevent Child Abuse Wisconsin .

With support from Governor Jim Doyle and leaders from both sides of the aisle in the state Legislature, as well as participation from all of the major state agencies whose work affects children and families, the State Call to Action is a bipartisan, statewide effort intended to:

- Raise awareness of the human and economic costs of child abuse and neglect;
- Propose short- and long-term child abuse and neglect prevention strategies; and
- Strengthen public will, resources, and community capacity to prevent child abuse and neglect.

The first phase of the State Call to Action was the combined work of 160 participants in the April 2004 Governor's Summit to Prevent Child Abuse and 443 people who attended web cast discussion forums held across the state. They brainstormed, shared experiences, and generated hundreds of ideas about strategies to make child maltreatment prevention more effective in Wisconsin.

From this input, six areas of concern were selected to be the focus of the State Call to Action. In Phase 2, between October 2004 and March 2005, workgroups in each of those six areas formulated specific recommendations for short- and long-term implementation. The recommendations of those six workgroups make up Phase 3, *Wisconsin's State Plan to Prevent Child Maltreatment*. The recommendations are listed here, following descriptions of the workgroups that generated them.

Recurring ideas indicate an emerging consensus about priority strategies.

The *State Plan* includes recommendations that can be enacted at the state and local level, as well as legislative changes that would pave the way for some state and local initiatives. Several recommendations appear more than once, and others overlap with one another. These recurring ideas, arrived at independently by multiple workgroups, indicate an emerging consensus about priority strategies coming out of the State Call to Action.

The Workgroups and Their Recommendations

- **Uniform, Comprehensive Systems of Family Support.** Family support is an investment in the creation of happy, healthy, and productive citizens, and is effective in preventing child abuse and neglect and in reducing the stresses that contribute to child maltreatment. All families should have access to family support systems in communities throughout Wisconsin.

  Recommendation 1.1: Establish multidisciplinary local community coordinating councils throughout Wisconsin to build non-stigmatizing systems of prevention that promote a culture where all families receive support

  Recommendation 1.2: Establish a universally accessible continuum of family support in all communities in Wisconsin, beginning before or at the birth of an infant and available, as needed or desired by the family, throughout the child's growth and development

  Recommendation 1.3: Expand to all communities in Wisconsin an intensive, evidence-based home visiting program that makes available ongoing support services for challenged, new families and their infants and young children

  Recommendation 1.4: Build a system of Family Response Teams in Wisconsin counties to foster critical circles of support for challenged families and children

- **Family Economic Success.** Stressors stemming from poverty and the inability to meet basic needs put children and families at increased risk for abuse and neglect. Both at a policy level and in approaches to supporting individual families, Wisconsin can take steps to alleviate those stressors.

  Recommendation 2.1: Raise the minimum wage in accordance with the Governor's Minimum Wage Council

  Recommendation 2.2: Increase awareness of, access to, and the amount received of federal and state tax credits for low-income families

  Recommendation 2.3: Increase access to Wisconsin SHARES child care assistance for parents pursuing educational programs

  Recommendation 2.4: Increase eligibility for BadgerCare

  Recommendation 2.5: Support innovative approaches to increasing employer provision of health insurance

Mental Health and Substance Abuse. Adults who struggle with issues of mental health and substance abuse are faced with significant challenges to their ability to parent and nurture children in their care. Both substance abuse and mental health have a major impact on the child welfare system.

Recommendation 3.1: Support the development of local collaboratives to implement evidence-based or promising practices for child abuse and neglect prevention targeted at families where the parent has a mental illness or substance abuse disorder

Recommendation 3.2: Implement universal and targeted home visiting statewide in Wisconsin

Recommendation 3.3: Enact mental health and substance abuse parity in commercial insurance to improve access to treatment services

Recommendation 3.4: Increase Medicaid reimbursement for mental health and substance abuse assessment and treatment

Recommendation 3.5: Provide additional funding to address the stigma associated with mental illness and substance abuse disorders

Recommendation 3.6: Create state-level policies that focus on enhancing parenting among adults with mental illness and substance abuse disorders

Child Abuse and Domestic Violence. Independent of one another, child abuse and domestic violence can endanger children, impair development, and lead to long-term negative outcomes. The co-occurrence of domestic violence and child abuse compounds even further the negative effects children are likely to experience in the short-term and over their lifetime.

Recommendation 4.1: Establish and distribute multidisciplinary training grants for agencies working on the intersection of domestic violence and child abuse and neglect

Recommendation 4.2: Promote and support the development of multidisciplinary teams in Wisconsin communities

Recommendation 4.3: Improve training for law enforcement related to children on the scene of domestic violence

Children's Mental Health. Many children suffer from organic mental illnesses and have loving and devoted families, but their parents often need support to help them cope with the special needs of their child. These families should have access to quality mental health care as well as support for parents and caregivers.

Recommendation 5.1: Increase the availability of respite care services for families that include children with mental, emotional, or behavioral disorders

Recommendation 5.2: Increase the availability of parent-to-parent support systems, including advocacy, for families that include children with mental, emotional, or behavioral disorders

Recommendation 5.3: Promote and implement collaborative systems of care to provide comprehensive mental health screening, assessment, early intervention, and treatment

Recommendation 5.4: Institute policies and structural changes to expand collaboration within and across state agencies

Recommendation 5.5: Implement evaluation systems to determine the efficacy of children's mental health programs

Recommendation 5.6: Address workforce shortages among mental health care providers

Recommendation 5.7: Enact mental health insurance parity

Child Sexual Abuse Prevention. Currently, the majority of programs addressing child sexual abuse in Wisconsin focus their efforts on educating children, instead of emphasizing adult responsibility to protect children and seek treatment. New approaches are needed to strengthen families and communities in preventing or stopping child sexual abuse.

Recommendation 6.1: Design and launch a child sexual abuse prevention initiative to be implemented throughout Wisconsin, using community and statewide resources

Next Steps in the State Call to Action

Moving from the drafting of a *State Plan* to changes in how Wisconsin works to prevent abuse and neglect of children will not take place overnight, nor will it be a centralized process. Some recommendations will be taken up and implemented on a large scale; others will be implemented at the local level, depending on each community's needs and readiness. Ultimately the success of the State Call to Action will rest on each of us—community members and leaders, at all levels—strategically implementing recommendations in our communities, in our agencies and organizations, and in our interactions with families.

The success of the State Call to Action rests on each of us—community members and leaders, at all levels.

The Steering Committee for the State Call to Action will continue to promote and monitor the implementation of the *State Plan* at all levels. During 2006, several conferences will offer training that focus on *State Plan* recommendations. Details about these conferences will be posted on the Call to Action website at http://wctf.state.wi.us. The Steering Committee will also advocate making funds available at the state level to support implementation.

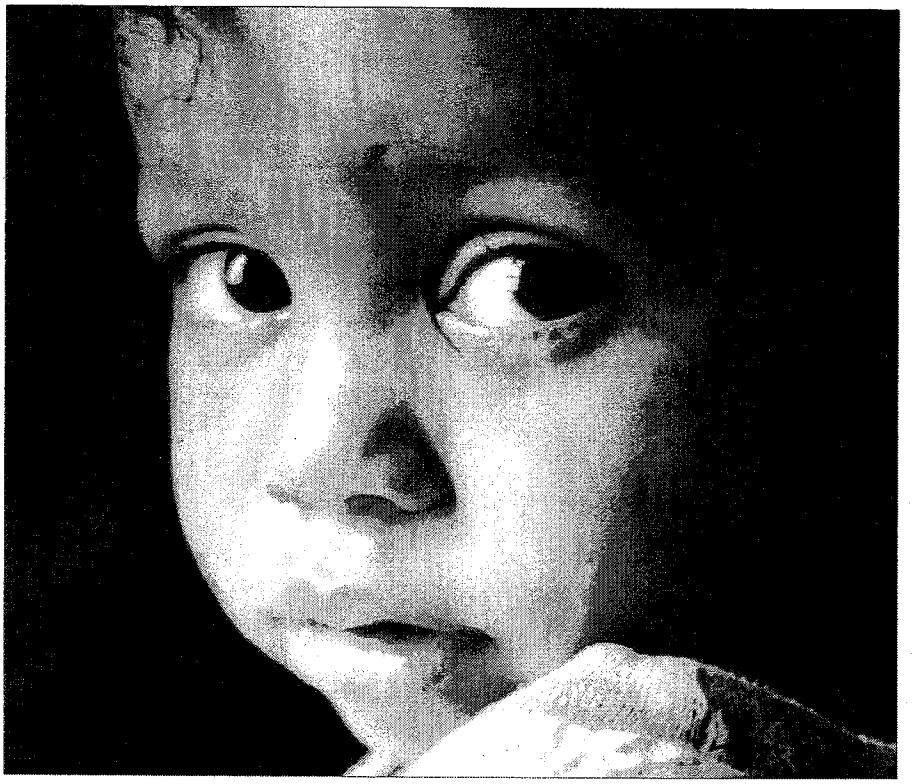
While much can be accomplished through increased collaboration and pooling of funds within communities and state agencies, there is also a need for substantial new investments in prevention. Wisconsin needs to identify partners who may not already be at the table, seek out influential champions for new initiatives, and explore various funding options as critical steps in the implementation of the State Call to Action.

Implementation of the State Call to Action will demand increased collaboration at all levels, creative thinking about funding sources, and a long-term commitment to the vision of a society where all children are safe from abuse and neglect.

THE STATE CALL TO ACTION

Child maltreatment—encompassing physical, emotional, and sexual abuse as well as physical and emotional neglect—is an everyday tragedy for thousands of children in Wisconsin. In addition to the devastating immediate effects of abuse and neglect on a child's physical and emotional health, maltreatment has effects that are long-term and far-reaching, not only for children and their families, but also for society. Maltreated children are more likely than other children to do poorly in school, to commit crimes as adolescents and adults, to struggle with drug and alcohol addictions, and to abuse their own partners and children when they become adults [1]. Indeed, child maltreatment is a strong contributing factor to many of our social problems.

There is growing evidence of the effects of child maltreatment, as well as increasing understanding of the effectiveness of preventive interventions. As this knowledge base develops, it becomes more and more clear that allowing abuse and neglect to occur is unconscionable. In terms of child and family development, we know what children need to be healthy, and we understand how parents can be supported by formal and informal systems. In terms of economics, we know that early investments in children and families yield significant returns—with levels of effectiveness rarely achieved through treatment [2]. We also know that the American public views child abuse as a major social problem, but most people don't know what they can do to make a difference [3]. It is time for all of us who care about children's well being to rethink how we work with children and families. This means making a commitment to invest in prevention, expand proven strategies, and implement new approaches to the prevention of child maltreatment.



Don't give up!
I believe in you all!

A person's a person,
no matter how small.

Horton Hears a Who
by Dr. Seuss

A New Approach to Prevention

In recent years, at the national level and in several states, coalitions of government agencies, nonprofit organizations, advocates, and families have come together to formulate a new approach to child maltreatment prevention [4, 5]. Initiated in 2004, Wisconsin's State Call to Action is spearheaded by a public-private partnership of the Wisconsin's Child Abuse and Neglect Prevention Board (also known as Children's Trust Fund), the Child Abuse Prevention Fund of Children's Hospital and Health System, and Prevent Child Abuse Wisconsin.

With support from Governor Jim Doyle and leaders from both sides of the aisle in the state Legislature, as well as participation from all of the major state agencies whose work affects children and families, the State Call to Action is a bipartisan, statewide effort intended to:

- Raise awareness of the human and economic costs of child abuse and neglect;
- Propose short- and long-term child abuse and neglect prevention strategies; and
- Strengthen public will, resources, and community capacity to prevent child abuse and neglect.

Work on the State Call to Action has taken place in three phases.

Governor Jim Doyle's Summit to Prevent Child Abuse and Neglect:

A STATE CALL TO ACTION

PHASE I: The Governor's Summit and Statewide Web Casts

In the spring of 2004, Governor Jim Doyle announced the State Call to Action to end child abuse and neglect. In partnership with the Children's Trust Fund, the Child Abuse Prevention Fund of Children's Hospital and Health System, and Prevent Child Abuse Wisconsin, Governor Doyle convened a Summit April 29 and 30 in Madison. The Summit had two objectives:

- Define the critical elements needed in a comprehensive, community-based family support system that prevents child maltreatment; and
- Identify action steps that Wisconsin can take to prevent child abuse and neglect.

Within that context, Summit participants began to identify community expectations, forms of personal conduct, policies, and programs that prevent the initial occurrence of child abuse and neglect.

The Governor's Summit to Prevent Child Abuse and Neglect was videotaped for an archived web cast that took the Call to Action statewide. During May and June 2004, at 23 meetings across the state, volunteer facilitators worked with concerned citizens to view key portions of the Governor's Summit via web cast, to review the Summit's draft recommendations, and to submit their own recommendations to the State Call to Action Steering Committee.

The first phase of the State Call to Action was the combined work of the 160 people present at the April 2004 Governor's Summit; the 443 people who attended one of 23 web cast discussion forums held across the state; and several individuals who participated in an online web cast and responded to a related survey. The outcomes of these discussions are summarized in "A Report on Governor Jim Doyle's Summit to Prevent Child Abuse and Neglect: A State Call to Action" (available at http://wctf.state.wi.us).

PHASE II: Workgroup Recommendations

Based on the work of Phase I, workgroups were formed around six topic areas to continue into Phase II of the State Call to Action. The workgroup topics are:

- **Uniform, Comprehensive Systems of Family Support.** Family support is an investment in the creation of happy, healthy, and productive citizens, and is effective in preventing child abuse and neglect and in reducing the stresses that contribute to child maltreatment. All families should have access to family support systems in communities throughout Wisconsin.

- **Family Economic Success.** Stressors stemming from poverty and the inability to meet basic needs put children and families at increased risk for abuse and neglect. Both at a policy level and in approaches to supporting individual families, Wisconsin can take steps to alleviate those stressors.

- **Mental Health and Substance Abuse.** Adults who struggle with issues of mental health and substance abuse are faced with significant challenges to their ability to parent and nurture children in their care. Both substance abuse and mental health have a major impact on the child welfare system.

- **Child Abuse and Domestic Violence.** Independent of one another, child abuse and domestic violence can endanger children, impair development, and lead to long-term negative outcomes. The co-occurrence of domestic violence and child abuse compounds even further the negative effects children are likely to experience in the short-term and over their lifetime.

- **Children's Mental Health.** Many children suffer from organic mental illnesses and have loving and devoted families, but their parents often need support to help them cope with the special needs of their child. These families should have access to quality mental health care as well as support for parents and caregivers.

- **Child Sexual Abuse Prevention.** Currently, the majority of programs addressing the problem of child sexual abuse in Wisconsin place the responsibility for prevention on the child victims instead of emphasizing adult responsibility to protect children and seek treatment. New approaches are needed to strengthen families and communities in preventing or stopping child sexual abuse.

Workgroups were charged with the task of formulating recommendations for long-term and short-term strategies for the prevention of child maltreatment. Each workgroup put forth extraordinary efforts to submit short-term recommendations by the end of 2004 for the Governor's Office to consider for the 2005–2007 budget proposal. The workgroups then elaborated and expanded upon their ideas and submitted their full reports in March 2005. (The full report of each workgroup is available on the the State Call to Action website at htpp://wctf.state.wi.us.)

The creativity of their ideas and the quality of their work on a short timeline are impressive, and the State of Wisconsin owes each of the co-chairs and members of the workgroups a debt of gratitude. The co-chairs and members of the workgroups are listed in the Apendix A on page 63, along with the scope and purpose from which they worked.

PHASE III: The *State Plan to Prevent Child Maltreatment*

This report comprises Phase III of the State Call to Action, summarizing the recommendations of the six workgroups. It includes recommendations that can be enacted at the state and local level, as well as legislative changes that would pave the way for some state and local initiatives.

Within each of the six workgroup topics, a brief background explains how the issue relates to child abuse and neglect. The recommendations that follow are those submitted by the workgroups to the State Call to Action Steering Committee in March 2005. Implementation details for each recommendation are provided, including partnerships and lead agency, legislative and policy changes needed, existing efforts that can be duplicated, immediate steps and short-term strategies, and accountability and evaluation.

The State Plan contains recommendations for state and local levels and for policy changes.

Details about the financial resources needed to implement a recommendation are included in those cases where workgroups were able to estimate them. These details are most often given for statewide, legislative or policy change recommendations. For implementation of a recommendation at the community level, it is difficult to generalize resources needed. If quality

programs are in place, resources are already directed toward prevention, and partners are flexible in how they deliver their services, communities may find that not many additional resources are needed to implement a recommendation. On the other hand, communities that are not already investing in prevention may need to consider redirecting resources, or seek new funds from local and state sources to make implementation of a recommendation possible. Because of this variation among communities, financial details are included only when state-level expenditures could be estimated.

Cultural competence needs to be a focused component when implementating any recommendation.

Workgroups also included suggestions on how to address cultural competency in the implementation of each recommendation. Cultural competency goes beyond an awareness of and tolerance for diversity. Culturally competent individuals and organizations enhance their knowledge of cultural values and traditions to more effectively reach out to families and communities of various backgrounds and cultures. With increasing diversity in Wisconsin, cultural competence has become a necessity for community leaders and service providers, and a concern of policymakers. It needs to be a focused component of the implementation of any recommendation from this report, just as it needs to be woven into any initiative that reaches out to families and communities.

Several strategies were recommended by more than one workgroup. In this report, the details of those recommendations from multiple workgroups were combined and placed with the first appearance of the recommendation. Subsequent appearances of the same recommendation are kept brief.

Why a State Call to Action Now?

Wisconsin's State Call to Action began in 2004 when the environment in the state was conducive to this type of initiative for many reasons. Collaboration between systems was increasing at state and local levels, facilitating conversations between service providers, administrators, and policymakers who had previously worked in relative isolation from one another. Encouraging even greater integration between systems is logical because various agencies have similar long-term goals for children and families. It is also promising from a fiscal perspective as shrinking federal and state budgets necessitate more effective use of available resources.

Another impetus for this initiative is the accumulating evidence about the effectiveness of preventive interventions. With advanced statistical methods such as meta-analysis, and the application of economic principles to conduct cost-benefit analysis, stronger arguments are being made for the effectiveness of certain types of interventions with children and families [2, 6]. These advances make it clear that by directing funds toward thoughtfully chosen programs and policies, Wisconsin can reduce child maltreatment, thereby reducing future expenditures on social services, crime, and treatment of abuse victims.

This evidence also demonstrates what we have long known—that experiencing abuse or neglect has devastating effects on children, both at the time of the abuse and throughout their lives. The State Call to Action seeks to harness the knowledge and energy of diverse agencies, organizations, and individuals in Wisconsin to put an end to the maltreatment of the most vulnerable members of our society.

Finally, Wisconsin was ready for a State Call to Action in 2004 because the political will was there for it.

Governor Doyle's *KidsFirst* Initiative placed children's welfare in the spotlight. In the State Legislature, there was bipartisan support for improving the state's approach to child abuse prevention. Among state agencies and nonprofit organizations, individuals and agencies were ready to engage in public-private partnerships to better serve children and families. In short, Wisconsin was ready to make a statement that it would no longer tolerate the abuse or neglect of its youngest citizens, and the State Call to Action was launched.

Implementing the *State Plan*

Moving from the drafting of a *State Plan* to changes in how Wisconsin works to prevent child maltreatment will not take place overnight, nor will it be a centralized process. Some recommendations will be taken up and implemented on a large scale; others will be implemented at the local level, depending on each community's needs and readiness. Ultimately the success of the State Call to Action will rest on each of us—community members and leaders, at all levels—strategically implementing recommendations in our communities, in our agencies and organizations, and in our interactions with families.

The Steering Committee for the State Call to Action will continue to promote and monitor the implementation of the *State Plan* at all levels. Their efforts will include incorporating many recommendations from the *State Plan* into the sponsoring organizations' strategic plans, identifying partners to champion other recommendations, and advising and supporting local community coordinating councils in implementing recommendations. The Steering Committee will also engage interested legislators in efforts to enact policies and legislation recommended in the *State Plan*.

The Steering Committee will promote and monitor the implementation of the State Plan.

To track the impact of the State Call to Action and the *State Plan to Prevent Child Maltreatment*, the Steering Committee created an electronic feedback form on the Children's Trust Fund's website at http://wctf.state.wi.us. The Steering Committee asks local leaders and community coordinating councils to fill in the form when they implement a recommendation from the *State Plan*. This feedback will be used to:

- Help the Steering Committee monitor the implementation of recommendations around the state;
- Attract additional funding and resources to support implementation efforts;
- Build a network of communities implementing similar recommendations;
- Share lessons learned; and
- Select local initiatives to highlight in newsletters, on the Call to Action website, and in other materials developed by the Call to Action partners.

Just as representatives of many state and private agencies and concerned citizens formulated the *State Plan*, it will be implemented at many levels, in large and small ways, through the collective power of the people of Wisconsin.

Note: To track the impact of the State Call to Action and the *State Plan to Prevent Child Maltreatment*, a feedback form is available on the Children's Trust Fund's website at http://wctf.state.wi.us.

REMARKS to Wisconsin's Child Abuse and Neglect Prevention Board May 16, 2005

In submitting these recommendations, we hope that they will assist those who must make the difficult decisions about the use of Wisconsin's resources to understand how those decisions affect young children and their families. Research emphatically tells us that the foundations for later learning and emotional health are laid down in the first 3 years of life. This new understanding of child development is at once promising and disturbing. With the right input at the right time, almost anything is possible for a child—but unless someone holds, strokes, sings, talks, smiles, reads, and plays, a child may never recover from those lost opportunities.

We cannot afford to ignore the infants and toddlers who are born to parents who are too young, inexperienced, poor, or overwhelmed to care for their children without support. It's not okay that there are children born in our communities whose parents have neither a blanket to wrap them in nor a home to take them to. It's not okay to send babies home with terrified parents who don't have a clue what to do with them and for them. And it is an enormous risk to send a child home with a single parent who has no one to call when the baby won't stop crying and the sleep-deprived parent is at the end of her rope. No one I know has raised a healthy, well balanced child alone—we all had help. Yet there are countless parents who are very much alone, and they need and deserve our support.

We have a continuing, collective responsibility to create a community that is nurturing, supportive, and enriching for every child. We can't let budget decisions just be about politics. The stakes are far too high. And we can't end child abuse and neglect in a 4-year term. Children are counting on us. There is nothing we can do that is more important than to care for them.

If we fail to spend time and money for prevention and early intervention, is it really money saved, or just debts postponed?

We are aware that there are more problems than there are resources, and that we have to learn to prioritize. The ever-present problems of poverty, family violence, substance abuse, crime, and unemployment are familiar to all of us. But we believe that until we make children a priority in our communities, none of these problems will go away. If we fail to spend time and money for prevention and early intervention, is it really money saved, or just debts postponed? Most of the adults we are trying to fix were once the children that someone else abused or neglected. It seems so much cheaper and wiser to take care of children now than to pay for the results of child abuse and neglect later.

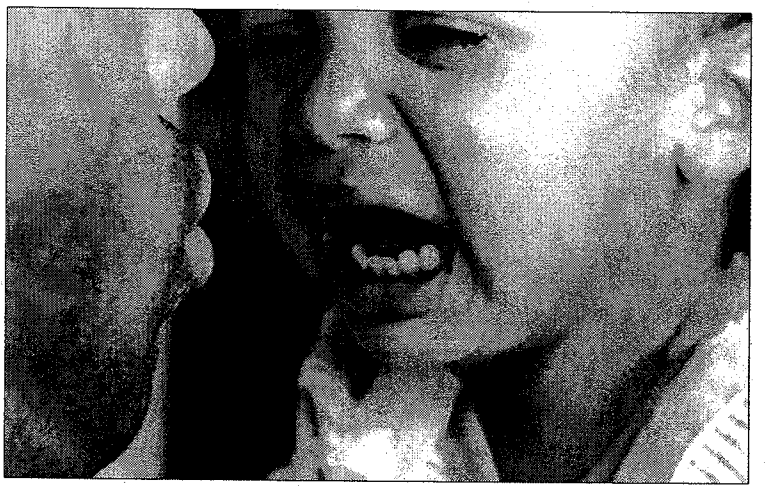
Our workgroup took on this daunting task because we believe that it is absolutely possible to change the world by creating communities that nurture and support and cherish children. But we know that can only happen if people like you, people like us, and others around the state are willing to accept responsibility for children, and willing to motivate and educate others to accept theirs.

Polly Snodgrass

Co-Chair of the Uniform, Comprehensive Systems of Family Support Workgroup

Program Director of Healthy Families/Early Head Start/Family Service of Northeast Wisconsin in Green Bay

SECTION I: FAMILY SUPPORT



One of the best ways to serve children is to support parents. When programs and services reach parents early, and when parents are better linked to positive resources in the community, their children benefit. When individuals feel responsible for their communities and the safety and health of other residents, children also benefit. Corroborated by research, these common sense principles have led to a growing family support movement.

This section addresses ways to improve family support in Wisconsin to more effectively prevent child abuse and neglect. A uniform, comprehensive system of family support, at the state level as well as in each community, will ensure that families have access to the supports they need and want. Policy changes will make it possible for more families to achieve economic success and provide for their children financially and emotionally.

CHAPTER 1: Uniform, Comprehensive Systems of Family Support

Family support, defined as "a set of beliefs and an approach to strengthening and empowering families and communities so that they can foster the optimal development of children, youth, and adult family members" [7], is effective in preventing child abuse and neglect and in reducing the stresses that contribute to child maltreatment. In addition, research shows that high-quality family support programs can increase self-confidence, knowledge of child development, and parenting skills among parents and other caregivers; improve behavior and performance of children at school; reduce teen pregnancies and juvenile delinquency; help move families from welfare to work; increase educational achievement among parents; and increase employee productivity and satisfaction [8].

The primary responsibility for the development and well being of children lies within the family. The cornerstone of a healthy society is to ensure that all families have access to the supportive services they want. This requires that universally accessible programs of family support services be available in all communities throughout Wisconsin.

Future family support and parent education programs to improve the lives of Wisconsin's families need to be established along three key principles:

- Promote systemic institutional reform of health and social service institutions with an established series of solid, well-implemented direct service programs that alter the way major institutions interface with families;

2. Establish efforts that offer communities flexibility in planning and building their own prevention programs, with the involvement of local stakeholders; and

3. Build intensive efforts and programs needed for those families that face the greatest challenges, nested in the broadly defined community network of family support services [9].

The workgroup formulated the following recommendations with these principles in mind. They are based on the literature on effective family support and parent education strategies, as well as on current national and state initiatives with a goal to improve the lives of Wisconsin's families and children.

Note: A comprehensive summary of the research done is available in the full report of the Uniform, Comprehensive Systems of Family Support workgroup, available at http://wctf.state.wi.us.

Recommendation 1.1

Establish multidisciplinary local community coordinating councils throughout Wisconsin to build non-stigmatizing systems of prevention that promote a culture where all families receive support.

Just as children need to be seen in the context of their families, families are best understood and supported in the context of neighborhoods and communities [10]. By thinking, planning, and working together, the people and groups that make up a community can accomplish goals that individual programs or agencies could not achieve alone. Collaborative partnerships are an ideal mechanism for designing comprehensive strategies that strengthen children and families.

Local collaborative councils in Wisconsin communities should be supported to conduct needs assessments; identify strategies to improve service delivery; and leverage federal, state, and private funding for local initiatives. These councils blend funds from various sources at the programmatic level, and leverage additional funds as needed. This model of local control promotes ownership and fosters innovation in design of programs and services for families [11].

Note: A similar recommendation was made by the Mental Health and Substance Abuse Workgroup, and appears as Recommendation 3.1 in this report. Details from the two recommendations have been combined here. A related recommendation comes from the Child Abuse and Domestic Violence Workgroup, and appears as Recommendation 4.2.

Because every community is different, a "cookie cutter" approach will not work. Many factors shape an initiative: demographics, community and neighborhood needs, who initiates the change effort, the amount of support from local government, prior experience working together, and existing resources. In order for these partnerships to develop into credible and accountable bodies of local governance, the report "Changing Governance" indicates that they must:

- Take sustained responsibility for designing and implementing strategies to achieve clearly defined results for families and children;
- Operate according to a set of principles concerning service delivery and a community's commitment to its families and children;
- Have legitimacy and credibility to adequately represent local residents, communities, and state and local government;
- Influence the allocation of resources across systems as necessary to accomplish the desired results; and
- Maintain standards of accountability for individual systems, as well as for the community as a whole, concerning the agreed upon outcomes for children and families [12].

Recommendation 1.1 – Implementation Details

Partnerships Required and Lead Agency

The community coordinating council must be community driven and representative of agencies that touch families and children—including but not limited to professionals, parents, local leaders, early intervention, different levels of government, informal agencies, cultural and religious leaders, health care and human service providers (including mental health and substance abuse treatment providers), family resource centers, schools, child care, educators (from early childhood through high school), workforce development, law enforcement and judiciary, business and philanthropic leaders, staff and administrators from community organizations, and representatives of institutions of higher learning.

Parents must have an integral role in the work of the community coordinating council with, at minimum, 20 percent representation.

Each local collaborative would determine the appropriate lead agency for their community.

Leadership at the state level, including setting a framework of expectations for local councils, may result from the work currently occurring in consultation with the National Governor's Association.

Legislative and Policy Changes Needed

Enabling legislation would be required to create granting authority and minimum standards for local collaborative councils.

State agencies must also establish policies that promote a systemic approach, and be held accountable to better coordinate services and funds.

Key foci of legislation and policies impacting family support must include the following:

- Processes to provide support for existing collaborative systems;
- Provision of financial incentives for creating collaborations in communities where they do not exist;
- The need to look at regions and existing regional infrastructure to serve as a link between state level planners and community level needs and activities, not only at counties, when determining funding; and
- Mechanisms to require all agencies that administer programs and services for families to collaborate on policy decisions and coordinate services (e.g., formal memoranda of understanding, terms of agreement, or joint administrative authority over funding streams).

Existing Efforts That Can Be Duplicated

Coordinated family councils remain in some communities as a result of the Family Preservation and Support collaboration planning dollars and Department of Public Instruction (DPI) Early Learning grants provided by the state from the federal government in the early 1990s. Some examples are:

- Every Family Coordinating Council, Sheboygan County
- Joining Hands for Our Families and Community, Monroe County Planning Council
- The Brighter Futures Initiative
- Family Policy Board, La Crosse County
- Coordinated Service Teams
- Healthy Families Partnership, Hampton, Virginia [13]
- Missouri's Caring Communities initiative

Immediate Steps and Short-Term Strategies

Would vary depending on readiness of partners in each community and availability of funding.

Accountability and Evaluation

Researchers who consult with community providers on collaborative practices have determined 20 important factors that relate to the success of the collaboration over time [11].

Local collaboratives should establish benchmarks for measuring their own success. While it may be difficult to show changes in actual levels of child abuse and neglect over short periods of time, especially if programs are limited in scope, collaboratives should be able to demonstrate:

- Implementation of evidence-based practices and programs
- Leveraging of other funding and resources
- Evidence that support is being provided earlier to targeted populations
- Evidence of communities doing things differently
- Level of collaboration achieved
- Evidence of enhanced or new collaborations and collaborative services

Recommendation 1.2

Establish a universally accessible continuum of family support in all communities in Wisconsin, beginning before or at the birth of an infant and available, as needed or desired by the family, throughout the child's growth and development

To prevent child maltreatment, prevention programs need to work with caregivers and parents before negative patterns develop and produce unwanted or poor outcomes. The most effective programs begin working with parents at the time of the birth of their first child [14, 15] or prenatally [14, 16].

Although the strategic focus should be on prevention and supporting families as early as possible in their child rearing responsibility, it is also necessary to protect this investment by supporting healthy development throughout the school age years.

It is important to focus efforts on all families and use an inclusive definition of family.

It is important to focus efforts on all families and use an inclusive definition of family. A universal program designed for families who have a range of skill sets and needs potentially benefits all parents and caregivers [17].

An initial contact with all new parents and caregivers affords easy access to information on parenting, child development, and available support services and community-based programs (e.g., schools, libraries, recreation centers, and family resource centers). In addition, pediatricians, family practitioners, and other health care providers should be engaged to identify family needs, refer children for assistance, and provide information to parents on child development. There should be a process in place to conduct information and outreach campaigns to build public will and inform parents about services and supports. This effort should reach out to at-risk and socially isolated families. Special outreach strategies should be employed to ensure that programs reach out to fathers and significant males living in the home.

The continuum of services from prenatal through high school would include programs that strengthen parenting skills and promote improved outcomes in the following areas: parent-child interactions, effective communication, positive discipline, stress and anger management, self-awareness and empathy building, early learning, and family literacy.

Programmatic services on a continuum of comprehensive family support programs should include multiple components to assure all families in the community have access to the support services they need and want. The continuum of family support services include parent education programs (including domains of physical, social, emotional, and intellectual development), support groups, play groups, parent-child activities, safe care while parents work, community resources and referral, parent-to-parent supportive services, home visiting, health services, mental health services, prevention and treatment for substance abuse, domestic violence, and family response teams.

Recommendation 1.2 – Implementation Details

Partnerships Required and Lead Agency

The key partnerships are outlined in Recommendation 1.1.

Legislative and Policy Changes Needed

Needs to be determined.

Existing Efforts That Can Be Duplicated

- Early Childhood Comprehensive Systems (ECCS) provides state leadership in formulating—collaboratively—a proposal for the development of a statewide, universally accessible, comprehensive system of services for children from birth through 5 years of age and their families.
- Wisconsin is one of seven states selected to participate in the Center for the Study of Social Policy (CSSP) Strengthening Families Initiative. This effort is enhancing the work of the ECCS and building strong alliances in the early child care education community.
- Communities should strongly consider programs categorized as Exemplary I, Exemplary II, and Model and promoted by the Strengthening Families Initiative [18].

Immediate Steps and Short-Term Strategies

Local coordinating councils must be established (see Recommendation 1.1) before work can begin on this recommendation.

Accountability and Evaluation

Local coordinating councils would set the parameters for the child and family outcomes they wish to track. Community outcomes and indicators may include the following categories:

1. Increased knowledge of positive parenting techniques
2. Lower rates of child abuse and neglect
3. Children with healthy attachments to their parents and caregivers
4. Healthy births
5. Children ready for school
6. Children succeeding in school
7. Young people avoiding school-age pregnancy, substance abuse, and involvement in violence as victim or perpetrator, including child abuse, suicide, homicide, and arrests for violent crimes

Recommendation 1.3

Expand to all communities in Wisconsin an intensive, evidence-based home visiting program that makes available ongoing support services for challenged new families and their infants and young children.

Home visiting is a strategy to improve family functioning; promote child health, safety, and development; and prevent child abuse and neglect. Key program elements include early identification of pregnant women and families of newborns through initial screening and assessment (often by trained paraprofessionals); psychosocial and other support; parenting and health education; nutritional counseling; individual planning with the family to build on their strengths and work on family-identified goals; and ensuring access to needed community supports and resources. A large body of research supports the effectiveness of home visiting, particularly for programs that adhere to the 12 critical elements identified by Daro [9] and endorsed by national organizations [19]. Strategies such as early enrollment into programs and sustained services by trained staff during the early childhood years demonstrate improved health and well being of pregnant women, children, and families, especially those at risk [20].

Early outcomes associated with home visiting include improved prenatal care, maternal health, and birth outcomes; increased father involvement; and increased use of health and other community resources by the new family. These effects continue for maternal outcomes after an infant's birth with fewer subsequent pregnancies; increased spacing between pregnancies; increased maternal employment and education; and improved mother-child interaction and maternal satisfaction with parenting [21]. Children continue to benefit from home visiting as they near school-age, with fewer emergency room visits; fewer accidental injuries and poisonings resulting in a visit to the physician; fewer verified incidents of child abuse and neglect; increased use of appropriate discipline for older children; increased use of appropriate play materials at home; and enhanced child development [22].

Several studies have demonstrated that home visiting programs made available to an entire segment of the population have distinct advantages:

- In-home programs are better able to engage and retain vulnerable families than center-based programs [23].
- Child abuse and neglect prevention programs have greater impact when they use population-based enrollment strategies—such as programs serving all teen mothers or first-time mothers—rather than screening-based enrollment using a risk tool to determine program eligibility [24].
- Early childhood home visitation programs are effective in reducing child maltreatment among high-risk families [25].

Wisconsin's "Family Foundations" program, previously known as Prevention of Child Abuse and Neglect (POCAN), was established in 1999 under authorization of the Wisconsin Legislature by passage of 1997 Wisconsin Act 293. POCAN aims to reduce child abuse, neglect, and out-of-home placements by improving child health and family functioning for participants through a comprehensive program of home visitation. This grant-funded pilot program, administered by the Wisconsin Department of Health and Family Services (DHFS), showed positive effects in a non-experimental evaluation [26]. Wisconsin should build on this success by expanding this program to all communities in the state. Base funding and collaborative systems of family support would sustain services in Wisconsin and provide communities with the opportunity to provide home visiting services for all families in their county or Tribe who need and want it.

Note: A similar recommendation was made by the Mental Health and Substance Abuse Workgroup, and appears as Recommendation 3.2 in this report. Details from the two recommendations have been combined here.

Recommendation 13 – Implementation Details

Partnerships Required and Lead Agency

Each community should determine a local lead agency.

Tribal governance, county human or social services, or local public health must be part of the leadership team to optimize reimbursement of Medicaid dollars. Other partners should include family support, public health, faith-based community, adult education, Prenatal Care Coordination, WIC Nutrition Program, University of Wisconsin-Extension, family resource centers, teen parenting programs in schools, law enforcement, parent education programs, respite, and support groups.

Legislative and Policy Changes Needed

- Legislation to modify and expand 1997 Wisconsin Act 293 as found in 46.515 WI Statutes .
- Family Foundations (part of the proposed budget for DHFS for 2005-2007, but not included in approved biennial budget)
- Policy support for training and technical assistance to support strengthening and expanding home visiting programs

Existing Efforts That Can Be Duplicated

- The Family Foundations program would expand the POCAN pilot project to the entire state, which would strengthen existing programs and create new programs as needed in Wisconsin communities.
- University of Wisconsin–Extension Family Living Program training program "Home Visitation: The Basics," a high-quality, research-based training package, covers beginning skills for home visitors. Advanced skill-building courses on key challenges of families such as poverty, substance abuse, and maternal depression and supervisory training are also available.

Immediate Steps and Short-Term Strategies

Gradual roll-out to county and Tribal sites representing 20 percent of potential state caseload over 5 years. Priority should be given to enhancing existing efforts in communities with established home visiting programs.

By 2010, the program of intensive home visiting should be available statewide (with target population and eligibility determined by each local community).

Accountability and Evaluation

Key indicators for monitoring program effectiveness are:

- Substantiated reports of child abuse and neglect
- Emergency room visits for injuries to children
- Out-of-home placements of children
- Immunization rates of children
- Health Check services provided to children
- Families who remained in the home visitation program for the time recommended in their case plan
- Strengthened family functioning
- Enhanced child development
- Positive parenting practices

Financial Resources Needed

The "Family Foundations" budget proposal called for $642,400 to start up the program in fiscal year 2006 and $2,639,000 for full implementation in fiscal year 2007. These funds would come from a combination of state and federal resources.

More details about the allocation and distribution of funds, including issues related to Medicaid reimbursement, are provided in the full report of the Uniform, Comprehensive Systems of Family Support Workgroup available at http://wctf.state.wi.us.

Recommendation 1.4

Build a system of Family Response Teams in Wisconsin counties to foster critical circles of support for challenged families and children.

In Wisconsin, coordinated systems of care and collaborative approaches to respond to individuals and families with multiple, often-serious needs have evolved in many counties since the early 1980s. These services, however, are generally only available to families that are involved with mental health services or have had substantiated reports of abuse or neglect. Families with other challenges or issues (whether self-identified or community-identified) can also benefit from coordination of services and collaborative approaches. Family Response Teams are an effective mechanism for meeting these families' needs and ensuring the safety of their children [27].

Coordinated Services Team (CST) initiatives provide both the model and some of the necessary infrastructure for building a system of Family Response Teams. CSTs are built on family-centered, strength-based core values. Effective CSTs result in meaningful individual, family and community outcomes; a reduction in the duplication of services; and a reduction in crises that rob families and the service system of time and limited resources [28].

Note: The Children's Mental Health Workgroup recommended expanding a similar initiative—Coordinated Services Team—to reach more families involved in mental health systems. See Recommendation 5.3 on page 46.

Family Response Teams are based in the community partnership model, stemming from the Community Partnership for Protecting Children initiative of the Center for the Study of Social Policy [29]. The community partnership approach starts from the premise that no single factor is responsible for child abuse and neglect, and therefore that no one public agency can safeguard children. Particularly for families that are involved in multiple service systems, coordination between agencies is critical.

A system of Family Response Teams would work in partnership with Child Protective Services to ensure access to services for families with unsubstantiated reports of abuse and neglect. Other agencies and organizations that come into contact with at-risk families would also refer families and participate in Family Response Teams as appropriate and as desired by the family.

Wisconsin should expand programs at current CST sites to include a broader range of families, expand CST and Family Response Team programs to counties and Tribes where none exist, and provide leadership and staffing at the state and community levels. Staffing would include state leadership staff to provide technical assistance to communities; community lead agencies to support the local coordination network and supervise the activities of local family partners; and local, family partner staff at the community level to set up family meetings, assist families in plan development, and provide ongoing support and assistance for families in implementing their plans.

Coordination between agencies is critical for families involved in multiple service systems.

Recommendation 1.4 – Implementation Details

Partnerships Required and Lead Agency

Use existing community partnerships supporting the Wisconsin Collaborative Systems of Care as the basis for any program expansion to additional eligible families. Each Coordinated Services Team (CST) site must also establish a local collaborative group or "Coordinating Committee" that may include schools, faith institutions, mental health professionals and healthcare providers, substance abuse and domestic violence programs, workforce development, police and juvenile justice, child care providers and educators, parents groups, and the public Child Protective Services (CPS) agency.

A team of state staff, county and community service providers, consumers, and advocates provides project direction and administration.

Legislative and Policy Changes Needed

Family response teams and CPS agencies will need to work together in a truly collaborative partnership to promote alternative ways of responding to reports of maltreatment that are not investigated or cannot be substantiated.

Existing Efforts That Can Be Duplicated

- Wisconsin's Collaborative Systems of Care, (i.e., Coordinated Services Team (CST) Initiative, Wraparound, the Integrated Services Projects, and "Children Come First") [28]
- Wisconsin Wraparound
- WI Act 293—flexible fund and informal planning for families at risk of child abuse and neglect
- La Crosse County's alternative or differential response, "No wrong door for kids"
- Community Partnership for Protecting Children initiative in Jacksonville, FL; St Louis, MO; Louisville, KY; and Cedar Rapids, IA [30]
- Family Teaming as reported by Hall, 2004 [27]

Immediate Steps and Short-Term Strategies

Phased in statewide over 8 years with additional counties added each year the new allocation is available. General strategies for implementation include:

- An existing or new local decision-making body in a community reviews the effectiveness of community child protection and engages community members to participate in and support building or adapting the initiative to include families at risk. Lead agency is determined locally, but the partnership must include Social Services and CPS.
- The CPS agency begins to adopt new policies, practices, roles and responsibilities, particularly in their approach to unsubstantiated reports of abuse and neglect.
- Each partnership organizes a network of neighborhood and community supports.
- An individualized course of action for all children and families who are identified by community members as being at risk of child abuse and neglect.

Accountability and Evaluation

Evaluation of program effectiveness and results should focus on the extent to which the local decision-making group:

- Uses many forms of data and broadly gathered information to make decisions;
- Intentionally seeks the involvement and perspectives of many members of the community and especially those whose points of view are not often heard;
- Sets a communitywide agenda for improving results that target the priorities of community residents;
- Assesses community resources and attempts to influence more informed, consolidated, and creative use of local assets to support the community's agenda;
- Ensures that arrays of community supports are in place that include effective informal networks as well as formal systems of care;
- Continuously informs members of the community about results and the state of communitywide conditions; and
- Uses results as a way for a community to establish and monitor accountability standards.

In addition, the Coordinated Services Team (CST) Initiative has established goals and expected outcomes for system change, and has developed a checklist tool for evaluating systems, processes, and family outcomes.

Financial Resources Needed

Combination of state and local funds (possible federal block grant reallocation) to provide the following fiscal incentives:

- Start-up and capacity-building dollars for local communities;
- Dollars to promote organization of the collaboration of the various network partners and support neighborhood sites for parent team meetings; and
- A pool of flexible dollars for assistance with individual family plan implementation.

More details about the proposed allocation of funds to counties and Tribes are provided in the full report of the Uniform, Comprehensive Systems of Family Support Workgroup.

CHAPTER 2:
Family Economic Success

Economic success is more than just "getting a family member a job"; it requires a comprehensive approach. Potential strategies for supporting family economic success range from more effective approaches to working with families in poverty, to policy changes that allow families to better support themselves. In making recommendations for the *State Plan to Prevent Child Maltreatment*, the Family Economic Success workgroup narrowed their focus to economic policy changes that would benefit Wisconsin's most vulnerable families.

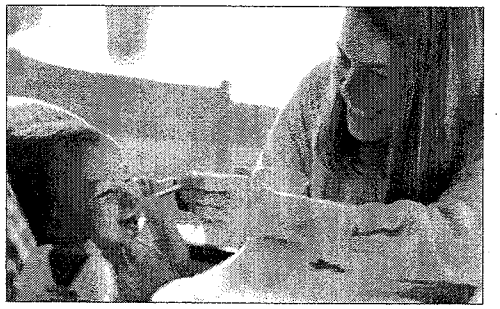
In addition to the policy recommendations here, there is a continuing need to explore how family support and early childhood programs can better communicate with and support families living in poverty and struggling with economic self-sufficiency.

Note: The workgroup's full report includes details about current eligibility guidelines for the various credits, benefits, and programs discussed here. The report is available at http://wctf.state.wi.us.

The 2000 U.S. Census reports that 12 percent of children in Wisconsin were living below the poverty line; 29 percent were living in families making less than 200 percent of the federal poverty line [31]. Children living in poverty suffer not only from their families' struggles to provide for their basic needs, such as healthy food and adequate shelter, but also from the related stresses that they and their parents encounter in their daily lives, which puts them at increased risk for abuse and neglect. In Milwaukee, a recent study found that 70 percent of families involved in Child Protective Services (CPS) had incomes below the poverty line [32].

Families living in poverty can and do benefit from family support and parent education services, but that is not enough. Wisconsin needs to support these families to achieve economic success or self-sufficiency so that they can meet their children's physical and emotional needs for healthy development.

The recommendations in this chapter focus on lack of education and job preparedness, underemployment and unemployment, economic development, and health care access and affordability.



Improving Low Wage Jobs

Many factors contribute to poverty and economic instability, such as low wage jobs, lack of transportation, lack of education or access to education, and disability. Many of these factors are inter-connected, and almost all are affected by government systems. Changing these conditions would contribute to greater economic stability for families in Wisconsin.

Recommendation 2.1

Raise the minimum wage in accordance with the Governor's Minimum Wage Council.

The Governor's Minimum Wage Council convened by Governor Jim Doyle—comprised of leaders from the business community, labor organizations, the University System, and both houses of the Legislature—proposes a two-phase minimum wage increase to $5.70 per hour in 2005 and to $6.50 per hour in 2006. The increase to $5.70 for adult workers ($5.30 for minor workers) was approved in May 2005 and took effect on June 1, 2005; further increases for 2006 are under consideration in both the Senate and Assembly.

The Department of Workforce Development (DWD) estimated in 2004 that 101,000 individuals would benefit in the first year of the increase and 150,000 in the second year. Although many minimum wage earners in Wisconsin are young people, nearly half are over 25 years of age. Nearly two out of every three are women. More often than not, they are single parents struggling to support themselves and their children. And, while many are part-time workers, almost one-third of minimum wage earners work full time [33].

Wisconsin should continue to assess the economic security of its lowest-paid workers, and should follow the advice of the Governor's Minimum Wage Council by further increasing the minimum wage in 2006.

Recommendation 2.1 – Implementation Details

Partnerships Required and Lead Agency	Governor's Minimum Wage Council already incorporates key partners.
Legislative and Policy Changes Needed	Approve further increases to the minimum wage for 2006.
Existing Efforts That Can Be Duplicated	The City of Madison had adopted the gradual increases recommended by the Governor's Minimum Wage Council earlier in 2005.
Immediate Steps and Short-Term Strategies	Approve further increases for 2006.
Accountability and Evaluation	Needs to be determined.

Recommendation 2.2

Increase awareness of, access to, and the amount received of federal and state tax credits for low-income families.

The Earned Income Credit (EIC) is a federal and state tax credit available to qualified low-income workers. Similarly, the Wisconsin Homestead Credit reduces the impact of property taxes and rent on low-income individuals and families. Both of these credits are underused by the families that they are designed to help.

EIC helps low-income workers increase income by reducing the income tax a family owes, sometimes providing a refund greater than taxes owed. Eligibility qualifications and credit amounts differ for the federal and state credits. Many Wisconsin Works (W-2) clients can benefit from the EIC program. The actual payment an applicant can receive is subject to a sliding scale based on annual earnings and the number of qualifying children. The U.S. General Accounting Office estimates that about 86 percent of eligible households with children claim the federal EIC [34]. Rates of claiming the state credit may be lower than that estimate.

The Wisconsin Homestead Credit reduces taxes for persons with lower incomes. Either property taxes paid or a portion of rent paid can be reimbursed through a credit of up to $1,160. To qualify, a person must own or rent his or her residence, be at least 18 years of age, and have household income of not more than $24,500. In addition, the individual cannot have received Temporary Assistance for Needy Families (TANF) or General Assistance payments during the filing year. The Homestead Credit is claimed even less often than the EIC, with as few as 43 percent of qualifying Wisconsin households taking advantage of the credit in 2001 [35].

More families must learn about these opportunities and understand the process for applying for available credits. A campaign should be coordinated by the Department of Workforce Development (DWD) to generate awareness of the EIC and the Wisconsin Homestead Credit. In addition, the qualifying earning thresholds should be increased so that more working families can benefit.

Recommendation 2.2 – Implementation Details

Partnerships Required and Lead Agency

The Department of Workforce Development (DWD) would serve as the lead agency, and would partner with the following organizations and agencies in the awareness campaign:

- W-2 agencies
- Job Centers
- Libraries
- Technical Colleges

Legislative and Policy Changes Needed

Legislative changes would be required to increase the qualifying earning thresholds.

Existing Efforts That Can Be Duplicated

DWD and the Wisconsin Department of Revenue (DOR) are working together on a pilot project covering Dane County and Milwaukee Region 5. DOR is matching W-2 participant data to determine eligibility for tax credits and refunds from current and prior years. DWD will inform those identified and direct them to free Voluntary Income Tax Assistance sites. The pilot will be evaluated to determine if it is cost-effective to provide this information statewide.

Immediate Steps and Short-Term Strategies

- Evaluation of pilot project in Dane and Milwaukee counties and statewide expansion if feasible and cost-effective
- Review of income thresholds for state Earned Income Credit (EIC) and Wisconsin Homestead Credit

Accountability and Evaluation

Needs to be determined.

Recommendation 2.3

Increase access to Wisconsin SHARES child care assistance for parents pursuing educational programs

Currently, families with child care needs are eligible for child care subsidies under Wisconsin SHARES for children under age 13 (or under age 19 if the child has special needs) if they meet the financial standards and the parent is working or participating in a W-2 or Food Stamp employment, work search, work experience, or employment skills training program. Parents pursuing education are only eligible for child care assistance if they are under 20 and enrolled in high school or the equivalent.

In contrast to Wisconsin SHARES, Food Stamp benefits are allowed while parents are pursuing any education up to a 4-year college degree. These are both federally funded programs with matching state dollars. Wisconsin SHARES should provide the same option as Food Stamps, using the same set of criteria.

Wisconsin SHARES is funded from a combination of federal Child Care Development Funds (CCDF), federal Temporary Assistance to Needy Families (TANF) funds, and state General Purpose Revenue (GPR).

The current statutory language allows for child care to be paid for a maximum of 2 years while an individual is employed. Changing the statute to allow parents to receive assistance (or subsidies) for child care for 4 years while they pursue a degree would increase the likelihood that they will be able to support their families in the long term, but would be somewhat of a departure from the philosophy that child care is needed to support immediate efforts to obtain and retain employment.

The statutes should be changed to cover child care for parents attending school by removing time limits, clarifying the work requirements for parents who are in school, and extending coverage so that any type of education qualifies a parent for child care assistance.

Recommendation 2.3 – Implementation Details

Partnerships Required and Lead Agency	Needs to be determined.
Legislative and Policy Changes Needed	Changes to the child care assistance statutes: ● The 2-year limit of using child care for attending school should be removed ● The level of employment for eligibility should be identified (20 hours per week, average of 80 hours per month) ● Qualifying education should not be limited to any type of degree or school
Existing Efforts That Can Be Duplicated	Needs to be determined.
Immediate Steps and Short-Term Strategies	Needs to be determined.
Accountability and Evaluation	Needs to be determined.

Access to Health Care and Affordability

Access to health care is a responsibility shared by both government and employers. The following recommendations focus on the role of the state in increasing access, both through its own programs and through influencing the private sector to provide health insurance benefits for more workers.

Recommendation 2.4
Increase eligibility for BadgerCare

Currently, to be eligible for Wisconsin's free or low-cost health insurance program, BadgerCare, families must:

- Have children under age 19 living in the household;
- Earn below 185 percent of the federal poverty line (there is no limit on assets); and
- Not be covered by health insurance.

To improve coverage of Wisconsin's most vulnerable families, BadgerCare eligibility should be expanded, and efforts should be made to simplify the application process and increase enrollment of qualified families. Specifically, Wisconsin should:

- Modify BadgerCare eligibility criteria to include a larger pool of individuals. For example, if an adult dependent is living with the family (beyond age 19, who does not qualify for Social Security Disability Insurance) the entire family unit should still qualify. In addition, low-income adults without children should be offered the opportunity to access this service. This would require legislative changes.
- Either eliminate or simplify the income verification paperwork required since May 2004. The verification requirement has created a barrier to accessing BadgerCare, with a net loss of almost 24,000 individuals from the BadgerCare rolls since it took effect [36]. This problem needs to be addressed at the same time consideration is made about eligibility expansion.
- Encourage collaboration with statewide coalitions, such as Covering Kids and Families, the Robert Wood Johnson Foundation funded project for Wisconsin. These coalitions are well positioned to work with state agencies on encouraging enrollment through 1) focused outreach efforts; 2) simplification of enrollment processes; and 3) coordination of enrollment between the different eligibility programs.

Note: Further implementation details for this recommendation need to be determined.

Recommendation 2.5

Support innovative approaches to increasing employer provision of health insurance.

As health care costs continue to soar, small businesses face greater hurdles in covering premiums for employee health insurance coverage. Rising costs will not be moderated without larger systemic controls, including incentives for employers to participate. Wisconsin should support innovative approaches that would make it more feasible and more attractive for employers to provide health insurance to their employees.

Wisconsin should provide employers with incentives to provide health insurance benefits to those employees who are working full-time for the employer.

Natural incentives already exist for employers to offer health insurance to their employees. Quality health benefits reduce turnover and allow employers to retain their trained workforce. Small businesses, however, are rarely able to fully fund high-quality health benefits. Depending on the employees' wages, co-payments on a monthly premium may also be out of reach.

Wisconsin already offers employers incentives for hiring people who are economically disadvantaged or those with barriers to employment. The state should consider an additional tax incentive for certified community development zone employers who have hired workers from the identified targeted categories and provided them with health insurance.

Wisconsin should support employer pooling of health insurance.

The state should support initiatives to encourage employer pooling of health insurance, such as Co-op Care. By funding the administrative start-up costs of this innovative plan (estimated to be about $150,000 for 3 years), Wisconsin would expand the reach of this program to allow small business owners, self-employed individuals, and farmers to obtain insurance for themselves and to provide health insurance benefits to their employees.

The Wisconsin Federation of Cooperatives has obtained $2.25 million in federal support to establish regional health care cooperatives throughout the state, providing reinsurance for members of the co-ops. The federal appropriation will fund Co-op Care's "stop-loss fund" that lowers premium costs by covering higher-cost claims for co-op members who, having been uninsured for many years, may be considered "high-risk" by insurance companies [37].

Besides the "stop-loss fund," Co-op Care will benefit members of the regional cooperatives by allowing them to negotiate as a group for better health insurance, and lower costs by pooling risk for insurance providers. Wisconsin should encourage small business owners and farmers to access Co-op Care and support its administrative costs.

Wisconsin should encourage employers to assist eligible families with BadgerCare awareness/applications and Electronic Funds Transfer to ensure timely payments of premiums paid by participants.

To further increase access to health care and insurance, Wisconsin should enlist employers in the campaign to increase awareness and use of BadgerCare. Part-time employees and employees of small businesses who are unable to provide health insurance should be made aware of their eligibility for BadgerCare—and would be reached more effectively through their employers than through many other means. Employers should be encouraged to inform employees of their eligibility and assist with their BadgerCare applications.

Note: Further implementation details for this recommendation need to be determined.

SECTION II: FAMILY MENTAL HEALTH

Mental health and substance abuse problems—whether for parents and caregivers or for children themselves—are a common factor in the lives of many abused and neglected children. Parents and caregivers experiencing mental health and substance abuse issues need support to provide the best possible care for their children. Parents experiencing domestic violence frequently struggle with mental health and substance abuse issues; their children are at increased risk for child abuse and neglect. Finally, children with mental, emotional, or behavioral disorders are also at increased risk of maltreatment, and their parents may need additional support to meet the challenges posed by special-needs children.

Each of the workgroups in this section focused on how the systems that respond to families experiencing issues of mental health, substance abuse, and domestic violence can take steps to prevent child abuse and neglect while promoting the mental health of all family members.

CHAPTER 3: Mental Health and Substance Abuse

According to the National Clearinghouse on Child Abuse and Neglect Information, adult substance abuse and mental health, which are often grouped together as inter-related issues, have a major impact on the child welfare system and on parents' or caregivers' abilities to parent and nurture children in their care. Children of substance abusing parents are more likely than others to have poor physical, intellectual, and emotional outcomes. Unaddressed mental health and psychological problems may lead parents and caregivers to engage in high-risk behaviors and to develop habits leading to poor health outcomes for themselves and their children.

The Office of Applied Studies reported in 2003 that about 9 percent of children live with at least one parent who abuses drugs or alcohol [38]. Of the many American adults who seek psychiatric care each year, more than half are parents. The National Comorbidity Survey also found that women and men with mental illness are at least as likely to be parents as adults without psychiatric disorders [39].

Substance Abuse and Mental Illness as Risk Factors

According to the U. S. Department of Health and Human Services, Administration for Children and Families, between one-third and two-thirds of child maltreatment cases involve substance abuse. Substance abuse was one of the two major problems that families struggle with, according to reports from across states [38]. The National Center on Addiction and Substance Abuse (CASA) recognizes that children whose parents abuse drugs and alcohol are almost three times likelier to be abused and more than four times likelier to be neglected than children of parents who are not substance abusers [40].

While comparable figures are not available for parents with mental illness, parental psychopathology is generally listed as a risk factor in child abuse and neglect. Additionally, the Substance Abuse and Mental Health Services Administration (SAMHSA) published a report stating that phenomena that co-occur with serious mental illness, such as poverty, substance abuse, and homelessness, may have serious implications for safe parenting and may increase risks to children and parents. It also found that regardless of actual substantiation of abuse, parents with mental illness are vulnerable to losing custody of their children [39].

Barriers to Addressing Parental Substance Abuse and Mental Illness

There are many barriers to service delivery in child welfare cases involving parental substance abuse and mental illness. In some cases child welfare workers are not appropriately trained in the area of substance abuse and mental illness [40]. Another barrier to effective service delivery is that the time required for sufficient substance abuse recovery to develop adequate parenting skills conflicts with legislative requirements for child permanency, and with the developmental needs of the children [41].

Services tend to be problem-focused and deficit-based rather than preventative or strength-based.

One of the most common themes in the literature around substance abuse, mental illness, and child abuse is lack of access to services and lack of quality health care. CASA conducted a 2-year study on child welfare professionals' perceptions of the extent of the problem. More than 60 percent of the professionals reported that what treatment is "available" determines what treatment is "appropriate" for the parent; only 5.8 percent of survey respondents said there was no wait for parents who need residential substance abuse treatment; and only 26 percent said that there is no wait for outpatient treatment. For adults with mental illness, this lack of access to services is also apparent [40]. The National Mental Health Association reports that the services that are available tend to be problem-focused and deficit-based rather than preventative or strength-based [42]. Typical needs for families with mental illness or substance abuse disorders include housing, transportation, employment, recreational activities, child care, health care, and respite from the 24-hour-a-day challenges of parenting. The stigma that accompanies mental illness and substance abuse is a pervasive factor affecting parents' access to and participation in services [39]. These combined factors suggest a strong need for coordination across systems to deliver effective services.

Note: The five recommendations related to reducing the risk of child abuse and neglect among families that have a parent with a mental illness and/or substance abuse disorder are listed in priority order. While any of these recommendations could make an impact individually, all five together could significantly improve the ability of persons with these disorders to be effective parents.

Recommendation 3.1

Support the development of local collaboratives to implement evidence-based or promising practices for child abuse and neglect prevention targeted at families where the parent has a mental illness or substance abuse disorder

Programming to support parents who have mental health or substance abuse disorders is best developed and operated at a local level, within a framework of expectations developed and supported centrally. Local collaboratives can provide multidisciplinary approaches that are critical to supporting parents with mental health and substance abuse disorders. The general framework for such collaboratives is described in more detail in Recommendation 1.1. Details specific to child abuse and neglect prevention targeted at families where the parent has a mental illness or substance abuse disorder are described here.

Note: The general framework for local collaborations and details for implementation appear as Recommendation 1.1 on page 13.

Local collaboratives should look to evidence-based programmatic approaches to addressing the needs of parents who may have a mental illness or substance abuse disorder. These approaches include gatekeeper training and specialized parent education and family support curricula.

- **Gatekeeper training.** Professionals in many public and private systems, including child welfare, home visiting and parent support programs, primary health care, schools, and law enforcement, come into daily contact with individuals who may be experiencing mental illness or substance abuse disorders. Workers in these systems are not adequately trained to recognize the symptoms or to respond when symptoms are recognized. Training for these gatekeepers would facilitate increased screening efforts that should lead to increased identification of individuals in earlier stages of the development or exacerbation of a mental health/substance abuse disorder, earlier access to treatment, and, consequently, a reduction in the negative effects of such disorders which may include abuse or neglect.

- **Specialized parent education and family support curricula.** A number of universal parenting curricula have been validated with parents who experience mental illness or substance abuse disorders, including *Parenting Wisely, Strengthening Families Program,* and *Nurturing Parenting Program*. For some families, universal interventions may not provide adequate support. There are a number of models designed specifically for supporting parents who experience mental illness or substance abuse disorders, including *Project HUGS*, the *Statewide Urban and Rural Projects for Substance Abusing Women*, and the *Invisible Children's Program*. More information about the above-mentioned programs, including websites and contact information, is included in the full report of the Mental Health and Substance Abuse workgroup, available at http://wctf.state.wi.us.

Recommendation 3.2

Implement universal and targeted home visiting statewide in Wisconsin

Universal home visiting, as proposed in Recommendation 1.3, allows all families to benefit from the wisdom of child development specialists as they begin the challenging task of raising a child. Such programs also allow the early identification of families where a parent has a mental illness or substance abuse disorder. These families, and others at risk, have been able to benefit from more intensive, targeted home visiting that provides regular visits to the family, parental guidance, and referrals and support to access relevant community resources.

Note: Details of this recommendation appear in Recommendation 1.3 on page 17.

Recommendation 3.3

Enact mental health and substance abuse parity in commercial insurance to improve access to treatment services

As noted earlier, the risk of child abuse and neglect is heightened by the presence of an untreated mental illness or substance abuse disorder in a parent. Even when such a disorder is recognized, efforts to seek treatment are often hindered by inadequate coverage of mental health and substance abuse treatment services in the public and private sector.

In the private sector, access to treatment services would be improved greatly if commercial insurance companies covered mental health and substance abuse treatment at the same levels as other health needs. Despite a progressive reputation, Wisconsin is one of only 17 states that have not adopted some form of mental health insurance parity. Current law requires commercial health insurance to pay only up to $7,000 per year for mental health and substance abuse treatment. This level, unchanged since 1985, will cover no more than one week of inpatient hospital care in some parts of the state, leaving no funds for follow-up treatment.

Note: A similar recommendation was made by the Children's Mental Health Workgroup, and appears as Recommendation 5.7 in this report. Details from the two recommendations have been combined here.

Experience in other states has shown that requiring parity—coverage for these disorders that is no more restrictive than coverage of other medical conditions—increases premium costs by only about 1 percent [43], particularly in systems that are already using managed care [44]. At the same time, the cost of not implementing parity is staggering. The combined indirect and related costs of mental illness, including costs of lost productivity, lost earnings due to untreated illness, and social costs are estimated to total at least $113 billion annually [45]. Health plans with the highest financial barriers to mental health services have higher rates of psychiatric Long-Term Disability (LTD) claims, while companies with greater access to mental health services see a reduced incidence of LTD claims [46].

Finally, there is no medical reason to continue to deny mental health parity. Mental health disorders, in general, are highly treatable. The National Institute of Mental Health has shown that success rates of treatment for disorders such as schizophrenia (60 percent), depression (70 to 80 percent) and panic disorder (70 to 90 percent) surpass those of other medical conditions such as heart disease, which has a treatment success rate of 45 to 50 percent [47].

Recommendation 3.4

Increase Medicaid reimbursement for mental health and substance abuse assessment and treatment

In the public sector, low Medicaid reimbursement rates present an obstacle to mental health and substance abuse treatment. Individuals on Medicaid, who are at greater risk of mental health and substance abuse disorders, have limited access to assessment and treatment because of reimbursement rates that are well below prevailing charges for these services, as well as cumbersome paperwork requirements. Increasingly, access is available only through county or Tribal agencies or through nonprofit providers who are able to subsidize the cost of care.

A challenging state financial picture as well as lack of federal Medicaid reform undermines the ability of county governments to meet the need for mental health and substance abuse treatment. At a minimum, the Medicaid program needs to increase reimbursement for these services to ensure an adequate supply of providers.

Wisconsin is one of only 17 states that have not adopted a form of mental health insurance parity.

Recommendation 3.3 – Implementation Details

Partnerships Required and Lead Agency	The Coalition for Fairness in Mental Health and Substance Abuse Insurance, which consists of more than 80 statewide and local organizations, has provided overall leadership for the parity effort the past 9 years. Member organizations include consumer, family and advocacy groups, provider agencies, unions, and faith-based groups.
Legislative and Policy Changes Needed	Legislative action is needed to change language in state statutes to modify current mandated minimums.
Existing Efforts That Can Be Duplicated	Enhance the work of the existing coalition.
Immediate Steps and Short-Term Strategies	The introduction of language to increase the mandated minimums based on inflation is considered to be an intermediate step given the repeated failure to have full parity legislation approved.
Accountability and Evaluation	Follow-up would be required to determine that health insurers are in compliance with changes to statutes. Evaluation could be done to determine if the changes lead to an increase in the access to mental health and substance abuse services and in improved health outcomes.
Financial Resources Needed	The Office of the Commissioner of Insurance estimated that a bill introduced in the 2003–2005 biennium, which would have increased the current mandated minimums based on the rate of inflation, would have increased premiums .15 to .5 percent, or by $10 to $30 million. The cost to the state because of increased insurance premiums has previously been estimated at less than $500,000.

Recommendation 3.4 – Implementation Details

Partnerships Required and Lead Agency	The lead unit in the Department of Health and Family Services (DHFS) would be the Division of Health Care Financing (DHCF). The Division of Disability and Elder Services would also have interest in this recommendation.
Legislative and Policy Changes Needed	The state budget process is the vehicle for addressing Medicaid rate increases.
Existing Efforts That Can Be Duplicated	DHCF implemented a rate increase for these providers a couple of years ago. DHCF can analyze the impact of a rate increase on recipient access to services and use that information to identify the level of increase needed to further improve access.
Immediate Steps and Short-Term Strategies	Rate increases can be incremental to accommodate the level of additional funds that the Governor and Legislature approve.
Accountability and Evaluation	DHCF can evaluate changes to recipient access to services through their information system.
Financial Resources Needed	Needs to be determined. The DHCF can assess the cost of the increase in Medicaid expenditures that would result from an increase in rates.

Recommendation 3.5

Provide additional funding to address the stigma associated with mental illness and substance abuse disorders.

While increased availability of mental health and substance abuse treatment is a necessary component to improving access to care, it is not always sufficient. The pervasive stigma surrounding these disorders often acts as a barrier to individuals seeking care. Healthiest Wisconsin 2010, the State's Public Health plan, identifies both mental illness and substance abuse as priority health conditions, and the recommendations in both areas include addressing stigma because it acts as a barrier to care.

The pervasive stigma surrounding these disorders often acts as a barrier to individuals seeking care.

Several current anti-stigma initiatives for mental illness and substance abuse disorders in Wisconsin (described in the implementation details on page 33) operate on limited resources compared to the need for public education. It is not clear that anti-stigma initiatives should be integrated at this time, but increased financial support is needed, and both initiatives may benefit from increased collaboration.

Recommendation 3.6

Create state-level policies that focus on enhancing parenting among adults with mental illness and substance abuse disorders.

While mental health and substance abuse treatment programs will identify if a client has children in his or her care, there is generally no assessment of the person's parenting skills and needs. A significant percentage of children enrolled in Integrated Service Programs for seriously emotionally disturbed youth and Coordinated Service Teams for families involved in multiple public systems have parents who have a mental illness or substance abuse disorder, but this is not universally assessed or addressed. The Women, Co-Occurring Disorders, and Violence Study [48] similarly recognized that the lack of services for mothers and children together acts as a major barrier to treatment and stressed the importance of addressing parenting roles. Even when this is addressed, there is a need for best practices.

The Department of Health and Family Services (DHFS) should take the lead to ensure that the mental health and substance abuse treatment community:

- Is educated about the importance of identifying persons with mental illness who are parents;
- Receives information about coordinated and comprehensive parenting assessments that providers can use to identify patients' needs about parenting;
- Receives information about referrals to appropriate services; and
- Receives information about best practices for providing parenting education to persons with mental illness and substance abuse disorders.

Finally, the state should ensure that policies are in place to support parenting roles, even when parents may need to be hospitalized or enrolled in residential treatment programs (e.g., the ability for parents to visit with children, as appropriate, or for younger children to stay with parents in residential settings).

Recommendation 3.5 – Implementation Details

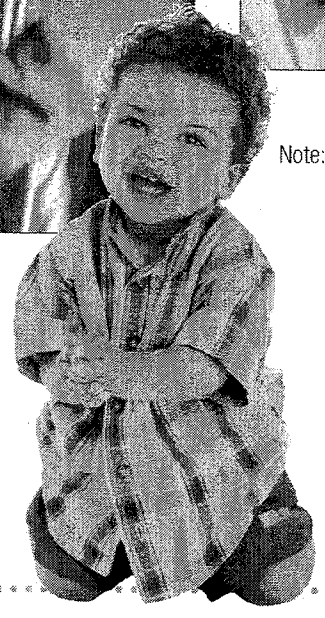
Partnerships Required and Lead Agency	See existing efforts (below). New partnerships are not required.
Legislative and Policy Changes Needed	The Legislature and Governor must approve any funds that might be requested through the state budget process.
Existing Efforts That Can Be Duplicated	Wisconsin United for Mental Health (WUMH) is a collaboration among a variety of state and private partners that has put on a number of media events, developed and distributed public service announcements, and supported development of local anti-stigma initiatives. This past year, as a pilot site for a federal anti-stigma initiative, the Eliminating Barriers Initiative, WUMH has been involved in rolling out anti-stigma materials for schools and businesses. Alliance for Recovery Advocate' (AFRA) mission is "to bring people of Wisconsin together to end stigma and discrimination against persons with addiction and to show, through education and advocacy, that recovery is a reality." Housed at the Wisconsin Association on Alcohol and Other Drug Abuse (WAAODA), AFRA has been instrumental in sponsoring a yearly rally to heighten awareness of substance abuse disorders and reduce stigma. More than 560 people attended the rally in 2004 called "Celebrating Recovery." WAAODA recognizes advocates at their annual conference and has created a "recovery pin" that people can wear to promote recovery.
Immediate Steps and Short-Term Strategies	Both WUMH and AFRA continue to seek other sources of funding and to engage in a limited range of activities with the resources available to them.
Accountability and Evaluation	WUMH is seeking funds from the two medical school Partnership Fund programs. These projects would include evaluation. There has also been an evaluation conducted as part of the grant received by WUMH from the Federal Department of Health and Human Services (DHSS).
Financial Resources Needed	Needs to be determined. Wisconsin United for Mental Health recently implemented a variety of anti-stigma activities through a $45,000 grant available through the federal DHSS. This should be viewed as a minimal amount of funds to maintain a viable initiative.

Recommendation 3.6 – Implementation Details

Partnerships Required and Lead Agency	The Bureau of Mental Health and Substance Abuse Services (BMHSAS) would be the lead unit in the Department of Health and Family Services (DHFS). Other consumer, family, advocacy, and provider groups can collaborate with the BMHSAS to identify the appropriate policies and practices to be developed and communicate to the provider community.
Legislative and Policy Changes Needed	Needs to be determined. Legislative changes may be needed to impact parenting supportive changes in regulated facilities such as hospitals and residential treatment facilities.
Existing Efforts That Can Be Duplicated	Assessments are available for partners to review and determine appropriateness. Similarly, evidence-based parenting curricula are available and information about these can be provided to the treatment community.
Immediate Steps and Short-Term Strategies	Needs to be determined.
Accountability and Evaluation	Needs to be determined.

CHAPTER 4:
Child Abuse and Domestic Violence

Co-occurrence of child abuse and domestic violence is highly prevalent and under addressed. Estimates show that in 30 to 60 percent of families experiencing domestic violence, there are child victims as well. Children living with domestic violence face increased risk of being neglected and abused, in addition to exposure to traumatic events that may affect their own psychological and physical well being. The recommendations that follow describe ways that Wisconsin can better identify, reach out to, and protect children who face these increased risks.



Note: The workgroup on Child Abuse and Domestic Violence researched and discussed several other strategies for preventing and identifying abuse and neglect in families that experience domestic violence. These strategies included discouraging dual arrest in domestic violence cases when children are present, expanding the unified family court model, and increasing access to sexual assault and domestic violence services for minors. Each of these issues are reported on in detail in the workgroup's full report (available at http://wctf.state.wi.us); however, the workgroup decided not to make formal recommendations in these areas because steps are already being taken to address them in Wisconsin.

Recommendation 4.1

Establish and distribute multidisciplinary training grants for agencies working on the intersection of domestic violence and child abuse and neglect.

To meet the needs of families affected by both domestic violence and child abuse and neglect, professionals working with these families must understand the scope of the issues and the work of the agencies involved. These professionals include Child Protective Services workers and supervisors, domestic violence and sexual assault advocates, law enforcement, and probation and parole agents.

Cross-training is most effective when it is planned and implemented on the local or regional level where it can address local issues and build community partnerships. For this reason, relevant state agencies should pool funds to create training mini-grants available to local communities, or a consortium of local communities in a region, for multidisciplinary training. The content of the training should include:

- Dynamics of domestic violence and its effects on children and youth
- Dynamics of child abuse and neglect
- Importance of keeping children and their most protective parent safe together and strategies for doing so
- What each participating agency can do to help hold abusers accountable
- Roles, values, capacity, policies, needs, and limitations of agencies involved in community response to domestic violence and child abuse and neglect

Funds would be made available to community-based agencies and local units of government. Applicants would submit a letter of intent describing the goals and content of the training, including cultural competency components, qualifications of trainers, anticipated participants, target audiences and projected number of participants, and how the training would create opportunities for cross-disciplinary collaboration.

Professionals working with families affected by both domestic violence and child maltreatment must understand the scope of the issues and the work of the agencies involved.

Recommendation 4.1 – Implementation Details

Partnerships Required and Lead Agency	State agencies contributing to the funding pool would be the Department of Justice (DOJ), Office of Justice Assistance (OJA), Department of Health and Family Services (DHFS), and Department of Corrections (DOC). An advisory committee would be formed composed of representatives of these agencies. The advisory committee would also include, but not be limited to, representatives from the following advocacy groups: Wisconsin Coalition Against Domestic Violence, Wisconsin Coalition Against Sexual Assault, Wisconsin Professional Society on the Abuse of Children; the Child Abuse Prevention Fund, Children's Trust Fund, and Prevent Child Abuse Wisconsin.
Legislative and Policy Changes Needed	None.
Existing Efforts That Can Be Duplicated	Several Wisconsin communities have organized successful multidisciplinary training events through existing groups such as Coordinated Community Response Teams, Child Advocacy Teams, or Coordinated Service Teams. These communities include Brown, Dane, La Crosse, Milwaukee, and Waukesha counties.
Immediate Steps and Short-Term Strategies	During a 6-month start up period, state agencies involved would earmark funds for the funding pool, designate staff, determine the mechanics of the funding process, and assemble the advisory committee. The advisory committee would meet to establish guidelines for the letter of intent and then again to evaluate these letters after they are submitted. Thereafter, funds would be awarded annually using the same process.
Accountability and Evaluation	Agencies receiving grants would be required to submit the following to the advisory committee: documentation of training (agenda, handouts) and number of participants, a summary of training evaluations, and documentation of follow-up activities. The advisory committee would meet annually to review the effectiveness of the application and distribution process and make any recommended changes.
Financial Resources Needed	Annual contributions from each state agency in the partnership.

Recommendation 4.2

Promote and support the development of multidisciplinary teams in Wisconsin communities

To better serve Wisconsin families, communities should be educated about and supported in the development of interagency multidisciplinary teams (MDTs) to respond to cases involving child maltreatment and domestic violence. These teams are similar to the community coordinating councils outlined in Recommendation 1.1, and might be implemented by coordinating councils or otherwise build on the partnership infrastructure provided by those councils. The creation of these teams leads to improved communication and collaboration, streamlined investigations, and better coordination of services to children and families. To promote and support increased use of MDT's, Wisconsin should:

- Hold a state summit on MDTs, inviting innovative programs from across the state and representatives from every county
- Create a sustainable and ongoing itinerant MDT professional development system tied into local service delivery networks

Implementation of this recommendation would require collaboration from the Wisconsin Children's Justice Act (CJA) Program, which has led the state in education and support for teaming in child abuse and neglect cases, and the Wisconsin Department of Health and Family Services (DHFS). Presently the CJA is nearing completion of a statewide survey about MDTs. This survey should be an invaluable tool in starting the planning process. Partnering with CJA to provide programming at their annual conference could provide a launch for this initiative. A launch at this venue would complement the CJA charge to present an annual training forum and connection to innovative and model programming.

In addition, educational programming and support for development of MDTs should be provided at multiple venues beyond a possible pre-conference at the CJA annual training. Ideas include making training available through the Children Come First Conference (Wisconsin Council on Children and Families), the Wisconsin Conference on Child Abuse and Neglect (Prevent Child Abuse Wisconsin), and regional training opportunities available through DHFS. Training efforts could be supported by the multidisciplinary training grants proposed in Recommendation 4.1.

Recommendation 4.2 – Implementation Details

Partnerships Required and Lead Agency	Lead agency: Wisconsin Department of Health and Family Services (DHFS). Partners may include the Department of Justice (DOJ) Children's Justice Act (CJA), Wisconsin Coalition Against Domestic Violence, the Wisconsin Coalition Against Sexual Assault, the Governor's Council on Domestic Abuse, Department of Public Instruction (DPI), and others.
Legislative and Policy Changes Needed	No state legislation is anticipated at this time. Interagency agreement for partnerships, either formal or informal, may be needed at the local level.
Existing Efforts That Can Be Duplicated	A survey of best practice issues should begin by examining the results of the statewide survey presently underway by CJA. In addition, present work by Coordinated Service Teams and resources available from the National Children's Alliance should be studied in the design and implementation of the trainings.
Immediate Steps and Short-Term Strategies	Efforts would be on-going with the goal of designing training modules that could be piloted in 2006, possibly at the CJA annual conference on MDTs. Evaluation and feedback from the participants would be sought to perfect the training and tailor the pilot for use in varied communities.
Accountability and Evaluation	Participants in training would complete post-training evaluations that would survey: 1. What they learned; 2. How they plan to use this knowledge; and 3. How they anticipate it will change the way they do things. Follow-up contact with participants at 6-month and 1-year intervals could then survey benchmarks of developing MDTs.

Recommendation 4.3

Improve training for law enforcement related to children on the scene of domestic violence

Currently, in Wisconsin, there are currently two sources of domestic violence training for law enforcement:

- **The Office of Justice Assistance (OJA) domestic violence training** funded by the Violence Against Women Act (VAWA) and offered at the request of local jurisdictions. This training does not follow a standard curriculum but is a set of topics designed to respond individually to local requests.
- **Recruit training**, which includes a specific curriculum on domestic violence as well as crimes against children, because of a recent collaborative effort between the Department of Justice (DOJ), Training and Standards (T&S) and Children's Justice Act (CJA), and Office of Justice Assistance (OJA).

Most law enforcement professionals surveyed believe that there is a pressing need for training that addresses other issues involving children at the scene:

- First responders assessing for safety
- Interviewing children
- Improved documentation about children in police reports

Recommendation 4.3 – Implementation Details

Partnerships Required and Lead Agency	• Department of Justice (DOJ), Training and Standards (T&S) and Children's Justice Act (CJA) • Office of Justice Assistance (OJA) • Local law enforcement agencies
Legislative and Policy Changes Needed	Needs to be determined.
Existing Efforts That Can Be Duplicated	Needs to be determined.
Immediate Steps and Short-Term Strategies	• Advocate a system change for DOJ T&S that would require specific training and certification for instructors who cover domestic violence, sexual assault, and child abuse in the sensitive crimes section of the recruit officers "500-Hour Certification Academies." This change would insure that fully trained instructors were a standard component of all police recruit academies and that new officers would receive appropriate training in basic investigation skills. • Work with DOJ CJA and OJA to supplement the existing Violence Against Women Act (VAWA) training to include more time devoted to issues involving children on the scene. • Provide feedback to DOJ T&S and OJA about emerging issues and best practice in domestic violence/children, to ensure that police recruits are receiving the most up-to-date training available. • Partner with OJA to close the training gap by providing regional domestic violence/children training to law enforcement from multiple jurisdictions, thus reaching a wider audience.
Accountability and Evaluation	Needs to be determined.

CHAPTER 5: Children's Mental Health

According to the U.S. Surgeon General, one in five children and adolescents has a diagnosable mental or addictive disorder, with 11 percent of children 9 to 17 years of age having a mental illness that results in significant impairments at home, at school, and with peers [49]. This statistic translates into almost 80,000 children in that limited age range who are likely affected in Wisconsin. Unfortunately, only about 20 percent of children with a mental illness receive needed treatment in any given year [50].

Children with disabilities are more vulnerable to maltreatment than children without disabilities [51]. Studies have found rates of maltreatment among children with disabilities ranging from 1.7 to 10 times that of the general population [52–54].

Emotional and behavioral disorders put children at greatest risk of abuse and neglect.

Of all types of disabilities, emotional and behavioral disorders appear to put children at greatest risk of abuse and neglect [52, 53]. The American Psychological Association [55] reports that "children with schizophrenia, affective disorder, anxiety disorder, conduct disorders, and autism are at particularly high risk, being seven times more likely to be abused and neglected than their non-disabled counterparts."

Numerous researchers cite caregiver strain as a critical factor in maltreatment of children with disabilities. Specific causal factors families face include stress, frustration, isolation, exhaustion, and feelings of hopelessness.

Targeted primary prevention provides interventions to individuals and families who face a higher-than-average risk for child abuse and neglect, and presents the most effective approach for reducing the initial occurrence of child abuse and neglect in families that include a child with mental, behavioral, or emotional health needs. Therefore, Wisconsin's approaches to reach the families of these children should be targeted specifically at that group, and should focus on risk factors within those families.

In reaching consensus on the recommendations detailed in this report, the Children's Mental Health Workgroup considered the factors that appear to increase the risk of maltreatment, the strategies supported by independent research, the relative impact of the options considered, and the feasibility of implementing the proposed solutions. A summary of this research is available in the full report of the Children's Mental Health Workgroup at http://wctf.state.wi.us.

High-Priority Prevention Strategies

Based on the research described above and on anecdotal reports from Wisconsin families, the Children's Mental Health Workgroup proposes three high-priority targeted prevention strategies, presented here as Recommendations 5.1 to 5.3. Recommendations 5.4 to 5.7 represent specific, system-level recommendations that the workgroup believes are necessary to significantly decrease the incidence of maltreatment of children with mental, emotional, or behavioral disorders.

Recommendation 5.1

Increase the availability of respite care services for families that include children with mental, emotional, or behavioral disorders

Respite is temporary relief for caregivers and families who are caring for children with disabilities or other special needs. Wisconsin was the third state in the nation to adopt lifespan respite care legislation in 1999. Lifespan Respite Care envisions a system of "one-stop shops" where family caregivers can access quality respite care regardless of age, disability, or income. There are currently five Lifespan Respite Care pilot projects in the state that provide stipends to families to purchase respite care.

Respite has been shown to improve family functioning and life satisfaction, enhance capacity to cope with stress, and improve attitudes toward the family member with a disability [56]. According to the paper *Family Caregiving and Public Policy, Principles for Change*, "Respite has been shown to help sustain family stability, avoid out of home placements, and reduce the likelihood of abuse and neglect" [57].

To increase availability of respite care for families that include children with disabilities, Wisconsin should use a combination of resources, including privately- and publicly-funded respite services, volunteers, and family co-ops.

- **Establish Parent Cooperatives:** Organize geographically-based parent co-ops to provide respite care. Families would "earn" respite by providing the same services to other families. Barriers that must be overcome include training, capacity of families that include children with disabilities to care for other children as well, developing a workable scheduling system, and family crises arising at times that impact the provision of scheduled respite services.
- **Use Volunteer Services**: Work with various faith, community service, and university programs to establish volunteer networks for providing respite services. Barriers anticipated are level of individual commitment, training, administration, and volunteer turnover.
- **Capture Additional Federal Funding:** Use HealthCheck as a funding mechanism for respite for the Medicaid-eligible population. Respite is a coverable federal Medicaid benefit (other states are covering respite in fee-for-service, home- and community-based waiver, and managed-care settings) and therefore should be covered by HealthCheck. This is a crucial way to stretch limited state funding by obtaining a 60 percent federal match. Identifying respite providers that are Medicaid-certified is a barrier that would need to be overcome.
- **Expand Lifespan Respite Care:** Consideration should be given to expanding funding for Wisconsin Lifespan Respite Care.
- **Use Family Support Program Funding:** Set aside a small portion of the Department of Health and Family Services' (DHFS) Family Support Program funding to provide crisis respite care to families that include children with mental, emotional, or behavioral disorders. Barriers may include amending current legislation and administrative rules.

Respite improves family functioning and life satisfaction, enhances capacity to cope with stress, and improves attitudes toward the family member with a disability.

Recommendation 5.1 – Implementation Details

Partnerships Required and Lead Agency

Identify the Wisconsin Department of Health and Family Services (DHFS) as the lead agency for the expansion of respite care. A key private, nonprofit resource is the Respite Care Association of Wisconsin (RCAW), which serves as a clearinghouse for information about respite care, provides training and technical assistance to respite care programs, and advocates for support of respite care at the state and federal levels.

RCAW, or another similar organization, should be engaged to provide critical training and technical assistance for family respite co-ops and volunteer-based respite care programs. Such an organization should also be involved in establishing standards, guidelines, and safety measures for respite programs.

Legislative and Policy Changes Needed

Beyond budget approval for any publicly-funded initiative, there may need to be legislation or administrative rule changes to set aside a small portion of funding from DHFS's in-home Family Support Program (for families who have children with severe disabilities) for crisis respite care for families that include children with mental, emotional, or behavioral disorders.

Existing Efforts That Can Be Duplicated

Wisconsin Lifespan Respite pilot projects

Immediate Steps and Short-Term Strategies

Needs to be determined.

Accountability and Evaluation

A comprehensive evaluation program would have to be developed to ensure that funded programs are achieving the results anticipated. Specifically, incidence of child abuse and neglect in the target population would need to be measured. This may require some additional information (i.e., disability of maltreated child) be gathered by child welfare agencies throughout the state.

Financial Resources Needed

Funding (specific amount to be determined) from public or private sources would be required to establish guidelines, standards, and training for volunteer- and co-op-based respite programs. Such policies are needed to ensure consistency of the level of care provided, safety of the child and respite provider, and maximum benefit from the service.

Expansion of Wisconsin Lifespan Respite at the current level of funding to all counties would require $1.8 million.

To provide 40 hours of respite per year to a portion of those children with the most significant needs (20 percent of those identified with a serious emotional disorder resulting in extreme functional impairment) would cost $7.7 million.

Recommendation 5.2

Increase the availability of parent-to-parent support systems, including advocacy, for families that include children with mental, emotional, or behavioral disorders.

Parent-to-parent support organizations provide a variety of services to families including, but not limited to, information about disorders, treatment options, service programs, providers, child and parental rights, mental health law, and special education; education and training; advocacy for the family as they deal with the systems that serve them; and, most importantly, emotional support.

Parent-to-parent support networks directly improve the caregiver strain factors that increase the risk of child maltreatment, including stress, isolation, hopelessness, fear, guilt, coping skills, and exhaustion. A large body of research speaks to the unique benefits of parent-to-parent support:

- Parent-to-parent support provides help in seeing hope for the future, feeling less alone, seeing positives in the situation, acceptance of the child's diagnosis, seeing family strengths, and dealing with stress [58].
- Support for parents has been found to facilitate attachment and lessen parental stress, anger, and depression [59, 60].
- Peer support was found to be helpful by more than 80 percent of parents using the services; it increased parents' sense of being able to cope and their acceptance of their situation [61].
- Parent-to-parent support is a means for helping parents feel less isolated, for providing empathy by those who truly understand, and for providing hope in what may seem a hopeless situation [62].

Recommendation 5.2 – Implementation Details

Partnerships Required and Lead Agency

Since parent-to-parent support networks assist children and families with all systems they may encounter, it is recommended that the lead agency consist of representatives from various state and local organizations, possibly to include the Department of Health and Family Services (DHFS) and the divisions of Community Mental Health, Maternal and Child Health, and Child Welfare, the Department of Public Instruction (DPI), the Department of Workforce Development (DWD), Office of Juvenile Justice, and Wisconsin County Human Services Association.

Wisconsin Family Ties, Families United, or another similar organization should be engaged to help develop standards, guidelines, and training to ensure implementation of quality-driven, outcome-oriented processes of parent-to-parent support.

Legislative and Policy Changes Needed

Other than budget approval of any additional public funding, no legislative or policy changes are needed to implement effective parent-to-parent support networks.

Existing Efforts That Can Be Duplicated

- Wisconsin Family Ties [63]
- UPLIFT in Wyoming [64]
- Florida Institute for Family Involvement [65]

Immediate Steps and Short-Term Strategies

Needs to be determined.

Accountability and Evaluation

All of the model programs listed above have developed outcome-oriented evaluation systems to measure the efficacy of services provided. Some items evaluated include the parents' perception of their ability as an advocate for their children, their ability to deal with the various systems serving their children, their ability to cope with their family situation and their feelings of hopefulness about the future. Elements to measure specific child maltreatment risk factors may need to be added to the evaluation.

As described in Recommendation 5.1, measuring the incidence of child abuse and neglect in the target population may require child welfare agencies to gather additional information (i.e., disability of maltreated child) throughout the state.

Financial Resources Needed

Using existing infrastructure, a $200,000 annual investment would reach 1,000 new families each year. To implement a parent-to-parent support network that could adequately cover the entire state would require about $2.5 million.

Recommendation 5.3

Promote and implement collaborative systems of care to provide comprehensive mental health screening, assessment, early intervention, and treatment.

Children with mental, emotional, or behavioral disorders need access to wraparound systems of care. Therefore, the wraparound (also known as "collaborative systems of care") concept should be applied to children's mental health services in the context of child abuse and neglect prevention. The wraparound process is an approach in which services are highly individualized to meet the needs of children and families. A "service coordinator" works with the family to discover their strengths, set goals, determine major needs, and develop strength-based options [66].

Apply the wraparound concept to children's mental health services in the context of child abuse and neglect prevention.

The process is "family-focused" in that the family is involved in all aspects of care planning, decision-making, and service delivery. By involving the family in all phases of the process, parents can regain a sense of control over what can be an overwhelming situation. They begin to view their family situation more positively and see hope for improvement, thereby reducing key child maltreatment risk factors of hopelessness and family stress.

Research also shows that collaborative systems of care positively impact the functioning of the child, which alleviates many stressors on the family. A study in Nevada showed that children receiving wraparound services were more likely to be moved to less restrictive placements, less likely to be moved to more restrictive placements, and more likely to improve school attendance and behavior than control group children with similar diagnoses [67]. In Hawaii, the percentage of children and adolescents with high Child and Adolescent Functional Assessment Scale (CAFAS) scores declined from 90 percent at intake to 67 percent after 2 years of wraparound [68].

Other wraparound studies also have shown positive outcomes for children, families, and communities. Studies report reduced rates of growth in foster care placements for communities using wraparound [69]; fewer criminal offenses among children enrolled in wraparound [70]; and a reduction in school suspensions among children receiving wraparound services [71]. A 1999 report to Congress detailed functional outcomes that improved for children involved in wraparound programs, specifically residential stability, school attendance, school performance, and the number of law enforcement contacts [72].

Recommendation 5.3 – Implementation Details

Partnerships Required and Lead Agency

Since the wraparound process promotes cross-functional collaboration, it is recommended that the lead agency consist of representatives from various state and local organizations, as well as family members. One possibility would be to use the existing Children Come First Advisory Committee in this capacity.

A training and technical assistance organization (of which several are active in Wisconsin) should be engaged to design an implementation process that would ensure adequate training and adherence to wraparound principles and would reduce any technical or implementation risk associated with the project.

Legislative and Policy Changes Needed

A legislative framework for implementing collaborative systems of care already exists, although statutes and administrative rules still presuppose the delivery of "categorical services." Eligibility requirements, points of entry, funding mechanisms, and organizational structures would need to be changed.

Existing Efforts That Can Be Duplicated

There are many model programs within Wisconsin's borders. Waupaca, Sauk, Calumet, and Jefferson counties all have strong collaborative systems of care, each having different areas of strength. Wraparound Milwaukee, which runs on a managed-care model, has produced impressive outcomes and has received national publicity for their accomplishments. (Please note that this is not intended to be a comprehensive list of model wraparound programs in Wisconsin.)

Immediate Steps and Short-Term Strategies

Needs to be determined.

Accountability and Evaluation

The collaborative systems of care in Wisconsin are the only public children's mental health programs in the state with documented, outcome-oriented evaluation processes, including measurements of family and team satisfaction. In addition, an annual report is issued by the Bureau of Mental Health and Substance Abuse Services. Nevertheless, there are opportunities for improvement:

- A tool to measure the quality of the wraparound process used, such as the Wraparound Fidelity Index [73], could be adopted.
- While outcome tools are common across Integrated Services Projects (ISP) and Coordinated Services Team (CST) sites, the managed-care programs in Dane and Milwaukee counties use different evaluation tools. This situation makes it impossible to aggregate data from all wraparound programs in the state.
- Providing a wide range of service options (such as in wraparound programs) will not necessarily lead to better outcomes unless the individual interventions and treatments are themselves effective [74]. Evaluation systems should incorporate efficacy measures for all treatment providers.

Financial Resources Needed

The current state funding level for all collaborative systems of care (operating under various program names) is $2.62 million annually. The additional funding that would be required to implement such systems in 70 counties is shown below, with three grant amounts. Two counties run managed-care wraparound systems funded by other sources and are not included in the calculations.

At a grant level of...	Additional funding need is...
$100,000	$4,380,000
$80,000	$2,980,000
$50,000	$880,000

System-Level Strategies for Sustaining Change

To permanently improve the care provided to families that include children with mental, emotional, or behavioral disorders would require changes in the systems that serve them. Little or no new state funding is required to implement the following four system-level recommendations.

Recommendation 5.4

Institute policies and structural changes to expand collaboration within and across state agencies.

Children with mental health needs and their families touch many different service systems. Among children 6 to 17 years of age in foster care, about 40 percent meet the criteria for a mental illness diagnosis with moderate impairment [50]. In response to health screenings conducted at admission to juvenile justice facilities, 73 percent of juveniles reported having mental health problems and 57 percent reported having prior mental health treatment or hospitalization [75]. Often, there are conflicting priorities between the various systems involved, leaving families confused and frustrated.

Just as collaboration is needed among local service providers, state agencies need to work together to ensure that systems, policies, and programs are adequate and not in conflict with one another. Even within a single state agency, coordination and collaboration can be difficult. In a recent federal Child and Family Services Review, Wisconsin failed to meet the benchmark for "children receive adequate services to meet their physical and mental health needs." A key concern identified was that "children are not receiving mental health assessments even when the nature of the maltreatment, the dynamics of the family, and the family's and child's history indicate that a mental health assessment is warranted" [76].

As soon as reasonably feasible, the Governor should establish a forum for the exchange of information and ideas between state agencies to:

- Develop a common knowledge base on children's mental health;
- Ensure that workers in child-serving professions are able to recognize when a child should be referred for further evaluation;
- Focus on outcomes;
- Identify and eliminate barriers to collaboration;
- Coordinate services between agencies;
- Develop flexible and compatible policies, processes, and procedures; and
- Identify and remedy gaps, inconsistencies, and conflicts between systems.

State agencies should be directed to work with all other appropriate agencies to determine the impact of any change in policy or practice or creation of a new initiative affecting children or families. These same agencies should also be directed to look at their current policies, procedures, or processes to determine if there are any that may be inconsistent with the outcome of preventing the initial occurrence of child maltreatment.

State agencies must also investigate and consider alternate organization structures that would foster a comprehensive and cohesive view of child and family needs, promote effective distribution of resources, and ensure that children's mental health programming is prioritized appropriately. This effort should begin as soon as possible.

Wisconsin has applied for a Mental Health System Transformation Grant, at least part of which would be focused on changing state-level systems. This effort can be facilitated in the context of that grant program regardless if the grant is received.

Recommendation 5.4 – Implementation Details

Partnerships Required and Lead Agency	Informal partnerships among all state agencies whose policies and programs affect children and families. Governor's Office to establish forum and advocate for collaboration.
Legislative and Policy Changes Needed	Needs to be determined.
Existing Efforts That Can Be Duplicated	The Wisconsin Initiative for Infant Mental Health Plan [79] articulates a design for building provider capacity and supporting a collaborative, cross-system infrastructure for infant mental health providers.
Immediate Steps and Short-Term Strategies	Initial forum to be convened by the Governor's Office, with collaboration and consultation between agencies to continue from there.
Accountability and Evaluation	Needs to be determined.

Recommendation 5.5

Implement evaluation systems to determine the efficacy of children's mental health programs

According to Wisconsin's application for the federal Community Mental Health Services Block Grant [77], 14,799 children with a serious emotional disorder received public mental health services in 2003 in the state. Of this number, only 14.3 percent were involved in programs with a strong evaluation component [78].

Wisconsin simply must be able to measure the effectiveness of existing children's mental health programs if it is to optimally deploy limited fiscal resources.

All children's mental health programs should develop comprehensive, outcome-oriented evaluation processes within 5 years; the data related to these programs that are currently collected should be identified within a year; and additional data that need to be collected should be identified within 2 years.

Recommendation 5.5 – Implementation Details

Partnerships Required and Lead Agency	Department of Health and Family Services (DHFS)
Legislative and Policy Changes Needed	Needs to be determined.
Existing Efforts That Can Be Duplicated	Needs to be determined.
Immediate Steps and Short-Term Strategies	All children's mental health programs develop comprehensive, outcome-oriented evaluation processes within 5 years; identify within 1 year data related to these programs that are currently collected; and identify within 2 years additional data to collect.
Accountability and Evaluation	Needs to be determined.

Recommendation 5.6
Address workforce shortages among mental health care providers

In Wisconsin, there are several clear indicators of the need for additional service providers in child and adolescent mental health. In most parts of the state, there is a dearth of child and adolescent health care providers who are appropriately trained to prescribe medications to treat mental, emotional, or behavioral disorders. In one northern Wisconsin clinic, there is a 1-year waiting list to see a child and adolescent psychiatrist.

Two states have addressed this issue by granting prescription privileges to specially-trained psychologists [80]. Wisconsin should explore this issue and review the experiences of states that have adopted the practice of prescribing psychologists.

In general, there is a medical service gap in the state: Wisconsin has almost 8 percent fewer physicians per 100,000 civilian population than the national average [81]. While child and adolescent psychologists and psychotherapists are more plentiful than psychiatrists, low provider acceptance of Medicaid makes the situation dire. The Wisconsin Department of Health and Family Services (DHFS) should compare state certification requirements and Medicaid reimbursement policies (see Recommendation 3.4) with those of neighboring states.

Note: Further implementation details for this recommendation need to be determined.

To address the general mental health workforce shortage across all domains, the workgroup recommends that incentives similar to those used for other areas of need be adopted. These could include loan forgiveness or reduction following five years of professional service in underserved areas of the state. An additional possibility includes increasing availability of tele-health services—video hookups between psychiatrists and patients for certain types of appointments.

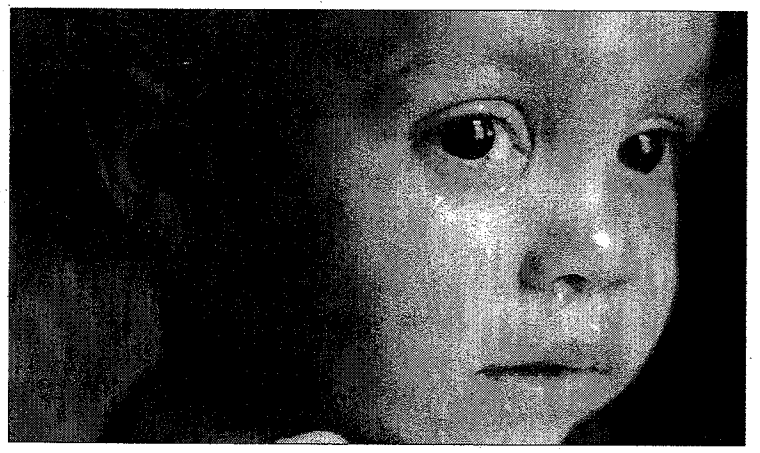
A further recommendation is to increase the availability of school-based mental health services. There are currently four groups of professionals in public schools who could provide mental health services: school counselors, school nurses, school psychologists, and school social workers. In all, these four groups have almost 3,800 master's-level professionals working in every school district in the state, many with additional graduate training beyond their master's degree. Schools have little to no incentive, however, to offer their services to children whose mental health needs do not rise to the level of needing special education. For children with documented disabilities who need special education and who also qualify for medical assistance, schools can obtain reimbursement for counseling, psychological services, rehabilitation counseling services, school health services, and school social work services. Schools cannot be reimbursed, however, for providing the same services to other children who may not require special education. Changing medical assistance rules to allow schools to provide these services to children with documented disabilities, and requiring private insurance reimbursement for these services (when provided by master's-level professionals in the school setting) would have the effect of making services available both earlier in the progression of the disorder and more widely in areas of the state where there is a documented need.

Recommendation 5.7
Enact mental health insurance parity

Note: The Mental Health and Substance Abuse Workgroup also recommended enacting mental health insurance parity. Details for this recommendation are provided under Recommendation 3.3.

SECTION III: CHILD SEXUAL ABUSE PREVENTION

Child sexual abuse accounts for close to 8,000 reports of child abuse each year in Wisconsin, with more than 4,000 substantiated cases in 2003 [82]. These cases are only the tip of the iceberg; it is estimated that fewer than 10 percent of child sexual abuse cases are reported to authorities [83].



One in three girls and one in five boys are sexually abused by 16 years of age [83, 84].

Victims of child sexual abuse suffer physical and psychological consequences when the abuse occurs and for as long as it continues. Also, victims are more likely than their non-abused peers to struggle throughout their lives with issues such as depression [85], post-traumatic stress disorder [86], eating disorders [87], alcohol and substance abuse [88], post-partum depression and parenting difficulties [89], sexual re-victimization, and sexual dysfunction [90].

The high incidence of this physically and psychologically damaging type of abuse makes it clear that child sexual abuse is a public health issue. To combat this epidemic, we need to be aggressive and invest in the prevention of child sexual abuse. Wisconsin's children need adults to prevent, recognize, and react responsibly to sexual abuse.

CHAPTER 6: Child Sexual Abuse Prevention

Wisconsin is woefully behind in strategies to prevent child sexual abuse. Children get information through most Wisconsin schools about how to keep themselves safe, usually beginning in elementary school. Because children have very little power and no authority over adult or older juvenile abusers, they have limited ability to prevent abuse.

It is, and must be, the responsibility of adults to assure the safety and well being of children. To carry out that responsibility, adults must understand the manifestations and consequences of child sexual abuse, recognize situations posing increased risk of such abuse, and respond appropriately to suspected abuse. Wisconsin has not focused on educating parents and other adults to take responsibility for preventing the sexual abuse of children, and that needs to change.

By improving the ability of adults to keep children safe from child sexual abuse we will, ultimately, help children to grow up safe and healthy.

Recommendation 6.1

Design and launch a child sexual abuse prevention initiative to be implemented throughout Wisconsin, using community and statewide resources.

To effectively reduce the incidence of child sexual abuse (CSA), Wisconsin needs a cohesive, multifaceted prevention initiative that empowers adults to take responsibility for children's safety. Existing Wisconsin resources should be used to implement a campaign combining individual components of two nationally recognized CSA prevention models, Stop It Now! and Darkness to Light. Both models target adults as those responsible for preventing CSA, but take different approaches and have varying strengths and weaknesses. Wisconsin's approach, described below, would be an innovative, "hybrid" CSA prevention effort.

Wisconsin needs a prevention initiative that empowers adults to take responsibility for children's safety.

The Stop It Now! model takes a public health approach to CSA prevention. The program's focus is preventing perpetration, stopping CSA before it occurs, and altering societal attitudes so CSA is no longer tolerated. The program targets abusers, those at risk of abusing, and their friends and family, as well as parents of youth with sexual behavior problems. It also educates adults in the general community on how to prevent CSA. The program challenges abusers to come forward to seek help and take responsibility. It asks family members and friends of abusers and those at risk of abuse to confront inappropriate sexual behaviors. Stop It Now! accomplishes these goals by using a toll-free helpline that provides information to the public and referrals for professional assistance. It has a comprehensive media component that includes public service announcements for print, radio, and television as well as advertisements in the community and via websites. The program also provides training to professionals on CSA prevention.

Darkness to Light is a national nonprofit organization promoting CSA awareness and education that targets the adults in a community. The program's strategy is to move adults from a position of awareness of CSA, to education about CSA and its prevention, to prevention-focused behaviors, and finally, to advocacy for CSA prevention. Darkness to Light has a solid media component, based on "Seven Steps to Protecting our Children," that provides adults with a concrete proactive approach to preventing, recognizing, and reacting to CSA. The organization's "Stewards of Children" component trains professionals from youth-serving organizations and adults with a frontline responsibility for protecting children. The model includes a community resource guide, policy and procedure guidelines for youth-serving agencies, a website, and evaluation tools.

Wisconsin's Approach to Child Sexual Abuse Prevention

Steering Committee

A steering committee will guide the initiative. It will be composed of a diverse group of citizens and professionals with knowledge of CSA and child maltreatment prevention, a passion for working to end CSA, and commitment to ongoing participation in program implementation.

The steering committee will make major program recommendations about implementation; assist in identifying and securing funding for the initiative; monitor program implementation quality; and provide a forum for program accountability. The committee would develop its own governance structure, which may include identifying an executive group.

Advisory Committee

An advisory committee composed of a multidisciplinary group of professionals who are experts in CSA, marketing, research, and program evaluation would provide ad hoc guidance to the steering committee. The advisory committee's primary responsibility would be to provide support for program implementation in areas needing targeted expert opinion. Its members would include representatives of Wisconsin state agencies, as well as experts in the fields of CSA, marketing, research, and program evaluation. The steering committee would recommend candidates for the advisory committee.

State Coordinator

A state coordinator would be in charge of program implementation, guided by the steering committee and advisory committee.

Community Support

To respond to the needs of its members about CSA prevention, each community must have a suitable infrastructure. This requires knowledge of community resources, as well as collaboration among organizations and governmental units to provide services. A short-term goal is to identify existing resources for CSA prevention, as well as gaps and barriers to services within each community. The long-term goal would require not only this analysis, but also identification of treatment resources available for victims, families, and offenders.

Pilot Sites

The program should be piloted in 2 to 3 counties or regions in Wisconsin. Each pilot site must have a local coordinator and local steering committee. Pilot site selection would be accomplished by the Steering Committee. The Steering Committee would identify specific minimal criteria, benchmarks, and pre-existing collaborative relationships that must be in place to be a successful location for a pilot site.

Public Outreach Methods

The program must target the public through various avenues including the following:

- A telephone helpline that offers information, advice and referrals to the public, to be staffed by personnel trained in CSA and its prevention. The helpline would target adults interested in learning about CSA prevention, those with specific concerns about CSA in their own lives, as well as existing and potential CSA offenders (adolescent and adult). Purchasing 1 to 2 years of the Stop It Now! helpline would allow time to conduct an assessment of resources needed for Wisconsin to operate its own helpline. The assessment would include developing a resource map, learning about training helpline staff, as well as learning about relevant legal issues and annual costs. After further economic and efficacy research, the Steering Committee would make a recommendation to continue to purchase the Stop It Now! helpline or to develop a Wisconsin model.
- A cyber helpline that uses electronic mail as a means for the public to obtain information and referrals about CSA and its prevention.
- A program that arranges and provides in-person contact between individuals and a trained staff member from each community. This would provide an additional avenue for victims, offenders, and those suspecting CSA to seek information and referrals for ongoing services.
- A media plan that uses television and radio public service announcements, interviews, newspaper coverage, and printed program materials. The media component could be purchased from Darkness to Light for the first 1 to 2 years, with original media messages to be developed during that time using pro-bono services by various Wisconsin agencies. Media messages would be delivered through advertisements, interviews, informational articles, and brochures.
- Community meetings for the general public that would provide information on CSA and prevention, as well as testimonials by survivors, family members, and offenders.

Training Component

Training for parents and professionals caring for children and adolescents is crucial. Education would include basic facts about CSA, recognizing grooming behaviors, and recognizing and responding to sexual abuse perpetrated through use of technology. Primary methods of CSA prevention would be described in detail. Training would also cover healthy sexual behavior and development in children and adolescents. Several Wisconsin professionals would be trained in the Darkness to Light protocol and would begin trainings within the three pilot communities. A train-the-trainer format would facilitate expansion of the program, with trainers obligated to train others. Trainers would receive ongoing support from the CSA prevention program staff. All potential trainers would be subject to a background check.

Policy and Procedure Development

The initiative would provide help to child-serving organizations in designing appropriate policies and procedures about CSA prevention, including educating businesses and organizations about performing background checks on potential employees. It is recommended that Wisconsin purchase this component of the Darkness to Light program.

Sustainability

The lead agency and steering committee members would be responsible for developing and implementing a sustainability plan for the program. Plans include application for grants by the state coordinator and identification of funding sources by the committee members.

Sustainability of CSA prevention efforts must rely on more than a single, time-limited public awareness or education campaign. The statewide prevention initiative would foster community sustainability by providing ongoing education and training to many different professionals and citizens, with the goal that youth-serving organizations incorporate the training into their required continuing education practices, and communities make CSA prevention part of the ongoing education offered to the public. Multiple trainers from varied professions and sectors of the public would assure wide distribution of effort, maximizing the sustainability and effectiveness of the initiative.

Recommendation 6.1 – Implementation Details

Partnerships Required and Lead Agency

The steering committee would outline needs and criteria for a lead agency and publicize a request for proposals. The lead agency may or may not subcontract with another agency for some or all of the program implementation. It would be the responsibility of the lead agency to hire a coordinator, monitor the program funds, develop necessary contracts, and identify and secure funding.

The steering committee would be composed of representatives from state and private organizations and agencies. (See full report at http://wctf.state.wi.us for complete listing of suggested partners.)

Legislative and Policy Changes Needed

- Introduce legislation to mandate a crosscheck of the sex offender registry with registries of professionals who work with children.
- Examine and revise the Department of Public Instruction (DPI) statute about protective behaviors to complement best practices in the field of CSA prevention.
- Modify legislative and state agencies' policies, procedures, and state laws that potentially hinder CSA reporting or unwittingly allow CSA to occur.

Existing Efforts That Can Be Duplicated

- Existing written and videotaped educational materials about CSA prevention. May be used to complement the Darkness to Light materials.
- CSA prevention training for law enforcement recruits. This new program would be reviewed and efforts would be made, in collaboration with the sponsoring agency, to facilitate training of all law enforcement officers.
- Suspected Child Abuse and Neglect Mandated Reporter Training program (SCAN-MRT). Would be reviewed to maximize CSA prevention training for professionals.
- Darkness to Light community-asset mapping tools to identify existing community resources, activities, and programs related to CSA prevention. To be used by each of the pilot communities.

Immediate Steps and Short-Term Strategies

- Appoint Steering Committee.
- Identify existing resources for CSA prevention, as well as gaps and barriers to services within Wisconsin communities.
- Implement pilot projects at 2 to 3 sites for 3 years. Review and revise the approach for replication in other communities.
- Examine the issue of required training in CSA prevention for all licensed professionals working with children.

Accountability and Evaluation

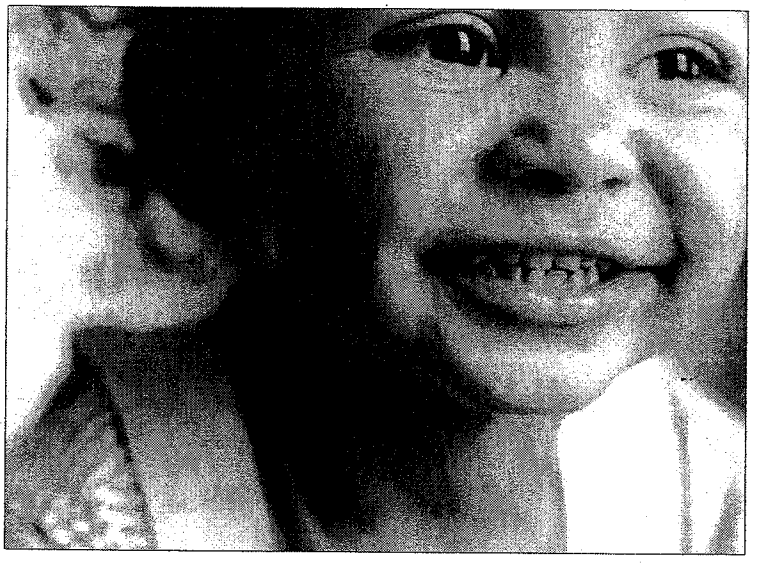
To ensure program accountability and success, the steering committee would consult professionals about formal impact and outcome measures. Several components would be evaluated, including the following:

- Outcome of legislative initiatives
- Number of helpline calls (including the number of calls from self-identified abusers, those at-risk for abuse, parents of youth with sexual behavior problems, and parents and professionals concerned about possible victims.)
- Number of helpline calls for information only compared to referrals
- Number of people trained (professionals and private citizens)
- Number of "hits" to the website
- Change in knowledge about CSA and its prevention, as measured in focus groups before and after implementation of the initiative
- Number of media exposures (interviews, radio spots, etc.)
- Number of communities that have adopted the program's infrastructure
- Change in the professional practice implemented by trained participants, as measured by a delayed post-test
- Number of agencies developing specific policies about CSA and its prevention.
- Number of electronic mail messages to the cyber helpline
- Number of in-person contacts between program staff and individuals seeking help and information
- Change in number of cases of CSA reported to Child Protective Services in pilot communities
- Change in number of child sex offense convictions in pilot communities

Financial Resources Needed

Total annual cost is estimated to be between $400,000 and $600,000. Additional funds would be required to strengthen community capacity for treatment and response.

SECTION IV: NEXT STEPS



**You're off to Great Places! Today is your day!
Your mountain is waiting. So...get on your way!**

***Oh the Places You'll Go!* by Dr. Seuss**

This *State Plan to Prevent Child Maltreatment* is not a product in and of itself; rather, it is a step in the process of the State Call to Action and a roadmap for state and local leaders. Its recommendations, formulated by the workgroups and based on topics and ideas that emerged from the Governor's Summit to Prevent Child Abuse, point us in the right direction to change our approach to the prevention of child abuse and neglect in Wisconsin.

Implementation of Recommendations

The recommendations presented in this *State Plan* encompass a wide range of approaches to preventing child maltreatment. They include new ways of working as well as expansions of existing efforts and modifications to increase the effectiveness of current policies and approaches. Following the release and distribution of the *State Plan*, the State Call to Action will move towards implementation. During 2006, several conferences will offer training that focus on *State Plan* recommendations. Details about these conferences will be posted on the Call to Action website at http://wctf.state.wi.us.

Some of the recommendations will be taken up by advocates and legislators at the state level. Some will be implemented in communities when key local players bring their energy and resources to the table. Others fall under the purview of state agencies, which may establish and distribute grants, provide technical assistance, and otherwise support efforts in communities around the state. All of these efforts will be tracked by the State Call to Action steering committee. (Local implementers, please share your progress with the steering committee by filling out the online feedback form at http://wctf.state.wi.us.)

Necessary Financial Investment

The cost of implementing the recommendations contained in the *State Plan* varies greatly. Many improvements to current prevention efforts can be accomplished with little new funding, and important elements of the State Call to Action are within reach of even the smallest community. The Steering Committee will continue to advocate making funds available at the state level to support such initiatives, and in many cases, a relatively small amount of money will go a long way.

To have a significant and lasting statewide impact on preventing child abuse and neglect, however, Wisconsin needs to make substantial investments in prevention. Investments in prevention now will reduce the need for costly interventions and treatments in the short and long run. Yet as a state and nation we continue to put the bulk of our resources into responding to child maltreatment and not enough into preventing its occurrence.

Wisconsin needs to make substantial investments in prevention.

The National Science and Technology Council estimates that only 2.7 percent of federal expenditures on children and youth go towards prevention [91]. A recent analysis by the Wisconsin Children's Trust Fund, considering only expenditures related to child maltreatment prevention and response, found that the state spent $673 million on the consequences of child maltreatment in 2002—including direct costs for responding to child maltreatment, and indirect costs in the long-term effects on past victims. Only $8.07 million, or about 1.2 percent of the total expenditure, was spent on prevention [92]. Of this amount, only $3.6 million went to programs that have child abuse prevention as a primary goal.

Many other states are shifting greater amounts of funding towards prevention, often using state appropriations. In 2004, twelve states used more than $5 million to fund child abuse and neglect prevention programs. In Kentucky, for example, $51 million of the state's general purpose revenue funds school-based family resource centers. Wisconsin's neighboring state, Minnesota, used more than $30 million to fund a variety of program approaches.

Wisconsin needs to explore various funding options as a critical step in the implementation of the State Call to Action. For example, participants in the Governor's Summit to Prevent Child Abuse were enthusiastic about a suggestion to draw on public and private sources to establish an endowment for prevention investments; another approach is to issue state bonds to fund prevention initiatives. One workgroup suggested giving Wisconsin taxpayers the option of donating to child abuse prevention through a check-off on their state income tax forms.

At the same time, Wisconsin must strive to make the best possible use of existing resources. Many of the recommendations of the *State Plan* call for cross-systems, public-private collaboration and cooperation at both local and state levels. Improved collaboration among systems and agencies will enhance families' access to the resources and services they need—while reducing duplication of services and ensuring the most efficient use of available resources.

Implementation of the State Call to Action will demand increased collaboration at all levels, creative thinking about funding sources, and a long-term commitment to the vision of a society where all children are safe from abuse and neglect.

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APPENDIX A: WORKGROUPS

Uniform, Comprehensive Systems of Family Support Workgroup

Premise

Family support promotes the positive things that families want for their children. It is an investment in the creation of happy, healthy, and productive citizens. Family support is effective in preventing child abuse and neglect and in reducing the stresses associated with child maltreatment. In addition, research shows that family support leads to increased self-confidence, knowledge of child development, and parenting skills among parents and other caregivers; fewer teenage pregnancies; less juvenile delinquency; more families moving from welfare to work; greater educational attainment among parents; improved behavior and performance of children at school; and increased employee productivity and satisfaction.

The primary responsibility for the development and well being of children lies within the family. The cornerstone of a healthy society is to assure the well being of all families, and this requires universal access to support programs and services. This workgroup will build upon Governor Jim Doyle's *KidsFirst* Initiative recommendation for a universal system of home visits to all first-time parents in Wisconsin. It will explore ways to ensure all families have access to cost-effective community support systems in Wisconsin.

Proposed Scope of Work

- Develop and recommend strategies to expand the availability of uniform, comprehensive systems of parent education and support.
- Focus on strategies that build upon an initial home visit to all first-time parents, maximize existing collaborations, and engage private sector resources.
- Examine community models that have established comprehensive, universal access systems of family support and parent education that build upon a base of home visitation to all new parents.
- Review existing efforts and evaluation data or research that holds promise for replication in Wisconsin.
- Identify strategies to expand recommended models that will result in uniform systems of parent education and support statewide.
- Develop policy and funding recommendations that focus on maximizing existing collaborations and engage public and private sector resources..
- Consider questions about crossover, duplication, and opportunities to regionalize services.
- Identify strategies for educating professionals across prevention and intervention systems about strength-based, family-centered best practices.
- Identify strategies to communicate to the public and policymakers about the need to invest in positive outcomes for children and families.

Uniform, Comprehensive Systems of Family Support Workgroup continued

Co-Chairs

Ann Altman Stueck	Department of Health and Family Services, Division of Public Health
Polly Snodgrass	Brown County Healthy Families and Early Head Start, Green Bay

Workgroup Members

Rachelle Ashley	Tribal Affairs Coordinator, Department of Workforce Development
Ann Conway	Wisconsin Association for Perinatal Care
Nancy Dewitt	Headwaters, Inc., Birth to Three Program, Rhinelander
Sandy Ellis	Children's' Service Society of Wisconsin, Wausau
Bonnie Geyer	University of Wisconsin-Extension
Lynn Good	Head Start Program, Cooperative Educational Service Agency (CESA) #7, Manitowoc
Linda Gratz	Head Start Program, CESA #7, Manitowoc
Anne Judge	Portage County Bright Beginnings Program, Stevens Point
Betsy Kelsey	United States Army, Family Advocacy Program, Fort McCoy
Rep. Steve Kestell	Representative, 27th Assembly District
Ann Laing	Racine Unified School District
Kimberly Porter	University of Wisconsin–Extension, Milwaukee County
Jim Schroeder	Respite Care Association of Wisconsin
Sandy Stetzer	Children's' Service Society of Wisconsin, Wausau
Mary Jo Tittl	Family Resource Centers of Sheboygan County
Karen Wall	School Social Worker, School/Home Liaison, Sparta
Susan Werley	Parents Plus of Wisconsin, Menasha
Trisha Ann Zdroik	Consumer Parent Consultant, Rosholt

Consultation and Programmatic Expertise Assistance

Mary Andersen	Waukesha County Division of Public Health
John Grace	Wisconsin Association of Family and Children's Agencies
Susan Harvey	Early Childhood Comprehensive Systems (ECCS) Coordinator, Department of Health and Family Services
Dan Naylor	Project Specialist, Coordinated Service Team (CST), Department of Health and Family Services
Kris Nelson	Brown County Healthy Families and Early Head Start, Green Bay
Pence Revington	University of Wisconsin–Extension
Laura Saterfield	Child Care Coordinator, Department of Workforce Development
Jen Wilen	Wisconsin Association for Perinatal Care

Special Programmatic Assistance from Participant Parents

Ashley
Chris
Beth
Jennifer

Family Economic Success Workgroup

Premise

Eleven percent of Wisconsin's children and youths live in poverty according to the 2003 *Kids Count Data Book*. Recent research in Milwaukee showed that the majority of families involved in the Bureau of Child Welfare were living below the federal poverty line. Families require twice the poverty-level income ($18,850 for a family of four) to meet basic needs. Many studies clearly document a relationship between poverty and child maltreatment, and yet there are many people that live in poverty that do not maltreat their children. Studies on familial stress also note that a large part of family stress is related to financial issues and the inability to meet basic needs.

While some look at economic success as "just getting a family member a job," we know it takes a more comprehensive approach. In general, neither family support nor early childhood programs focus much attention on helping families deal with issues related to family economic security. This workgroup will challenge the family support world to be more proactive and strategic about promoting family economic success. It will focus on strategies to reduce stressors relative to income, ability to meet basic needs, and primary prevention and early intervention of child abuse and neglect.

Co-Chairs

Charity Eleson	Wisconsin Council on Children and Families
Linda Preysz	Department of Workforce Development

Workgroup Members

Nancy Armbrust	Vice President, Education and Community Relations, Schrieber Foods, Green Bay
Jeannie Berry-Matos	The Vincent Family Resource Center, Milwaukee
Laurie Boyce	Special Assistant to Chancellor, University of Wisconsin–Extension
Emily Curtis	Coordinator, Community Services Block Grants, Department of Health and Family Services
Kathy Fullin	Department of Workforce Development
Al Holmes	George M. Sanders Fathers' Resource Center
Stacie Lobner	Family Advocate, Indianhead Community Action Agency Headstart
Dave Maurer	Racine County United Way
Jeremy Mavis	Children and Family Pastor, Hayward Wesleyan Church
Kath McGurk	Child Care Planner, Deparment of Workforce Development
Janice Peters	Deparment of Workforce Development
Richard Schlimm	Community Action Programs
Stan Stojkovic	Dean, Helen Bader School of Social Work, University of Wisconsin–Milwaukee,
Sue Werley	Parents Plus of Wisconsin
Peter Yang	Wausau Hmong Mutual Assistance Association

Proposed Scope of Work

- Examine family economic well being looking at such issues as poverty, homeless families, financial stressors, and ability to meet basic needs relative to child abuse and neglect prevention.
- Examine policy and funding recommendations.
- Identify strategies for improving family-centered systems and community supports.
- Identify strategies for integrating prevention and intervention services.
- Identify strategies for educating professionals who work with families at risk.
- Identify strategies to communicate to the public and policymakers about prevention and early intervention relative to family economic well being, poverty, financial stress, and ability to meet basic needs.
- Consider questions about crossover, duplication, and opportunities for collaboration.
- Consider efforts that may already exist about this issue and any evaluation data or research that holds promise for replication in Wisconsin.

Mental Health and Substance Abuse Workgroup

Premise

According to the National Clearinghouse on Child Abuse and Neglect Information, substance abuse and mental health, which are often grouped together as inter-related issues, have a major impact on the child welfare system and, clearly, on a parent's or caregiver's ability to parent and nurture the children in their care. Children of substance abusing parents are more likely to have poorer physical, intellectual, and emotional outcomes. Parents and caregivers with unaddressed mental health and psychological problems may lead the individual to engage in high-risk behaviors, and poor health habits leading to complicated poor health outcomes. Focus for this workgroup must be on primary and early secondary prevention relative to child abuse and neglect prevention.

Proposed Scope of Work

- Examine mental health and substance abuse as they relate to child abuse and neglect prevention.
- Examine policy and funding recommendations for mental health/substance abuse as related to preventing child abuse and neglect.
- Identify strategies for improving family-centered systems and community supports in addressing this area.
- Identify strategies for integrating prevention and intervention services relative to mental health/substance abuse, with the goal of reducing the incidence of child abuse and neglect.
- Identify strategies for educating professionals who work with families at risk for substance abuse and/or families with mental health issues as to how these issues are linked to child abuse and neglect.
- Identify strategies to communicate to the public and policymakers about prevention and early intervention relative to mental health and substance abuse as it relates to preventing child abuse and neglect.
- Consider questions about crossover, duplication, and opportunities for collaboration around this issue.
- Consider efforts that may already exist about this issue and any evaluation data or research that holds promise for replication in Wisconsin.

Co-Chairs

Susan Crowley	University of Wisconsin–Madison, University Health Services
Shel Gross	Mental Health Association in Milwaukee County

Workgroup Members

Al Castro	Rosalie Manor Community and Family Services
Ron Chance	Dane County Human Services
Sue Gadacz	Department of Health and Family Services, Bureau of Mental Health and Substance Abuse Services
Wendy Harter	Clark County Department of Social Services
Vanessa Key	New Concept Self Development Center
Don Maurer	Waukesha County Human Services
Wendy McCarty	Department of Health and Family Services, Division of Children and Family Services
Nina McLawhorn	Parent
Bea Moore Reas	Family Preservation Program, Bad River Tribe
Tim Otis	Mental Health Center of Dane County, Inc.
June Paul	Department of Health and Family Services, Division of Children and Family Services
Sue Weimerskirch	Children's Service Society of Wisconsin
Kathy Wolf	Wisconsin Clearinghouse for Prevention Resources

Staff

Julie Bark	Wisconsin Initiative for Infant Mental Health
Julie Rothwell	Mental Health Association in Milwaukee County

Domestic Violence and Child Abuse Workgroup

Premise

The co-occurrence domestic violence and child abuse is highly prevalent and under addressed. Estimates show that in 30 to 60 percent of families experiencing domestic violence there are child victims as well. Children living with domestic violence face increased risk of neglect, increased risk of being abused and risk exposure to traumatic events that may effect their own psychological and physical well being. Focus of this workgroup's work should be on primary prevention and early intervention issues relative to the intersection of child maltreatment and domestic violence.

Co-Chairs

Nancy Nusbaum	Department of Justice
Cyrus Behroozi	Task Force on Family Violence

Workgroup Members

Katie Aldrich	Legal Action of Wisconsin
Julie Braun	Department of Justice, Office of Crime Victims Services
Ann Brickson	Wisconsin Coalition Against Domestic Violence
Kelly Burger	Center Against Sexual and Domestic Abuse
Nic Dibble	Department of Public Instruction
Marianne Flynn-Statz	Madison Police Department
Judge Ramona Gonzalez	La Crosse County Circuit Court
Faith Holley-Beal	Women's Center, Waukesha
Ann Hraychuck	Polk County Sherrif
Robert Jambois	Kenosha County District Attorney
Michelle Jensen-Goodwin	Children's Court Improvement Program
Laurel Kieffer	Kieffer Consultants
Carolyn Lee	Bureau of Milwaukee Child Welfare
Sharon Lewandowski	Department of Health and Family Services
Kelly Longfield	Department of Justice
Ray Maida	
Sandy Nowack	Assistant Attorney General
Ben Ortega	La Causa, Inc.
Ann Rulseh	Children's Justice Act

Proposed Scope of Work

- Examine child maltreatment prevention and domestic violence prevention and the overlap of programs, best practices, and research.
- Examine policy and funding recommendations relative to the intersection of these two areas.
- Identify strategies for improving family-centered systems and community supports around this issue.
- Identify strategies for integrating prevention and intervention services to address the co-occurrence of domestic violence and child abuse and neglect.
- Identify strategies for educating professionals who work with families at risk for domestic violence about the link to child abuse and neglect.
- Identify strategies to communicate to the public and policymakers about prevention and early intervention relative to the link between child maltreatment and domestic violence.
- Consider questions about crossover, duplication, and opportunities for collaboration on this issue.
- Consider efforts that may already exist about this issue and any evaluation data or research that holds promise for replication in Wisconsin.

Children's Mental Health Workgroup

Premise

According to the Mental Health Resource Guide, one in five children and adolescents has a mental health treatment need and one in ten has a serious emotional disturbance that may severally impair the child's ability to function normally on a daily basis. Nearly two thirds of these children are not getting the help they require. Children can suffer from mental health issues like conduct disorder, anxiety disorder, and depression. When children carry these undiagnosed mental health issues into adolescence and adulthood, they are at greater risk for suicide, family conflicts, poor school and work performance, unhealthy peer relationships, and school and community violence.

Parents of children with undiagnosed mental health issues are challenged to parent and nurture these children, and many end up in the child protective service system. Children with both mental and physical disabilities are at greater risk for child abuse and neglect due to the intense nature of caring for these children. The focus for this workgroup is to consider the prevention and early intervention systems and networks of care for children aged 5 to 18. It is not the intent of this workgroup to replicate work completed by the Wisconsin Infant Mental Health Initiative, but to complement that work and expand it by considering the systems of care for school aged children.

Co-chairs

Hugh Davis	Wisconsin Family Ties
John Humphries	Department of Public Instruction

Workgroup Members

Therese Ahlers	Wisconsin Infant Mental Health Initiative
Scott Anderson	Wisconsin Council of Churches
Ron Biendseil	Dane County Youth Commission; Right from the Start Coalition
Kerry Bolger	University of Wisconsin–Madison School of Human Ecology
Dr. Sharon Foster	University of Wisconsin–Madison Medical School
Phyllis Greenberger	Wisconsin Coalition for Advocacy
Ann Hager	Family Advocate/Parent Representative, Wisconsin Family Ties
Bob Hillary	Franciscan Mental Health
Nancy Marz	Department of Health and Family Services
Dr. David Moulthrop	Rogers Memorial Hospital
Dan Naylor	Department of Health and Family Services, Bureau of Mental Health and Substance Abuse, Coordinated Service Team (CST)
Karen Ordinans	Children's Health Alliance of Wisconsin
Martha Rasmus	Mental Health Association, Milwaukee County
Jim Schroeder	Respite Care Association of Wisconsin
Kristyl Thomas	Parent Liaison, Special Needs Family Center in Milwaukee
Carol Ziesemer	Madison Metropolitan School District

Proposed Scope of Work

- Examine currently available systems of care for children aged 5 to 18 about prevention and early intervention of child abuse and neglect for children with undiagnosed as well as diagnosed mental health issues.
- Examine policy and funding recommendations relative to this issue.
- Identify strategies for improving family-centered systems and community supports to address children's mental health issues.
- Identify strategies for integrating prevention and intervention services for children's mental health issues relative to child abuse and neglect.
- Identify strategies for educating professionals who work with families about the mental health needs of children, and how those intersect with issues of child abuse and neglect.
- Identify strategies to communicate to the public and policymakers about prevention and early intervention relative to children's mental health.
- Consider questions about crossover, duplication, and opportunities for collaboration around children's mental health.
- Consider efforts that may already exist about this issue and any evaluation data or research that holds promise for replication in Wisconsin.

Child Sexual Abuse Prevention Workgroup

Premise

The majority of programs currently available to address the problem of child sexual abuse in Wisconsin suffer from the inherent flaw of placing responsibility for prevention on the child victim, rather than on the adults caring for them. These programs involve working with children to teach them the dangers of child sexual abuse and to help them learn behaviors and strategies to protect themselves from abusive situations. This information is important for children to learn, but it's no substitute for adult responsibility. Since children have very little power and no authority over their adult or older juvenile abusers, they have limited ability to prevent the abuse. It is, and must be, the responsibility of adults to assure the safety and well being of children.

A comprehensive approach to preventing child sexual abuse must be developed to address education about child sexual abuse (for caregivers, professionals, community members, and children/youth) and to decrease opportunities for abuse to occur (access to victims). Because child sexual abuse does not happen in one isolated part of the community's life, there needs to be a collaborative approach among the various organizations that interact with families and children, including schools, athletic groups, youth agencies/clubs, faith based organizations, and child welfare. A collaborative approach not only increases the effectiveness of the work but also makes best use of resources through non-duplication of efforts.

Co-chairs

Jordan Greenbaum, M.D.	Child Protection Center of Children's Hospital and Health Systems
Grace Roberts	Department of Corrections, Sex Offender Registration and Programs

Workgroup Members

Angela Carron	Child Protection Center of Children's Hospital and Health Systems
Susan Erlandson	School Social Worker, La Crosse School District
Joy First	Child Sexual Abuse Survivor and Researcher
Sharyl Kato	Rainbow Project
Phil Koss	District Attorney, Walworth County
Peggy Krusick	State Representative
Mark Lyday	Child Protection Center of Children's Hospital and Health Systems
Patty Marchant	Midwest Center for Human Services
Linda Morrison	Wisconsin Coalition Against Sexual Assault
Brenda Nelson	Safe Harbor of Dane County
Carl Niemiec	Psychologist
Mary Ann Renz	Child Abuse Prevention Fund Advisory Board Member
Ann Rulseh	Department of Justice, Children's Justice Act Program
Linda Selk	ASTOP
Kittie Smith	Office of Justice Assistance
Amy Smith	Child Protective Service Specialist, Department of Health and Family Services, Division of Children and Family Services
Michelle Watkins	Wisconsin Coalition Against Sexual Assault

Proposed Scope of Work

- Develop and expand child sexual abuse prevention programs that emphasize adult responsibility for prevention in communities throughout the state, with a focus on collaboration and use of existing resources.
- Develop policy and funding recommendations relative to developing and expanding child sexual abuse prevention programs.
- Identify strategies for improving family-centered systems and community support relative to child sexual abuse prevention.
- Explore strategies for integrating prevention and intervention services relative to child sexual abuse prevention.
- Identify strategies for educating professionals who work with families about child sexual abuse prevention.
- Describe strategies for communicating to the public and policymakers about the need to develop and expand child sexual abuse prevention programs that emphasize adult responsibility for prevention.

APPENDIX B: STEERING COMMITTEE

Wisconsin's State Call to Action is the product of an ongoing public-private partnership. The directors of the three sponsoring organizations form the Steering Committee, each bringing a unique perspective to the partnership. With the combined resources of these three organizations, the State Call to Action is able to reach a variety of stakeholders and advocate for the best interests of Wisconsin's children and families.

The Wisconsin Child Abuse and Neglect Prevention Board, also known as the **Children's Trust Fund**, is the state agency responsible for primary prevention of child abuse and neglect. For more than 20 years, the Children's Trust Fund has promoted strength-based, universally accessible family resource and support programs. Through its publications and outreach to consumers, the Children's Trust Fund seeks to raise public awareness about child development and positive parenting. The Governor-appointed Board also takes an active role in informing policymakers about the impact of legislation on children and families.

Children's Trust Fund

Mary Anne Snyder, Executive Director
110 East Main Street, Suite 614
Madison, WI 53703
608-266-6871
or toll-free 1-866-640-3936
http://wctf.state.wi.us

The Child Abuse Prevention Fund is a special initiative of Children's Hospital and Health System. Created in 1988 to raise funds and grant out dollars, the mission of the Child Abuse Prevention Fund expanded into program- and community-capacity building, community awareness, and advocacy in the mid-1990s. To date the Child Abuse Prevention Fund has supported more than 140 nonprofit agencies in Wisconsin for primary prevention of child abuse and neglect programming.

Children's Hospital and Health System™

Child Abuse PREVENTION Fund

Jennifer Hammel, Director
M.S. 3085 P.O. Box 1997
Milwaukee, WI 53201
414-266-6300
http://www.capfund.org

Prevent Child Abuse Wisconsin, formerly known as Wisconsin Committee to Prevent Child Abuse, was founded in 1978 as a private, nonprofit organization. As a state chapter of the national organization Prevent Child Abuse America, Prevent Child Abuse Wisconsin builds community resources, provides training and public awareness, and carries out advocacy activities to strengthen child abuse prevention efforts in Wisconsin.

Prevent Child Abuse Wisconsin

Patti Herman, Executive Director
211 S. Paterson Street, Suite 250
Madison, WI 53703
608-256-3374
or toll-free 1-800-CHILDREN
http://www.preventchildabusewi.org

Support Staff

Children's Trust Fund	Kathy Keehn, Sara Mooren, Cailin O'Connor, Jennifer Pavloski, Teressa Pellett, Norma Sampson, and Kathy Schultz
Child Abuse Prevention Fund	Lisa Lieske and Judy Zahn
Prevent Child Abuse Wisconsin	James Stickels and Hayley Williamson Tessier

A STATE CALL TO ACTION

Working Together to End Child Abuse and Neglect in Wisconsin

So be sure when you step.
Step with care and great tact

and remember that
Life's a Great Balancing Act.

Oh the Places You'll Go!
by Dr. Seuss

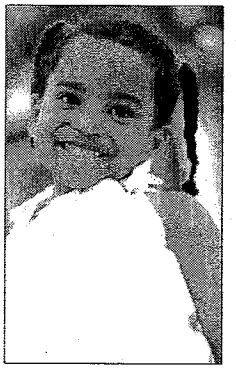
Join the State Call to Action effort!

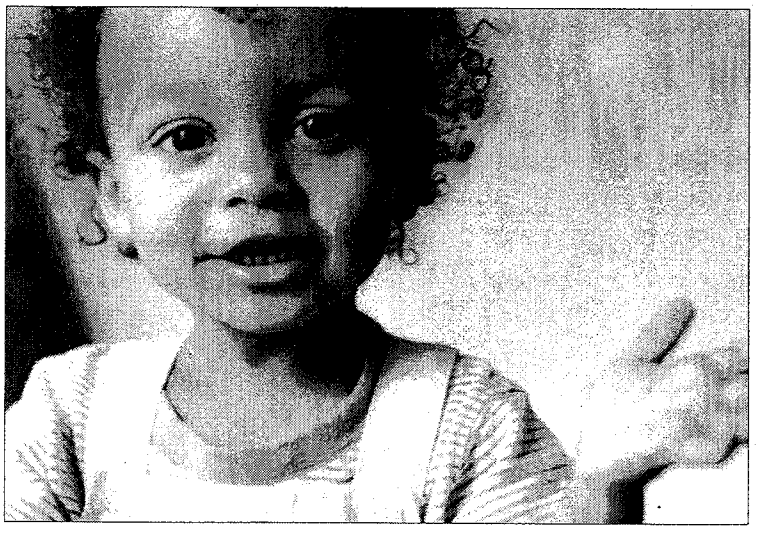
Successful implementation of the recommendations in *Wisconsin's State Plan to Prevent Child Maltreatment* will requre the coordinated and cooperative efforts of each of us---community members and leaders, at all levels.

- To join the effort, request or download a copy of *Wisconsin's State Plan to Prevent Child Maltreatment* at http://wctf.state.wi.us.
- Let us know what you are doing in your community to implement the *State Plan to Prevent Child Maltreatment*! Fill out a form about local initiatives at http://wctf.state.wi.us.

A STATE CALL TO ACTION

Working Together to End Child Abuse and Neglect in Wisconsin





Please don't harm all my little folks, who have as much a right to live as us bigger folks do!

Horton Hears a Who **by Dr. Seuss**

PFS-4102

Visit http://wctf.state.wi.us to request or download a copy of *Wisconsin's State Plan to Prevent Child Maltreatment*