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Give Slum Children a Chance

a radical proposal

By Charles E. Silberman

Can the nation afford a public-school system which is failing to educate between 50 and 80 per cent of its Negro and white slum children?

in handling abstract concepts that stem from independent causes, the slum child falls further and further behind after the third grade; the gap widens, and his IQ actually declines. His failure to read properly affects a lot more than

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October 13, 1966

MEMORANDUM

TO: Member Agencies - Executive and Board Liaison
Provisional Agencies
Associates
Board Members of CWLA

FROM: Joseph H. Reid, Executive Director

A REVIEW OF HR 16760*

Introduced by Congressman Fogarty in the House of Representatives

Background

In the 1962 amendments to the Social Security Act, Congress mandated that each state must extend its public welfare services to achieve complete geographic coverage of all child welfare services by 1975. However Congress did not provide the states with the necessary funds to carry this out. For many years states have been handicapped in their child welfare programs by lack of funds. The real estate tax base, which supports child welfare in many states, simply has not been sufficient to finance child welfare.

Furthermore in 1962 Congress passed legislation that provides 75% matching funds for administrative expenditures in the public assistance programs. This has meant that for any position in public assistance the state receives three Federal dollars for each dollar the state spends. In child welfare, however, the state receives no Federal funds for such positions. Although this legislation has greatly helped the public assistance categories, it has unintentially harmed the financing of child welfare services since state legislatures are naturally more willing to appropriate funds where each dollar they spend obtains three Federal dollars.

Two Federal advisory groups established by Congress to study public welfare--the 1959 Advisory Council on Child Welfare Services and the 1966 Advisory Council on Public Welfare, have both recommended that the Federal government share the financing of child welfare with the states.

* A copy of HR 16760 was sent to each member agency on September 19, 1966

Review of HR 16760

The following is a line-by-line review and interpretation of the content of the Bill.

Page 1, lines 1-10 and page 2, lines 1-4
This section contains authorization for Congress to appropriate such "sums as may be necessary." In other words, it is an authorization for an "open-end" appropriation. Instead of setting a fixed sum, such as five million dollars or fifty million dollars, Congress may appropriate whatever sum is needed to carry out the purposes of the act.

Page 2, lines 6-25 and page 3, 1-21
In the Social Security Act, Part IV, as amended in 1962, Congress established requirements for state child welfare programs. The following requirements of HR 16760 are essentially the same as the requirements under existing law. (1) Close cooperation between the child welfare programs of the state, the Aid to Families with Dependent Children and other public welfare programs. The purpose is to assure coordination and cooperation between the various programs affecting children. (2) A child welfare program must extend throughout all political sub-divisions of the state - (i.e. in every county). (3) Use of trained child welfare personnel to the extent feasible. (4) Each state must help finance the child welfare program. (5) A state public welfare agency must supervise the administration of the child welfare program whether it be administered locally by counties or administered statewide by the state public welfare department. (6) A merit system for public child welfare employees. (7) Reports from the states to the Secretary of Health, Education, and Welfare. (8) Families and children to be protected from the disclosure of confidential information to unauthorized persons.

Page 3, lines 22-25 and page 4, lines 1-3
A new and very important provision to insure that Federal dollars will not be used simply, replace state dollars. In other words, the states must continue to expend as much from their own funds as they expended in the fiscal year ending June 30, 1966. Federal funds therefore can be used only to extend and improve child welfare services, not just to substitute for state dollars.

Page 4, lines 4-25 and page 5, lines 1-17
Provisions are identical with present legislation that requires cooperation between the state health authority, the state agency responsible for the administration of the day care programs and the agency responsible for state supervision of public schools. It provides for an advisory committee made up of representatives of various groups. It also seeks to assure that day care will be used only for children where a valid need exists and requires that the family pay part or all of such costs when they are able. In addition the act also gives priority for use of day care services to low income groups, and requires licensing of day care centers.

Page 5, lines 18-24 and page 6, lines 1-3
The state plan must provide for payment of reasonable costs of adequate foster care and makes specific provision for purchase of care from non-profit agencies, including institutions.

Page 6, lines 4-8
Requires the state to obtain payments from the parents of a child in foster care, based on the parents' ability to pay.

Page 6, lines 9-20
Requires the state to establish criteria for determining when a child needs foster care. Provides for Federal reimbursement, only in foster care cases in which the state or local agency has responsibility for the child as a result of a written agreement with the child's parent or guardian or as a result of commitment by a court of competent jurisdiction.

Page 6, lines 21-24
Requires the state to make maximum use of funds available through title XIX of the Social Security Act. Title XIX is the recently passed Federal legislation "Medicaid" that provides Federal funds for the medical care of low income people.

Page 6, line 25 and page 7, lines 1-7
Requires that foster care be given only in licensed facilities or those meeting licensing standards, and that the state develop standards of reasonable cost. In other words, in purchase of care from private agencies the state would be required to set reasonable limits on what could be payed for care of a child.

Page 7, lines 8-10
This is an important new restriction on use of Federal funds, namely: a state or county cannot make a residence requirement as a condition for a child to receive service. (This restriction also appears in the Medicaid bill.)

Page 7, lines 12-24
Provides that the Federal government pay three quarters of whatever the state expends for personnel or the training of personnel utilized in the child welfare services program.

Page 7, line 25 and page 8, lines 1-5
Provides that the Federal government share in all other child welfare costs (including payment for foster homes, payment for institutional care and non-personnel administrative costs). The term "Federal child welfare percentage" is explained in detail on page 9.

Page 8, lines 6-25 and page 9, lines lines 1-9
Technical sections dealing with the transfer of funds.

Page 9, lines 10-19
The Federal share of the states' expenditures, for other than personnel, will be at least 50% and no more than 83%. Those states with the highest per capita income receive the smallest Federal share, and those with the lowest per capita income receive the greatest percentage of funds from the Federal government.

Page 9, lines 20-24 and page 10, lines 1-9
Technical material on the promulgation of the percentage.

Page 10, lines 10-24 and page 11, lines 1-2
Technical material on administration.

Page 11, lines 3-24 and page 12, lines 1-12
This section provides special funding for experimental projects and describes the conditions under which some special grants will be made. It will allow the state to develop an experimental program in a local area. Under previous sections of the bill, the child welfare service to be reimbursed had to be provided throughout the state. The purpose of this section is to encourage experimentations and demonstrations in programs that have not been sufficiently tried and tested to justify a statewide program.

Page 12, lines 13-22 and page 13, lines 1-22, page 14, lines 1-7
Changes Section 2 of Section 528 of the Social Security Act in order to add certain definitions. Previously "child" had not been defined nor had there been specific definitions for "foster family homes", "group homes" or "child care institutions."

Overall the CWLA thoroughly approves of HR 16760. The two questions that can be raised about the bill concern definitions.

The definitions on page 13, lines 6-7 restricts foster family homes to those that care for children who are "unrelated or not closely related to the family." Questions can be raised about the use of the term "not closely related." Many people believe that it is highly desirable to place a child in a home of a close relative where such home is available. A preferable definition might well be "a family home which cares for any child or children for whom the foster parents are not legally, financially responsible."

On page 13, line 21, question should be raised concerning restricting institutions to those that are "operated primarily for the care of dependent or neglected children." "Dependent and neglected" is a traditional narrow definition. A preferable definition would clearly include emotionally disturbed and delinquent children - or better, make no attempt to categorize children at all.

The overall importance to children of HR 16760 cannot be over-estimated. It would enable every state to do more than double its program for children without additional state expenditures, since the Federal government would be paying three quarters of all personnel costs and between 50% to 83% of all other costs, plus grants for special experimental projects. At a minimum, it would also double funds available for purchase of care from private agencies in states having such systems.

October 1966
JHR:rl

MINNESOTA

CHILD WELFARE PROGRAM

ANALYSIS OF FINANCIAL EFFECTS

of

H.R. 16760 INTRODUCED IN THE 89th CONGRESS-SECOND SESSION

F O G A R T Y B I L L

Proposal:

This bill provides for Federal financial participation in State child welfare expenditures on an "open end" basis, or on the basis necessary to carry out fully the purposes of the program. Present Federal financial participation in child welfare expenditures is limited to fixed amounts set by each Congress (which represented 8.8% of total child welfare expenditures in Minnesota in fiscal 1965).

Specifically, this bill provides for:

1. 75 percent Federal matching in that part of the cost of providing child welfare services that is attributable to compensation or training or personnel employed or preparing for employment.

2. 58.4 percent Federal matching for the amounts expended for other child welfare services under the plan. (This percentage would be effective July 1, 1967, through June 30, 1969; it will then vary according to the state per capita income relative to the national per capita income. In Minnesota the trend has been downward.)

3. Maintenance of state effort: The amount of state and local funds expended for child welfare services in each fiscal year must be no less than the amount so expended in the fiscal year ending June 30, 1966.

4. Research and demonstration funds in fixed amounts increasing to $50,000,000 in fiscal year 1971. This item is not part of this analysis of financial effects, since these Federal funds are given to states on the basis of individual project requests.

Financial Effects Statewide:

Because of item 3 above, Federal funds cannot replace state (and local) funds. Therefore, additional Federal funds can be obtained only by expanding the total program costs in child welfare services. The question is then, how far can the total child welfare program costs be expanded without incurring any additional state (and local) funds. The answer to this question can be made only in terms of where it is expected that the expansion will occur, since the rate of Federal

financial participation varies according to type of expenditure (as noted above).

Data on child welfare expenditures for the fiscal year ending June 30, 1966 are as follows:

(In millions)

	Total	Federal	State and Local
Total Cost	12.2	1.0	11.2
Foster Care	7.2	-	7.2
Salaries and Educational Leave	4.2	0.7	3.5
Other	0.8	0.3	0.5

The maintenance-of-state-effort provision requires the expenditure of at least 11.2 million in state and local funds. Assuming no change in the distribution of this amount among the above categories, the total program cost could be increased to 32.5 million dollars as follows:

	Total	Federal	State and Local
Total Cost	32.5	21.3	11.2
Foster Care	17.3	10.1	7.2
Salaries & Educational Leave	14.0	10.5	3.5
Other	1.2	0.7	1.2

On the other hand, if the program expansion can be planned in such a way as to put a larger share of the non-Federal money into "salaries and educational leave" without reducing the totals available for the other two categories of expenditures, the total program cost could be expanded to a maximum of 39.6 million as follows:

	Total	Federal	State and Local
Total Cost	39.6	28.3	11.2
Foster Care	7.2	4.2	3.0
Salaries & Educational Leave	31.6	23.7	7.9
Other	0.8	0.5	0.3

Possible Effect upon Individual Counties:

Although the maintenance-of-effort provision applies to the statewide total of state and county funds expended during the 1966 fiscal year, we will assume for the sake of simplicity that it applies to each county individually.

Example: Clearwater County

Child welfare expenditures for the year ending June 30, 1966 were ap-

proximately as follows:

	Total	Federal	State	Local
Total Cost	29,000	-	1,000	28,000
Foster Care	20,000	-	1,000*	19,000
Salaries	8,000	-	-	8,300
Other	700	-	-	700

(*Partial reimbursement for care of state wards.)

Assuming no change in the distribution of the $29,000 state and local funds among the three types of expenditures, Clearwater County's child welfare program could expand to a total cost of nearly $83,000, as follows:

	Total	Federal	State and Local
Total Cost	83,000	54,000	29,000
Foster Care	48,100	28,100	20,000
Salaries	33,200	24,900	8,300
Other	1,700	1,000	700

Under this plan, the county could add two or three case workers to spend full time on child welfare. Foster care payments could be greatly increased, since the amount available in this category would be more than twice that currently being spent for the purpose.

On the other hand, if emphasis is placed upon employment of additional staff while keeping expenditures for foster care and other child welfare purposes at their present levels, the Fogarty Bill would enable this county to have a child welfare program costing $102,000.

	Total	Federal	State and Local
Total Cost	102,300	73,300	29,000
Foster Care	20,000	11,700	8,300
Salaries	81,600	61,200	20,400
Other	700	400	300

It will be noted that this enormous increase in the amount to be expended for salaries and charged to the child welfare program could be achieved only if this agency devoted the equivalent of about eight workers' time to child welfare. Since the child welfare caseload (unweighted) in this county is estimated to include about 225 children and about 20 licensed homes, the establishment of individual caseworkers' loads containing no more than 60 unweighted cases would not call for the presence of eight full-time child welfare workers - unless there are in the community an appreciable number of children needing child welfare services and not currently known to the agency.

Example: Anoka County

In fiscal 1966, the child welfare program cost nearly $283,000, a sub-

stantial proportion of that amount being for salaries.

	Total	Federal	State	Local
Total Cost	282,700	5,300	8,900	268,500
Foster Care	145,000	-	8,900*	136,100
Salaries	132,400	5,300**	-	127,100
Other	5,300	-	-	5,300

(*Partial reimbursement for care of state wards.)
(**Program development grants for salaries of two homemakers.)

If the distribution of the $277,400 in state and local funds continues as above, Federal matching would enable this county to expand its program to a total of nearly $870,000, about three times the present total.

	Total	Federal	State and Local
Total Cost	869,700	592,300	277,400
Foster Care	348,600	203,600	145,000
Salaries	508,400	381,300	127,100
Other	12,700	7,400	5,300

This would permit some increase in rates of payment for foster care, as well as allowing for a probable increase in the number of children needing foster care. Also, it would enable the agency to add a considerable number of caseworkers to spend full time on child welfare services. To spend $508,400 on salaries in this program, the agency could assign the equivalent of 41 workers and 8 supervisors (including present staff) to spend full time on child welfare. If this happened, the agency's child welfare caseload could increase to 2,460 cases without departing from the caseload and supervisory standards established by the Children's Bureau. At present the agency has an estimated weighted caseload of 1,400 child welfare cases or an unweighted load of about 1,900 cases.

Alternatively, keeping totals for foster care and other expenditures at present levels and using the state and local funds thus freed for salaries, the Fogarty Bill would enable this county to have a million-dollar program without increasing the state and local totals.

	Total	Federal	State and Local
Total Cost	1,009,800	732,400	277,400
Foster Care	145,000	84,700	60,300
Salaries	859,500	644,600	214,900
Other	5,300	3,100	2,200

Expenditure of $859,500 on staff would be equivalent to 70 full-time child welfare workers and 14 supervisors, a staff sufficient for a child welfare caseload of 4,200. If the caseload were to increase so dramatically, it is clear that present levels of spending for foster care and other purposes would not be adequate.

It should be clear from the above examples that the total amount that could become available depends to some extent upon the relative magnitude of salary and non-salary items in the budget. Program expansion beyond the 11.2-million dollar level can take a variety of forms, as long as the purposes for which the money is budgeted are consonant with the general categories of expenditures acceptable to the Children's Bureau. By way of illustration, here are some possible uses of the additional Federal funds: payment of the state's full share of the cost of caring for dependent and neglected children under state guardianship, reestablishment of the reimbursement account for costs of care of unwed mothers from out of state, establishment of a program of family life education, and development of group work services to child welfare cases.

Federal Sharing in a more Limited Program:

All of the foregoing discussion has been designed to show the maximum extent to which the Fogarty Bill would permit the program to grow without any increase in state and local spending. But factors other than money affect the size of the child welfare program: the availability of caseworkers and other personnel to fill any new positions that may be established, characteristics of the local agency and the local community, availability of services from voluntary agencies or other specialized resources, and the number of children needing child welfare services, to mention some of the obvious determinants. For these reasons and others, it seems quite unrealistic to expect Minnesota's public child welfare program to become a 32-million dollar program immediately upon passage of the Fogarty Bill.

To illustrate how the Federal matching would operate in the event of a more modest expansion, let us assume that the program grows to the size shown (in millions) in the first column below. If it were not for the maintenance-of-effort provision, this 15-million dollar program would be supported by 9.59 millions in Federal funds and 5.41 millions from state and local sources. (The Federal amounts were computed by taking 75% of the amount spent on salaries and educational leave, 58.4% of the expenditures for foster care, and 58.4% of the third category of expenditures, while the amounts in the last column were obtained by subtraction.)

		Source of funds if bill contained no Maintenance-of-effort provision	
	Total	Federal	State and Local
Total Cost	15.0	9.59	5.41
Foster Care	8.5	4.96	3.54
Salaries & Educational Leave	5.0	3.75	1.25
Other	1.5	0.88	0.62

As stated above, this would be the picture in the absence of a maintenance-of-effort provision. Since the bill does contain such a provision,.. however, the program shown in the first column above would receive only 3.8 million in Federal funds, because:

Total Program	15.0
State and local funds in fiscal 1966	11.2
Federal Share	3.8

In this example, only about 25% of the program is being financed from Federal funds. Nevertheless, this 3.8 million is more than the Federal funds received by Minnesota in 1966, and it does cover the entire cost of the program expansion.

To state the case in another way: It is true that one dollar of non-Federal funds will buy four dollars'worth of staff or $2.40 worth of foster care or other services, but only if the non-Federal dollars total at least 11.2 million per year.

89TH CONGRESS
2D SESSION

H. R. 16760

IN THE HOUSE OF REPRESENTATIVES

AUGUST 2, 1966

Mr. Fogarty introduced the following bill; which was referred to the Committee on Ways and Means

---

A B I L L

To amend title V of the Social Security Act so as to extend and improve the Federal-State program of child-welfare services.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That sections 521 through 525 of the Social Security Act are amended to read as follows:

"APPROPRIATION

"SEC. 521. For the purpose of enabling each State to extend and improve public child-welfare services, there are authorized to be appropriated for the fiscal year ending June 30, 1967, and each of the succeeding fiscal years, such sums as may be necessary to carry out the purposes of this part. The sums made available under this section shall be used for making payment to States which have State plans for child-welfare services developed jointly by the State public-welfare agency and the Secretary.

"STATE PLANS FOR CHILD-WELFARE SERVICES

"SEC. 522. (a) A State plan for child-welfare services developed for purposes of this part must--

" (1) provide for coordination between the care and services provided under such plan and the care and services provided for dependent children under the State plan approved under title IV, and with care and services provided for children under other State or local programs, with a view to . . .

provision of such services as will best promote the welfare of such children and their families;

" (2) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them, and that child-welfare services under the plan shall be provided by the staff (which to the extent feasible shall be composed of trained child-welfare personnel) of the State public-welfare agency or the local agency participating in the administration of the plan in the political subdivision;

" (3) provide for financial participation by the State;

" (4) provide for administration, or supervision of administration, of the State plan by the State public-welfare agency;

" (5) provide such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Secretary to be necessary for the proper and efficient operation of the State plan;

" (6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and will comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

" (7) provide safeguards which restrict the use of disclosure of information concerning children receiving child-welfare services to purposes directly connected with the administration of the State plan;

" (8) provide that the amount of non-Federal funds determined by the Secretary to have been expended in the State under the State plan developed for any fiscal year will not be less than the amount of non-Federal funds determined by the Secretary to have been expended under the State plan ;

developed under this part for the fiscal year ending June 30, 1966; and

" (9) provide, with respect to day care services (including the provision of such care) provided under the plan--

" (A) for cooperative arrangements with the State health authority and the State agency primarily responsible for State supervision of public schools to assure maximum utilization of such agencies in the provision of necessary health services and education for children receiving day care,

" (B) for an advisory committee, to advise the State public-welfare agency on the general policy involved in the provision of day care services under the State plan, which shall include among its members representatives of other State agencies concerned with day care or services related thereto and persons representative of professional or civic or other public or nonprofit private agencies, organizations, or groups concerned with the provision of day care,

" (C) for such safeguards as may be necessary to assure provision of day care under the plan only in cases in which it is in the best interest of the child and the mother and only in cases in which it is determined, under criteria established by the State, that a need for such care exists; and, in cases in which the family is able to pay part or all of the costs of such care, for payment of such fees as may be reasonable in the light of such ability,

" (D) for giving priority, in determining the existence of need for such day care, to members of low-income or other groups in the population and to geographical areas which have the greatest relative need for extension of such day care, and

" (E) that day care provided under the plan will be provided only in facilities (including private homes) which are licensed by the State, or

approved (as meeting the standards established for such licensing) by the State agency responsible for licensing facilities of this type; and

" (10) provides, with respect to foster care (including the provision of such care) provided under the plan--

" (A) for payment of the reasonable cost for adequate care of each child receiving such foster care under the plan (as determined in accordance with standards established by the State agency and approved by the Secretary), including care purchased from nonprofit private agencies, group homes, and child-care institutions,

" (B) in cases in which the child's family is able to pay part or all of the cost of foster care of the child under the plan, for payment of such amount of such cost as may be reasonable in the light of such ability,

" (C) such safeguards as may be necessary to assure provision of such care under the plan (i) only in cases in which it is determined, under criteria established by the State agency, that a need for such care exists and that the type of care and services provided are in the best interest of the child, and (ii) except in situations in which emergency care is required, only in cases in which the State or local agency has responsibility for the child as a result of a written agreement with the child's parent or guardian or as a result of commitment by a court of competent jurisdiction,

" (D) for maximum utilization of health care and services available under State plans approved under part 1, 2, or 4 of this title or under title XIX, and

" (E) that such care will be provided only in facilities (including foster family homes) which (i) are licensed by the State, or approved (as meeting the standards established for such licensing) by the State agency responsible for licensing facilities of this type, and (ii) meet the

standards of reasonable cost for adequate care included in the plan pursuant to clause (A) of this subsection.

" (b) No plan developed for purposes of this part may impose any residence requirement as a condition of eligibility for services under the plan.

"PAYMENT TO STATES

"SEC. 523. (a) From the sums appropriated therefor, the Secretary shall pay to each State which has a plan developed as provided under this part, for each quarter, beginning with the quarter commencing October 1, 1966--

" (1) an amount equal to 75 per centum of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to compensation or training of personnel employed, or preparing for employment by the State agency (or by the local agency administering the plan in the political subdivision), for the purpose of providing child-welfare services; plus

" (2) an amount equal to the Federal child-welfare percentage of the remainder of the amounts expended during such quarter as found necessary by the Secretary, for the proper and efficient administration of the State plan, and of the amounts expended for other child-welfare services under the plan.

" (b) (1) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsection (a) for such quarter, such estimate to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such other investigation as the Secretary may find necessary.

" (2) The Secretary shall then pay, in such installments as he may determine,

to the State the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.

" (3) The pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered, during any quarter by the State or political subdivision thereof with respect to child-welfare services, shall be considered an overpayment under this subsection.

" (4) Upon the making of any estimate by the Secretary under this subsection, any appropriations available for the payments under this section shall be deemed obligated.

" (c) (1) The Federal child-welfare percentage for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the United States and shall in no case be less than 50 per centum nor more than 83 per centum. The Federal child-welfare percentage shall be 83 per centum for the Commonwealth of Puerto Rico, the Virgin Islands, and Guam.

" (2) The Federal child-welfare percentage for each State shall be promulgated by the Secretary between July 1 and August 31 of each even-numbered year, on the basis of the average per capita income of each State and of the United States for the three most recent calendar years for which satisfactory data are available from the Department of Commerce. Such promulgation shall be conclusive for each of the two fiscal years in the period beginning July 1 next succeeding such promulgation; except that the Secretary shall promulgate such percentage as soon as possible after the enactment of this part, which promulgation shall be conclusive for each of the quarters in the period beginning October 1, 1966, and ending with the close of June 30, 1969.

" (3) The 'United States' for purposes of this subsection only, means the fifty States and the District of Columbia.

"OPERATION OF STATE PLANS

SEC. 524. If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan developed as provided in this part, finds that in the administration of the plan there is a failure to comply substantially with any such provision, the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

"PROJECTS FOR EXPERIMENTAL AND SPECIAL TYPES OF
CHILD-WELFARE SERVICES

"SEC. 525. (a) For the purpose of encouraging experimental and special types of child-welfare services, there are authorized to be appropriated $15,000,000 for the fiscal year ending June 30, 1967, $20,000,000 for the fiscal year ending June 30, 1968, $30,000,000 for the fiscal year ending June 30, 1969, $40,000,000 for the fiscal year ending June 30, 1970, $50,000,000 for the fiscal year ending June 30, 1971, and for each succeeding fiscal year.

" (b) From the sums appropriated pursuant to subsection (a), the Secretary is authorized to make grants to the State agency administering the plan and (with the consent of such agency) to the local agency of any political subdivision of the State supervised by the State agency, for all or part of the cost, as determined by the Secretary, of developing and maintaining projects for experimental types of family or group care and services and for types of care and services that have been proved effective in special situations, including care and services for children

with special needs. No project shall be eligible for a grant under this section unless there is submitted to the Secretary an application providing (1) a description of the services available to, and the method of selection of, the children included in the project, (2) a description of the geographic area to be served by the project, and (3) reasonable assurance that there will be coordination of the care and services provided under the project with other State programs providing services for children.

" (c) Payment of grants for special projects under this section may be made in advance or by way of reimbursement and in such installments, as the Secretary may determine; and shall be made on such conditions as the Secretary finds necessary to carry out the purposes of the grants."

SEC. 2. (a) Section 528 of such Act is amended by--

(1) striking out the heading and inserting in lieu thereof "DEFINITIONS";

(2) striking out so much thereof as precedes "the term 'child-welfare services' means" and inserting in lieu thereof the following:

"SEC. 528. For purposes of this part--

" (a) ";

(3) striking out the period at the end and inserting in lieu thereof a semicolon; and

(4) adding after such semicolon the following new paragraphs:

" (b) The term 'child' means a child who is under the age of 21;

" (c) The term 'foster family home' means a family home which cares for any child or children who are unrelated, or not closely related, to the family and which is licensed by the State in which it is situated or has been approved, by the agency of such State responsible for licensing homes of this type, as meeting the standards established for such licensing;

" (d) The term 'group home' means a small, public or nonprofit private, residential home which cares for children and (A) is administered by a public or

nonprofit private agency concerned with child welfare services, and (B) is licensed by the State in which it is situated or has been approved, by the agency of such State responsible for licensing homes of this type, as meeting the standards established for such licensing;

" (c) The term 'child-care institution' means an institution operated primarily for the care of dependent or neglected children which (A) is a public institution operated by the State agency, or which has policies and methods of operations which have been approved by the State agency or (B) is a nonprofit private institution which is licensed by the State in which it is situated or approved, by the agency of such State responsible for licensing or approval of institutions of this type, as meeting the standards established for such licensing."

SEC. 3. As used in the provisions of the Social Security Act, amended by this Act, the term "Secretary" means the Secretary of Health, Education, and Welfare.

CWLA

CHILD WELFARE LEAGUE OF AMERICA

44 East 23rd Street, New York, N.Y. 10010

President's Letter

President's Letter

Dear Friends:

The most important piece of child welfare legislation since the thirties was introduced in the last Congress. It is legislation that would remedy a long-standing inequity by bringing programs for children into parity with other Federal welfare programs for the aged, blind, financially dependent, sick and disabled. The bill, which was introduced by Congressman John E. Fogarty of Rhode Island, lapsed when the Congress adjourned. We are assured, however, that the bill will be reintroduced in the 90th Congress.

Since the proposed legislation is of such direct interest to all who are concerned with the welfare of children, I would like to devote the major portion of this issue of the President's Letter to a discussion of its provisions and its significance.

The legislation provides for Federal sharing of the cost of a state's child welfare services, based on the state's per capita income, and would authorize whatever sums are necessary to carry out the purposes of the act. This is essentially what the Child Welfare League of America and other leaders in child welfare have been advocating for years.

Specifically and briefly the Fogarty bill would authorize:

1. *75 percent matching for salaries and training*
   The Federal government would pay 75 percent of the total of each state's salary and training costs for child welfare personnel employed or preparing for employment.

2. *50 percent to 83 percent for all other child welfare costs*
   Each state would receive funds to pay for a percentage of the cost of all child welfare services for every child who is the responsibility of the state or local public welfare agencies. Such funds would include coverage for purchase of care from voluntary agencies, and for administrative costs other than salaries.

   Payments would be made on a matching basis, depending on a state's per capita income. The Federal share of each state's expenditures (for other than salaries and training) would be at least 50 percent and no more than 83 percent with those states having the lowest per capita income receiving the largest Federal share.

3. *States must spend no less than before*
   To make sure that the additional Federal money made available by the bill would be spent to strengthen and expand child welfare programs, rather than used to replace state dollars, the legislation requires that state and local expenditures for child welfare services may not be less than such expenditures were for the year ending June 30, 1966.

4. *Services to children throughout the state*
   To be eligible for funds, a state must have a plan for a comprehensive child welfare program—a program that would include services to help children remain in their own homes as well as foster care services. The plan must meet Federal requirements that are essentially the same as those already established (by the 1962 amendments of the Social Security Act, part IV). They include the important proviso that the program must extend throughout all political subdivisions of the state. That is, services must be provided for children in all counties of the state.

5. *Grants for experimentation*
   Federal project grants would be available to states for developing and maintaining new or experimental forms of child welfare services, including services for children with special needs. Such grants would give states a specific incentive to develop new projects and to try them out within a limited local area, thus encouraging experimentation with programs that have not been sufficiently tested to justify their application on a statewide basis.

In other words, the bill would enable every state to more than double its program for children without any additional state expenditures: the Federal government would be paying three quarters of all personnel costs and from 50 to 83 percent of all other costs, plus grants for special experimental projects. At a minimum it would also double the funds available for purchase of care from private agencies in states having such systems.

The Effect on Children

How would such legislation affect our children? For children in half the counties of the nation, in which there are presently no child welfare services, it would mean the availability of services for the first time.

For children living in families where the problems are often large and the parents' ability to cope limited, it would mean more services to help the child and family stay together. With a program of increased services to children in their own homes, many of the children who are now placed in foster care could remain with their families. Today almost 90 percent of public child welfare funds is spent on foster care. With more social services available for the child in his own home (social work with children or parents, protective service, homemaker service, day care service) fewer children will need to be separated from their parents.

The legislation would enable communities to establish protective services for children. It is a shocking fact that in few communities today are abused and neglected children afforded the same protection given to abused and neglected animals.

Our first obligation in serving children is to give parents all the help possible to help them fulfill their roles as parents and meet the needs of their children. By increasing services to children in their own homes, as this legislation would permit, we could support and supplement parental care and thereby reduce the number of children who are—only for want of services—now separated from their families.

Urgency of the Need

We have reason to believe that only one-fourth to one-half of the children in need of child welfare services are receiving them. The total number of children potentially in need of help is estimated to be over 2½ million.

There is an enormous difference in the quality and quantity of child welfare services given by the states. Per capita expenditures vary: Texas spends as little as 27 cents annually per child; New York spends $12.87. In New York there are thousands of children for whom adoptive homes cannot be found because of lack of funds. Day care facilities are most inadequate, and in no area of child welfare do truly adequate services exist. If this is the situation in a state that spends a relatively large amount for its children, it is painful to imagine how children fare in states spending but a few pennies per child.

Last year Congress appropriated 30 million dollars for grants-in-aid to the states for child welfare services. This is less than ten percent of the total expended by public agencies on child welfare which, in 1964, was 313 million dollars. In addition more than 200 million dollars is spent annually from private funds.

Though major responsibility for the care of children is left up to the states, responsibility for other dependents has long been assumed by the Federal government. Since the Social Security Act of 1935, it has been recognized that the burden of financing services for the disabled, the widowed, the aged, the blind, and the many other categories of human need is too great for local taxes to support. (Three quarters of all taxes are raised by the Federal government.) But the Federal government has heretofore failed to offer comparable help to the states in meeting the heavy costs of child welfare services. The money spent for child welfare services is one of the smallest expenditures for any of the programs under the Social Security Act. It is indeed ironical that children should come last.

Recent Amendments

In 1962 Congress amended the Social Security Act to require that each state extend its child welfare services to achieve complete coverage throughout all counties of the state by 1975. Congress did not provide necessary funds to carry out this mandate, however. The proposed bill would correct this omission.

Congress also passed legislation in 1962 that provides 75 percent matching funds for personnel expenditures in public assistance programs. Thus, for any position in public assistance the state receives three Federal dollars for every one dollar the state spends. For child welfare, however, the state receives no Federal matching funds. Although the legislation has greatly helped the public assistance programs, it has inadvertently harmed the financing of child welfare services since state legislatures are naturally more willing to appropriate funds where each of their dollars can obtain three Federal dollars.

National Recognition of the Problem

Attempts to redress this national neglect of our children have been growing in recent years. The first official governmental recognition of the problem was by the bipartisan Advisory Council on Child Welfare Services, established by Congress to make recommendations to the Secretary of Health, Education and Welfare. The Council issued a report in 1959 recommending that the Federal government pay part of the total cost of the states' child welfare services through matching funds. In 1966 another bipartisan citizen group established by Congress to study public welfare recommended similar Federal responsibility for child welfare costs. The Fogarty bill provisions incorporate the recommendations of both advisory groups.

In February of this year, Senator Harrison Williams of New Jersey introduced a bill which would provide matching funds for child welfare expenditures. Its provisions were limited, however, to foster care. The bill subsequently became the Long-Williams bill; a similar bill was also introduced in the House by Congressman Cecil R. King.

To Redress the Long Inequity

For many years the League has led efforts to bring about national recognition of Federal responsibility for children. Through testimony before Congressional committees, consultation to individual Congressmen and to representatives of the press, through research studies and community surveys, through its publications, through conferences and forums, the League and its member agencies have exposed the inadequacy of programs throughout the country, have documented the tragic consequences of the lack of services in terms of children's lives, have advocated a national program to meet children's needs. The proposed Fogarty legislation is the culmination of years of effort to redress an inequity of long-standing—since the Social Security Act of 1935.

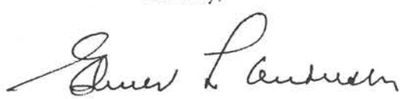
But we are still far from our goal. There is much that you, that all of us can do right now before the new Congress convenes on January 10th. Here is what the League is suggesting at this time:

Congressmen are at home now during the Congressional recess. Inform them of the need for legislation such as the Fogarty bill. It is important to remind them that child welfare is the only area of social welfare in which the Federal government does not participate. (Some Congressmen are unaware of this.) It is also important to point out in detail what such an act of Congress would mean in specific terms of programs for the children in your community.

Since the Administration has not yet indicated whether it will support such legislation, letters should also go to the President and to the Secretary of Health, Education and Welfare, strongly endorsing the principles of the Fogarty bill as introduced in the 89th Congress and urging the Administration to give its full backing to a new bill when it is introduced in the next Congress.

I hope you will join with us and with individuals and organizations throughout the county to help bring about the passage of this legislation.

Sincerely,



ELMER L. ANDERSEN, *President*
Child Welfare League of America

Membership Growth

League membership has now reached 286 private and public agencies in the United States and Canada. With the newly admitted agency from British Columbia, we have member agencies in four of the Canadian provinces. One of our new provisional members, the Boston Center for Blind Children, is the first League agency serving handicapped children exclusively. Membership has not included this kind of specialized facility in the past largely because institutions dealing with handicapped children have viewed themselves as educational or medical facilities.

New Member Agencies

The following agencies were admitted to provisional membership at the October 1966 meeting of the League's board of directors:

Albany Home for Children, Albany, New York
Boston Center for Blind Children, Boston, Massachusetts
Catholic Social Services of the Diocese of Grand Rapids, Grand Rapids, Michigan
Children's Aid Society of Vancouver, B.C., Vancouver, British Columbia
Good Shepherd School for Girls, Phoenix, Arizona
Jewish Family and Children's Service, Phoenix, Arizona

The following agencies were admitted to accredited membership at the October 1966 meeting of the League's board of directors:

Catholic Welfare Bureau, Inc., San Antonio, Texas
Child and Family Service of Saginaw County, Saginaw, Michigan
Family Counseling and Children's Service, Waco, Texas
Jewish Social Service Agency and Jewish Foster Home, Washington, D.C.

New Associate Agencies

These agencies have been enrolled in the Associate program during the past few months:

Children's Aid and Family Service of Beaver County, Beaver, Pennsylvania
Fort Worth Day Nursery, Fort Worth, Texas
Talbot Hall (Episcopal Church Home of Jonestown), Jonestown, Pennsylvania

OFFICIAL NEGATIVE ON WELFARE

(Obviously one may want to speak more specifically to the proposal made from the floor)

The League of Women Voters of Minnesota has been on the periphary of Welfare for some time, through our Indian study and through the National topic on Development of Human Resources. Is this then the year for a state Welfare study? The majority of members thought not. The state Board ~~did~~ is not recommending a Welfare study.

Certainly there are some things that might be accomplished through a state study, residence requirements, statewide standards and Minesota's participation in new federal programs such as the one for unemployed parents....

But, a ~~state~~ welfare item at this~~t~~ point would ~~be~~ prove very frustrating. Welfare is presently in a great state of ferment. Would you like to abolish all categorical welfare in favor of a single category of need? Are you interested in the negative income tax? How about a program of guaranteed employment? Should or could one don anything about the great differences in welfare standards in Minnesota and Missippi? How does one break the cycle of dependency that is ledaing to third and fourth generations on welfare?

These are the exciting questions in the welfare field. ~~Questions that~~ And, these questions are going to be decided in Washington, not in St. Paul.

~~The~~ strength of the ~~League is in its ability to study and make decisions on~~ Members in Minnesota would wish to be concenred with the ~~policies~~ broad policies involved in these questions. But, though we could study it would be impossible for us to act for

+ therefore I urge those of you who are interested in welfare to work for its adoption as a National Item

from: Jean Rubin, Consultant
Public Affairs
Child Welfare League of America
September 5, 1967

B. Public Assistance Provisions of H.R. 12080 - Title II

Since many of the Public Assistance provisions were discussed in the National Social Welfare Assembly memo prepared by Elizabeth Wickenden which was sent to you with our August 23rd memo, we will here highlight those matters on which we have additional comments to make.

Major Provisions of HR 12080
relating to Public Assistance and Child Welfare

II. Public Welfare

A. Amendments Related to the Aid to Dependent Children Program and Child Welfare

1. REQUIREMENT FOR STATES TO DEVELOP PROGRAMS FOR AFDC RECIPIENTS

The bill would require the States to develop a program for each appropriate relative and dependent child who is receiving aid to dependent children which would assure, to the maximum extent possible, their entry or re-entry into the labor force with the goal of making them self-sufficient. The States would have to give each appropriate adult and each child over age 16 who is not in school such services as employment counseling, testing, and job training. Day care services would have to be provided for the children of mothers who are determined to be able to work or take training, as well as such other services which may be necessary to make the family self-sustaining. A dependent child's adult caretaker who refuses employment or training without good cause would be cut off the rolls, but payment to the child would be made to someone else on the child's behalf.

The bill would also require the State agencies to bring to the attention of appropriate court or law enforcement agencies all situations involving the neglect, abuse, or exploitation of children. Protective or vendor payments would have to be provided in cases where it is determined that the adult relative cannot manage funds in the child's behalf.

States would be required under the bill to develop programs aimed at preventing or reducing the incidence of illegitimate births and strengthening family life. States would have to undertake to establish the paternity of an illegitimate child receiving aid to dependent children and to secure support for him. Family planning services would have to be offered (on a voluntary basis with respect to individuals) to AFDC recipients in all appropriate cases.

These provisions would become effective October 1, 1967, and would be mandatory on all the States after July 1, 1969. Provision is made for 85-percent Federal matching until July 1, 1969, and 75 percent therafter.

2. COMMUNITY WORK AND TRAINING PROGRAMS

The States would be required, effective July 1, 1969, under H. R. 12080, to have community work and training programs designed to conserve work skills and develop new skills for appropriate relatives and children receiving aid to families with dependent children. Programs would have to be in effect in all political subdivisions of a State in which there is a significant number of AFDC recipients. Assistance would not be paid for any person from whom participation in a work and training program was deemed appropriate if he refused to participate without good cause. The programs would have to conform to standards prescribed by the Secretary. Provision is made for 85-percent Federal matching for training, supervision, and materials until July 1, 1969. Matching would be 75 percent thereafter. Under present law, community work and training programs are optional with the States, and only 12 States have undertaken them. There is no provision in present law for Federal matching for the costs of training, supervision, and materials.

3. EARNINGS EXEMPTIONS

H.R. 12080 would require that each State provide in its program of aid to families with dependent children for an exemption of certain earnings by recipients. In determining the amount of assistance payments, States would have to disregard the first $30 of earned family income, plus one-third of earnings above that amount for each month. Earnings of children under age

16 and of those age 16 to 21 who are attending school full time would be fully exempt.

In order to qualify initially for assistance and for the earnings exemption a family would have to have an income below the State standard of need. The work exemption would not apply if a person terminated his employment or reduced his earned income without good cause, or if he refused without good cause a bona fide offer of employment.

4. DEPENDENT CHILDREN OF UNEMPLOYED FATHERS

H.R. 12080 would provide that under State programs of aid to families with dependent children of unemployed parents, which are now in effect in 22 States, Federal matching would be available only for the children of unemployed fathers. Under present law States may include children on the basis of the unemployment of mothers, as well as fathers. The bill also provides that the Secretary will prescribe standards for the determination of what constitutes unemployment. The term is defined by the States under present law.

Under the bill, State plans would have to provide for the payment of assistance when a child's father has not been employed for at least 30 days prior to receiving aid, if he has not refused a bona fide offer of employment or training without good cause, and if he has had a recent and substantial connection with the labor force, as specified in the bill. Assistance would be denied if the father is not currently registered with the public employment office in the State, if he refuses without good cause to undertake work or training, or refuses without good cause to accept employment, or if he is receiving unemployment compensation.

The States would have to assign recipients to work and training programs within 30 days after first providing assistance.

States which are operating programs for the children of unemployed parents as provided for under present law would not have to add any additional children or families as a result of the new provisions prior to July 1, 1969, and are not required to have community work and training before that date. However, the amendment establishing criteria for persons covered would be effective October 1, 1967, and no Federal matching would be provided for persons who do not meet these criteria.

5. SERVICES FURNISHED BY PUBLIC EMPLOYMENT OFFICES OF THE STATE

The bill directs the Secretary of Health, Education, and Welfare to enter into cooperative agreements with the Secretary of Labor for the provision through the public employment offices in each State of the services specified as necessary to assure that assistance recipients are registered at such offices, are receiving testing and counseling services, and are given job referrals.

6. FEDERAL PARTICIPATION IN PAYMENTS FOR FOSTER CARE OF CERTAIN DEPENDENT CHILDREN

Effective July 1, 1969, States would have to provide AFDC payments for children who are placed in foster homes, if in the 6 months before court proceedings started the children would have been eligible for AFDC payments if they had lived in the home of a relative. Federal matching would be available for grants up to an average of $100 a month per child. The provision would be optional with the States before July 1, 1969.

Under present law, children in foster care are eligible for AFDC payments only if they actually received such payments in the month they were removed from their homes by a court.

7. EMERGENCY ASSISTANCE FOR CERTAIN NEEDY FAMILIES WITH DEPENDENT CHILDREN

The bill would provide for 50-percent Federal matching for cash payments, and 75-percent matching for services which are needed to provide emergency assistance to needy families with dependent children. The assistance would be

limited to 30 days, and no more than one 30-day period could be provided for in 1 year. Included among the items which could be covered are money payments, payments in kind, payments for medical care, and other services specified by the Secretary.

8. CHILD WELFARE SERVICES

The bill would provide for transferring the provisions for all child welfare services from title V to title IV of the Social Security Act, the title which now provides for programs of aid to families with dependent children. At present child welfare services which are for children other than AFDC recipients are provided in title V. States would be required to furnish services to all children through the organizational unit which administers the AFDC program. Federal matching would be 75 percent of the cost of child welfare services to AFDC children. The authorization for services for non-AFDC children would be increased to $100 million for fiscal year 1969 ($55 million under present law) and to $110 million for each year thereafter ($60 million under present law).

9. LIMITATION ON FEDERAL PARTICIPATION IN AFDC PROGRAMS

The bill would provide that the proportion of all children under age 21 who were receiving AFDC payments in each State in January 1967 on the basis of the absence from the home of a parent could not be exceeded after 1967. Payments for any number above this proportion would have to be made without Federal participation.

B. Medical Assistance (Title XIX) Amendments

1. LIMITATION ON FEDERAL PARTICIPATION IN MEDICAL ASSISTANCE

The bill would provide for a limitation on the income levels which States can establish in determining eligibility for medical assistance. Federal matching would be made only if the family income level determining eligibility was not higher than (1) 133⅓ percent of the highest amount ordinarily paid to a family without any income or resources of the same size under the AFDC program, or (2) 133⅓ percent of the State per capita income for a family with four members (and comparable amounts for families of different sizes). The percentages would be effective July 1, 1968, except that for States which already have medical assistance programs in operation the proportion would be 150 percent from July 1, 1968, to January 1, 1969, and 140 percent from January 1, 1969, to January 1, 1970.

2. REQUIRED SERVICES UNDER STATE MEDICAL ASSISTANCE PROGRAMS

The bill would allow the States to provide under their medical assistance programs either those five types of benefits which are now required, or any seven of the first 14 which are specified in the law. See page 42 for list.

3. ADVISORY COUNCIL ON MEDICAL ASSISTANCE

H.R. 12080 provides for the creation of an Advisory Council on Medical Assistance to advise the Secretary on questions of administration under the title XIX program. The Council would be composed of 21 persons chosen from outside the Government.

As stated clearly in the Ways and Means Committee Report on this bill, the Committee's goal is to curb the growth in the AFDC caseload. This is to be done by putting as many as possible of the AFDC parents and out-of-school youth over 16, into work and training programs, by preventing illegitimacy and desertion among poor people, and by limiting the numbers of needy children who could be eligible for AFDC assistance. This approach reflects a major shift in the emphasis of AFDC which was originally designed to provide care for dependent children in their own homes by providing financial assistance to help parents to attain self-support "consistent with the maintenance of continuing parental care and protection." (Social Security Act, Sec. 401). In addition, federal financing for these needy children was to be available on a flexible "open end" basis to meet whatever future needs arose.

The Ways and Means Committee recommendations are predicated on the Committee's belief that families stay on AFDC for generations, but the facts do not prove this. According to recent HEW statistics, there is a great turnover in the AFDC rolls. Averaged over the year, about 45,000 new families come on the rolls each month, and about 41,000 leave. The caseload is not static, and in most cases, the same families do not continue to receive assistance for long periods of time. 20% turnover a year.

The House bill requires the states to make work or training available to "appropriate" individuals (including mothers) on assistance, as a condition of receipt of federal financial participation. It also requires that assistance be denied to such individuals if they refuse assignments to work projects unless they can show "good cause" for their refusals. It assumes in most cases that mothers should work rather than look after their children.

Under present work training programs which are voluntary, both as to the states and as to recipients, there is a requirement that appropriate arrangements be provided for the care and protection of a child while his parent is participating in the program. This is designed to assure that the participation will not be inimical to the welfare of the child. H.R. 12080 does not include this safeguard. The Administration has asked for its restoration.

Federal funds for mandatory day care programs would be available on a 75 percent matching basis to the states through the AFDC program, but would be limited solely to day care for children of AFDC mothers in work or training programs.

In testimony before the Senate Finance Committee, HEW Secretary Gardner said, "It is perfectly obvious that not all mothers would wish to, or should, or could, work full-time or perhaps even part-time, but the unknown number who wish to, or should, or could, ought to have that chance . . . All things considered, we believe that the establishment of training programs should be mandatory upon all the states but voluntary as far as the AFDC mothers are concerned."

The League holds that mothers should have a choice about working, and that day care services should be available for all children in need of such care. This need is not necessarily dependent on a mother's employment. The League's Day Care Standards also preclude day care for children not ready or able to benefit from it. The provision for day care under AFDC in H.R. 12080, however, contains no condition for the use of day care for AFDC children other than the training or employment of their mothers.

Projected cost figures contained in the full Committee Report indicate that in 1972, under H.R. 12080, the government would be spending $695 million for the work and training programs and for the day care of children whose mothers were working or in training, whereas, there would be savings of only $130 million caused by the estimated resulting number of welfare recipients going off the rolls. This means that $5 would be spent for every $1 saved by this program. And the psychological damage to the children might far exceed the cost in dollars if work and training programs were mandatory for AFDC mothers.

H.R. 12080 wisely includes a requirement that states have an earning exemption to provide incentives for work by AFDC recipients. For adult recipients and children over 16 not attending school, the exemption is the first $30 of monthly earnings plus one-third of additional earnings. The Administration has asked the Senate to increase this to $50 plus one-half of additional earnings. All earnings of AFDC children under 16, or those over 16 attending school full-time would also be exempted.

The bill also makes possible a program of emergency assistance for children and their families by providing 50 percent federal matching for state expenditures for such purposes for up to 30 days in a 12-month period. This is an excellent new provision, but the Administration suggests that emergency assistance should be available up to 120 days and that the federal share be increased to 75 percent. This program would be optional with the states.

H.R. 12080 provides, to the extent specified by the Secretary of HEW, for the purchase of child welfare services, family planning services and family services.

Under present law, if a state is meeting full need, and if a recipient is not capable of handling funds, "protective payments" may be made to a third party on behalf of the recipient. To safeguard against abuse of this provision "protective payments" are presently limited to 5 percent of the caseload. This provision has been used very little by the states, primarily because so many states do not qualify because they do not meet the full need requirement. Under H.R. 12080, however, these limitations are lifted, and states are required to make use of protective payments, or vendor payments when the parent is fiscally irresponsible or, on behalf of the children when

the mother or father refuses to accept work or training "without good cause." Vendor payments would be permitted for the first time since the passage of the Social Security Act when cash payments of assistance were required to eliminate the abuse of vendor payments by landlords, grocery stores, etc. Although there are a relatively few cases of demonstrated fiscal irresponsibility this new provision would open the door to widespread use (and possible abuse) of protective and vendor payments which would further discriminate against AFDC families. The Administration has suggested that a state should be limited in its use of protective or vendor payments to 10 percent of its AFDC caseload. Other persons believe that vendor payments should not be permitted at all.

H.R. 12080 would also require states to institute programs for AFDC families to reduce illegitimacy, establish paternity, and secure support for illegitimate, deserted, or abandoned children. States would be m andated to offer family planning services to all AFDC families, with provision for freedom of choice as to their use. Such services would help reduce the number of births out of wedlock and the number of families so large as to make it difficult for them to provide their families with adequate support and care. Perhaps, however, the stress should be on the use of family planning services for the strengthening of family life which would put the prevention of illegitimacy in its proper perspective.

The bill would also require the states to institute programs to establish paternity and secure support for the illegitimate, deserted, or abandoned child. This is unrealistic and unwise in some cases. It may be impossible or inadvisable even to attempt to establish paternity in some cases, and where desertion or abandonment is of long-standing, it may be inadvisable to locate the parent and impossible to obtain support. The attempt, in fact, might in some cases be severely destructive to existing good relationships within the home. The law presently already requires referral of all cases involving desertion or abandonment of a child to law enforcement officers or courts for the purpose of obtaining support payments. The bill also enables welfare departments to reimburse the law enforcement agencies and courts for the costs of obtaining support payments. Past experience has shown that in many cases the costs of tracking down a parent are greater than the funds which can be obtained from him.

The bill would require welfare departments to develop agreements covering referrals of cases to law enforcement agencies where it is believed the child's home is unsuitable because of neglect, abuse, or exploitation. This singles out AFDC children, whereas welfare departments should be expected to report any such case where it is appropriate to do so, regardless of whether the child is on AFDC or not. The League believes that sound protective service programs should be an ongoing function of public child welfare departments

and should not be relegated to police and law enforcement agencies. It should be noted that more foster care for AFDC children is contemplated by the Ways and Means Committee Report and that illegitimacy may constitute cause for removal of children. "Your committee believes that some children now receiving AFDC would be better off in foster homes or institutions than they are in their own homes. This situation arises because of the poor home environment for child upbringing in homes with low standards, including multiple instances of illegitimacy." (Page 7)

In testifying on H.R. 5710, the League stressed the importance of the proposal requiring states to meet the financial needs of families with children, as determined by the state's own budgeting standards of minimum need. The League said, "The best social services in the world cannot help feed the hungry or provide them with the other necessities of life. Living in constant poverty is not the way to promote the healthy physical or emotional growth of the next generation on which this country must depend." Unfortunately, the House Ways and Means Committee dropped that requirement from H.R. 12080. The League and the Administration continue to press for its inclusion in the Senate version of the bill. Only 20 states and the District of Columbia provide the amount that their own standards indicate is needed. Of these 20 states, only 12 have updated their standards to reflect price levels as recent as 1966. (Florida, for example meets 28.1 percent of need; South Carolina, 32.4 percent; Indiana, 38 percent.)

The League also supported the provision in H.R. 5710 relating to assistance for children in need because of unemployment of a parent (AFDC-U) and urged that this program be mandatory upon the states. League testimony stated, "We are shocked that only 22 states have included provision for this type of assistance since 1962. We believe it unsound and unwise to continue any welfare practice which actually encourages the break-up of families."

Although H.R. 12080 would make the AFDC-U program a permanent part of the Social Security Act, it has further restricted the number of fathers who would be considered "unemployed" for the purposes of this program. No father would qualify if he received any amount of unemployment insurance, no matter how small, nor would he qualify if he had not had six or more quarters of work within a prescribed period. This would exclude the children of fathers who have not been in the labor force or whose attachment to the labor force has been casual. This would exclude from AFDC some of the neediest families, especially those hit by a severe or prolonged recession, or a prolonged illness or incapacity from which the father had recovered. The League continues to urge that the AFDC-U program be made mandatory upon the states, and that the restrictions on the definition of "unemployment" be eliminated.

As you know, H.R. 12080 imposes a ceiling on federal participation in the AFDC program. The proportion of children dependent because of absence of a parent, through illegitimacy, or desertion, would be frozen as of January, 1967 for purposes of federal financing. If this proportion rose, the states would face a financial squeeze which would result either in more restrictive eligibility requirements, or would lower the already inadequate assistance payments.* Ultimately, it would be the children who would suffer as a result of the circumstances of their birth, the behavior of their parents, economic conditions, or heavy migration into the state in which they lived -- all matters quite beyond their control.

In urging the Senate to delete the ceiling in H.R. 12080, Secretary Gardner testified, "I realize that the House is concerned about the steady rise in AFDC rolls. I share that concern. But the measure they propose is not a solution; it is simply a decision to turn our backs on the problem."

Children and families not eligible for federally aided AFDC assistance either because of new restrictive provisions in the law or those cut off the rolls because of failure to comply, would obviously have to become the responsibility of the states and localities or of the voluntary welfare field. Neither the states nor the localities are in a position to finance such assistance, particularly if the rise in need is caused by a decline in the economy, or by the expected continued in-migration of people from poor rural areas seeking to better their lives in urban centers. Voluntary welfare agencies do not and cannot provide universal coverage to meet the needs of children, and this should continue to be one of the responsibilities of the federal government, as it has been since the passage of the Social Security Act in 1935.

PUBLIC ASSISTANCE AMENDMENTS

I. AID TO FAMILIES WITH DEPENDENT CHILDREN

Item	Existing law	H.R. 12080
A. Family and employment services: 1. Plan requirement	States are required to: (a) provide a description of services which the State agency makes available to maintain and strengthen family life for children, including a description of the steps take to assure maximum utilization of other agencies providing similar or related services, and (b) provide for a program of services for each child as may be necessary in the light of home conditions and other needs of such child, and provide for coordination with child-welfare services under pt. 3 of title V.	Adds the following additional State plan requirements: (a) The development of a program by the State agency for each appropriate relative and child recipient and each appropriate "essential person" (individual living in the house whose needs are taken into account for determining eligibility and amount of assistance) with the objective of (1) assuring, to the maximum extent possible, that these persons will enter the labor force and become self-sufficient, and (2) reducing the incidence of illegitimacy and otherwise strengthening family life. The plan must provide that the employment potential of each such person is evaluated and that they are furnished such services as testing, counseling, basic education, vocational training, and special job development; that day-care service be provided and family planning services in all appropriate cases; and that vendor or protective payment be provided in appropriate cases in order to assure a means for caring for such children. Each such program must be reviewed at least once a year, and the Secretary of Health, Education, and Welfare must be given reports showing the results of such programs. The bill also requires that to the extent such services are provided by State or local agency staff that a single organizational unit be established in such State or local agency for furnishing such services.
	No provision	(b) Provision that where the State agency has reason to believe that the home is unsuitable for a recipient child because of neglect, abuse or exploitation that this be brought to the attention of the appropriate court or law enforcement agency.
	No provision	(c) Development of a program for establishing the paternity of illegitimate children receiving assistance and for securing support for these children as well as those who have been deserted or abandoned by their parents, utilizing any reciprocal arrangements adopted with other States to obtain or enforce court orders for support. A single organizational unit in the State or local agency administering the plan must carry out this provision.
	No provision	(d) Provision for entering into cooperative arrangements with appropriate courts and law enforcement agencies to assist in securing support for children, including entering into financial arrangements with such courts and agencies in order to obtain optimum results for the program.

PUBLIC ASSISTANCE AMENDMENTS—Continued

I. AID TO FAMILIES WITH DEPENDENT CHILDREN—Continued

Item	Existing law	H.R. 12080
4. Report to Congress	No provision	The Secretary of Health, Education, and Welfare, on the basis of a review of the reports from the States, shall report his findings on the effectiveness of programs of services developed by the States. The Secretary shall annually report to the Congress (beginning July 1, 1970) on the programs developed by each State.
5. Effective date		The State plan requirements shall be effective October 1, 1967, but a State plan will not be out of compliance because of not meeting these requirements until July 1, 1969. The Federal matching for services implementing the new State plan requirement will be available on or after the modification of the State plan.
B. Income exemption	The State agency in determining need, upon which eligibility for and the amount of assistance is based, must take into account any other income (including expenses reasonably attributable to the earning of income) and resources of any child or relative claiming assistance. The States, at their option, may disregard not more than $50 per month of earned income of each dependent child under age 18 but not more than $150 per month in the same home. The States also have the option of disregarding up to $5 of any income before disregarding child's earned income as noted above. Finally, States have the option of permitting all or part of earned or other income to be set aside for future identifiable needs of a child.	To provide incentives to work, the bill sets out the following exemption of earnings: All earned income of each child recipient under age 16 and age 16 to 21 if he is a full-time student attending a school, college, or university, or a course of vocational or technical training to fit him for gainful employment, is exempt. In the case of a child over 16 not in school, a relative, or an "essential person," the first $30 of earned income of the group in a month plus ⅓ of the remainder of such income for the month would be exempt. The optional provision for setting aside a portion of income for future identifiable needs is continued, as well as the option of the States to disregard $5 a month of any type of income. The provision exempting $50 a month of a child's income is superseded by these provisions. The earnings exemption will not be available in any month for a person who voluntarily terminated his employment or reduced his earned income within such period preceding the month assistance is applied for as may be prescribed by the Secretary (but such period must not be less than 30 days), or to persons who refused without good cause to accept employment in which they were able to engage, offered by or through the public employment office or by a private employer, which is determined to be bona fide by the State or local agency. The earnings exemption will also not be available to persons whose income in the month of application was in excess of their need as determined by the State agency, unless in any of the 4 preceding months they were receiving assistance. Makes specific reference to "essential person" so his income and resources can be taken into account in determining the need of the child or relative claiming aid.

2. Federal matching	**The Federal Government shares with the States on a dollar-for-dollar basis (50 percent) in the administrative costs of carrying out the program. However, the Federal Government will pay 75 percent of the cost of—** (a) certain services, prescribed by the Secretary of Health, Education, and Welfare "to maintain and strengthen family life for children, and to help relatives specified in the act with whom children * * * are living to attain to retain capability for self-support or self-care." (b) other services provided to applicants or recipients specified by the Secretary as likely to prevent or reduce dependency; **(c) services described in (a) and (b) specified by the Secretary as appropriate for individuals who, within the periods prescribed by the Secretary, have been or are likely to become applicants for or recipients of public assistance and who request such services;** (d) training of personnel employed or preparing for employment with a State or local public assistance agency.	**The Federal Government will pay 75 percent of the cost of—** **(a) Services under the new plan requirements set forth above which are provided to a child or relative receiving assistance or to an "essential person."** The Federal matching under this provision shall be 85 percent rather than 75 percent for services provided under these programs during the period October 1, 1967 to July 1, 1969. It reverts thereafter to 75 percent. (b) Services to a child or relative receiving assistance or applying for assistance or an "essential person"—such services may include child-welfare services, family services, and other services specified by the Secretary, to maintain and strengthen family life for children, and to help relatives and "essential persons" to attain or retain capability for self-support or self-care. Child welfare services are defined on page 43. Family services means "services to a family or any member thereof for the purpose of preserving, rehabilitating, reuniting, or strengthening the family, and such other service as will assist members of a family to attain or retain capability for the maximum self-support and personal independence." (c) Any of the services in (a) or (b) above to children, relatives, or "essential persons" who are applicants for assistance or who, within such period as the Secretary may prescribe, has been or is likely to become an applicant for or recipient of assistance. (d) No change. The Federal 75-percent matching for services within (a), (b), and (c) is contingent on the establishment of the separate organization unit in the State or local agency administering the plan which was mentioned earlier under I above.
3. Providers of welfare services	Services are to be provided by the staff of the State welfare agency but, in the provision of these services, there must be maximum utilization of other agencies providing similar or related services. Services may also be furnished, pursuant to agreement with the State welfare agency, by a State health or vocational rehabilitation agency or by other State agencies which the Secretary deems appropriate (whether provided by its staff or by contract with nonprofit private or local public agencies). The provision of services by other agencies are subject to limitations by the Secretary and must be services which in the judgment of the State welfare agency, cannot be as economically or effectively provided by its staff and are not otherwise reasonably available to individuals in need of such services.	**Provides an exception to the requirement of obtaining services from public agencies for child-welfare services, family planning services, and family services, to the extent specified by the Secretary, so that they may be provided from other sources.**

Makes specific reference to "essential person" so his income and resources can be taken into account in determining the need of the child or relative claiming aid.

Effective date: The earnings exemption must be in effect in the States by July 1, 1969, but will be optional with the States from October 1967 on.

There are a number of income exemptions applicable to the AFDC program in other legislation. For instance, title VII of the Economic Opportunity Act provides that the first $85 a month of such income and ⅓ of the remainder must be disregarded. Sec. 109 of the Elementary and Secondary School Act of 1965 provides that, for a period of 1 year, the first $85 a month earned in any month for services under that act shall be disregarded for purposes of determining need under the AFDC program.

The new provisions override any other provisions of any other law disregarding earned income.

C. Families with unemployed fathers

For period ending June 30, 1968, Federal participation is authorized in payments to children who are deprived of parental support or care "by reason of the unemployment of a parent" as defined by a State. Program optional with the States, and 22 have such programs.

Permanent provisions of law limit Federal matching to needy dependent children under 18 (and specified relative with whom they are living) who have been deprived of parental support or care by reason of the death, continued absence from the home, or physical or mental incapacity of a parent. (Specified relatives include grandmother, grandfather, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, 1st cousin, nephew, or niece.)

Limits the program to children who need support on the basis of the unemployment of the father. Unemployment will be defined by Secretary of Health, Education, and Welfare. Program made permanent but still optional with the States.

Federal matching specifically authorized to meet needs of "essential persons."

Adds new plan requirement relating to when aid to dependent children assistance will be paid on the basis of an unemployed father:

Requires the payment of aid with respect to a child within such definition when his father has been unemployed for a minimum period of 30 days before receipt of aid, has not without good cause within such period refused a bona fide offer of employment or training, and has at least 6 quarters of work in a 13-calendar quarter period ending within 1 year before the application for aid or, within such 1-year period, received unemployment compensation under any State or Federal program or was "qualified for unemployment compensation."

The bill defines a "quarter of work" as a calendar quarter in which the father received at least $50 of earned income (or which is a "quarter of coverage" for purposes of the old-age, survivors, and disability insurance program under title II of the act), or in which he participated in a community work and training program.

The father shall be deemed "qualified for unemployment compensation" under the State's unemployment compensation law if he would have been eligible therefor upon application, or if he had been in uncovered work which, had it been covered, would (with his covered work) have made him eligible for such compensation upon application. The bill provides that persons who have fulfilled the requirements at any time after April 1961 (related to the date of enactment of the original unemployed parent legislation) will be considered to be eligible with respect to the quarters of work provision for up to 6 months after a State plan under these provisions becomes operative.

PUBLIC ASSISTANCE AMENDMENTS—Continued

I. AID TO FAMILIES WITH DEPENDENT CHILDREN—Continued

Item	Existing law	H.R. 12080
C. Families with unemployed fathers—Con.		Fathers who are now on the rolls, and who met the work requirements at any time after April 1961, would continue to be eligible if other requirements are met.
	The State plan must— (1) no provision;	The State plan must— (1) provide for the establishment of a work and training program and for assurances that fathers of children within the above definition are assigned to projects under such program within 30 days after receiving aid;
	(2) give assurance that assistance will not be granted if, and for as long as, the unemployed parent refuses, without good cause, to accept employment in which he is able to engage and which is offered through either a public employment office or by an employer if the offer is determined by the State agency to be a bona fide offer of such employment;	(2) provide for denial of aid if and for as long as such a father fails to register at the public employment office, refuses without good cause to participate in a work and training program, refuses without good cause to accept employment in which he is able to engage (which is offered to him from certain sources), refuses without good cause to undergo retraining under the vocational education program.
	(3) provide for entering into cooperative arrangements with the system of public employment offices in the State looking toward the employment of unemployed parents, including appropriate provision for periodic registration of the unemployed parent and for the maximum utilization of the job placement and other services and facilities of such offices; and	(3) provide that the services of public employment offices in the States shall be utilized to assist fathers to secure employment and occupational training, including registration and maximum use of job placement services.
	(4) provide for entering into cooperative arrangements with the State vocational education agency looking toward maximum utilization of its services and facilities to encourage retraining of such unemployed parent.	(4) No change.
	(5) Any State, *at its option*, to provide for the denial of all (or any part) of aid under the plan to which any child or relative might be entitled for any month, if the unemployed parent receives compensation under an unemployment compensation law of a State or of the United States for any week, anypart of which is included in such month.	(5) Receipt of unemployment compensation bars assistance.
		Effective date: Oct. 1, 1967, but no State with an unemployed parent program on July 1, 1967, shall be required to include any additional recipients by reason of this amendment before July 1, 1969, and no State shall be required to deny aid because of not having a community work and training program before July 1, 1969.

shall be [illegible] community work and training program before July 1, 1969.

D. Community work and training	Federal matching is authorized, for the period July 1, 1961, to June 30, 1968, for payments for work performed by a relative (18 years of age or older) with whom the child is living. Twelve States make such payments. Federal participation in these payments may be made only under limited conditions designed to assure protection of the health and welfare of the children and their relatives: (1) The work must be performed for the State public assistance agency or another public agency under a program (which need not be in effect throughout the State) administered by or under the supervision of the State public assistance agency. (2) There must be State financial participation in these expenditures. (3) The State plan must include provisions which give reasonable assurance that— (a) appropriate health, safety, and other conditions of work will be maintained; (b) the rates of pay will be not less than the applicable minimum rate under State law for the same type of work, if there is any such rate, and not less than the prevailing wage rates on similar work in the community; (c) the work projects will serve a useful public purpose; will not displace regular workers or be a substitute for work that would otherwise be performed by employees of public or private agencies, institutions, or organizations; and (except in the case of emergency or nonrecurring projects) will be of a type not normally undertaken by the State or community in the past; (d) the additional expenses of going to work will be considered in determining the worker's needs; (e) the worker will have reasonable opportunities to seek regular employment and secure appropriate training or retraining and will be provided with protection under the State workmen's compensation law or similar protection; and (f) aid will not be denied because of a relative's refusal with good cause to perform work under the program.	Makes such community work and training programs mandatory on the States effective with July 1, 1969. Age 18 is changed to age 16. Also includes "essential person." (1) Community work and training programs must be established in every political jurisdiction where a significant number of AFDC families reside. (2) No change. (3) (a) No change. (b) Federal minimum wage legislation would also apply, except that payments for work by individuals who are learners or handicapped workers may be at special lesser rates that are in accord with such State and Federal laws. (c) Removes requirement that project will not be of a type normally undertaken. (d) No change. (e) No change. (f) Bill also provides that (1) all appropriate recipients of AFDC to register and periodically reregister at the State employment office, and (2) requires that if any child or relative refuses (a) to register or reregister (b) to accept bona fide offers of employment, or (c) to accept training, the adult relative, essential person or child who so refuses shall not have his needs taken into account, and in the case where the caretaker relative so refuses, his needs cannot be taken into account and the payments can be made to the children only if by a protective payment, vendor payment, or to a foster parent. (However, the usual determination that the caretaker cannot handle the funds would not have to be made.)

PUBLIC ASSISTANCE AMENDMENTS—Continued

I. AID TO FAMILIES WITH DEPENDENT CHILDREN—Continued

Item	Existing law	H.R. 12080
D. Community work and training—Con.	(4) The State plan must also include provision for— (a) cooperative arrangements with the public employment offices and with the State vocational education and adult education agency or agencies looking toward employment and occupational training of the relatives and maximum use of public vocational or adult education services and facilities in their training or retraining; (b) assuring appropriate arrangements for the care and protection of the child during the relative's absence from the home in order to perform the work under the program; (c) such other provisions as the Secretary finds necessary to assure that the operation of the program will not interfere with the objectives of the aid to dependent children program. (5) A State participating in such a program must also provide (in its State plan) that there will be no adjustment or recovery by the State or any locality on account of any payments which are correctly made for the work. The cost of administration of a State plan for which Federal funds are paid may not include the cost of making or acquiring materials or equipment in connection with work under a community work and training program or the cost of supervision of that work, and may only include those other costs attributable to the programs which are permitted by the Secretary.	(4) Services and facilities under the MDTA and other work programs shall be utilized. (a) Provides also that the Secretary of Health, Education, and Welfare enter into cooperative arrangements with the Secretary of Labor for the provision of the services offered by State employment offices to recipients and applicants for AFDC. The expenses furnished to recipients or applicants for testing, counseling and other individual employment services would be reimbursed at the 75 percent rate (85% until July 1, 1969). (b) No change. (c) Essentially the same. (5) No change. Provides for Federal matching of the costs of materials, training, and supervision at the rate of 75 percent on July 1, 1969, and 85 percent from Oct. 1, 1967 to July 1, 1969 if the program meets the new conditions.
E. Program of Federal payments for foster care of dependent children. 1. Eligibility	Allows Federal payments with respect to any child otherwise not eligible who— (1) is removed, after Apr. 30, 1961, from home of specified relative as a result of a judicial determination that continuation therein would be contrary to his welfare;	

	(2) is placed in a foster family home (approved by the State), with payment to the child care agency permitted for the period through June 30, 1968 as a result of such determination; or (for the period through June 30, 1968) in a nonprofit private child-care institution, subject to limitations prescribed by the Secretary to include within Federal participation only cost items which are included in foster family home care. Provision is made for payments by the State or local agency for foster care in a foster family home or a child-care institution either directly or through a public or nonprofit private child-placement or child-care agency. (3) was receiving aid to dependent children in the month when court proceedings were started, and for whose placement and care the State agency administering the program is responsible.	(2) Makes permanent the inclusion of child care institutions and permission for payment for care to an agency in foster family situations. (3) Modifies provisions to cover children: (1) who were not receiving payments in the month court proceeding started but would have received such aid if they had applied for it, or (2) who had been living with one of the relatives specified in the law within 6 months of the start of the court proceedings and if in the month they were removed from home of the relative they would have been eligible for assistance if they had applied for it.
	For the period through June 30, 1968, responsibility for the placement and care of dependent children place in foster care homes may rest either with the State or local agency administering the program under title IV or with any other public agency with whom the administering agency has an agreement. Such agreement must include provision for assuring development of a plan for each child which is satisfactory to the State public assistance agency and such other provisions as may be necessary to assure that the objectives of the State plan approved under title IV are met.	Makes provision permanent.
2. Federal matching for foster care	The Federal share is ⅝ of the 1st $18 per recipient per month with variable grant matching on the amount up to $32 per recipient per month. Variable grant matching above first $18 has a Federal share which varies from 50 to 65 percent depending on per capita income of State.	Provides an alternative Federal matching maximum of $100 a month for children in foster care. Effective after September 1967.
F. Emergency assistance for certain needs.	No provision	
1. Definition of assistance	do	Emergency assistance to needy families with children is defined to mean, (1) money payments, payments in kind, or such other payments as the State agency may specify, or medical or remedial care recognized under State law on behalf of an eligible child or any other member of household in which such child is living, and (2) such services as the Secretary may specify. It may be provided where such child and his family are without available resources and the payments, care, or services involved are necessary to avoid destitution of the child or to provide suitable living arrangements in a home for such a child.

PUBLIC ASSISTANCE AMENDMENTS—Continued

I. AID TO FAMILIES WITH DEPENDENT CHILDREN—Continued

Item	Existing law	H.R. 12080
F. Emergency assistance for certain needs—Continued		
2. Duration of assistance	No provision	Emergency assistance may be given for a period not excess in of 30 days in any 12-month period in the case of a needy child under age 21 who is (or, within a period specified by the Secretary, has been) living with any of the relatives specified in the act in a place of residence maintained by such a relative as his home.
3. Federal matching	do	The Federal share will be 50 percent of the total expenditures under such plan for such assistance in the form of payments for items, services, and medical care and 75 percent of the total expenditures for such assistance in the form of welfare services. Effective upon enactment.
G. Protective and vendor payments and other State action to protect interests of AFDC children.	Authorizes protective payments to be made, in a limited number of cases (limited in number to 5 percent of recipients), to a person who is interested in or concerned with the welfare of the dependent child and relative, under a State plan which provides for—	Deletes 5-percent limitation on number of recipients who can be under this method of payment. Adds authority for vendor payments under same conditions for protective payments as outlined below. (Vendor payments are made on behalf of family or child directly to a person furnishing food, living accommodations, or other goods, services, or items to or for such family.)
	(1) determination by the State agency that payments in this form are necessary because the relative is so unable to manage funds that it would be contrary to the child's welfare to make payments to such relative;	(1) In the case of an individual who refuses to take the steps leading to employment, noted earlier under the community work and training, vendor or protective payments can be provided without meeting the requirements.
	(2) meeting all the need of individuals (in conjunction with other income and resources), with respect to whom they are made, under rules otherwise applicable under the State plan for determining need and the amount of assistance to be paid;	(2) Deletes requirement of meeting full need.
	(3) special efforts to improve the ability of the relative to manage funds, and periodical review of the situation to determine whether such payments to another interested person are still necessary—and with provision for judicial appointment of a guardian or legal representative if the need for payments to another interested person continues beyond a period specified by the Secretary;	(3) No change.
	(4) opportunity for a fair hearing before the State agency on the determination that payments to another interested person on behalf of the child and relative are necessary; and	(4) No change.
	(5) aid in the form of foster family care, as provided for in the Social Security Act.	(5) No change.
	Effective until ending June 30, 1968	Provision made permanent.

	relative are necessary; and (5) aid in the form of foster family care, as provided for in the Social Security Act. Effective until ending June 30, 1968	(5) No change. Provision made permanent.
	Authorizes the State agency to take the following steps, without losing Federal matching funds, whenever it has reason to believe that payments to a relative for the benefit of a child are not being or may not be used in the best interests of the child. (1) To provide the relative with counseling and guidance concerning the use of payments and management of other funds to assure their use in the best interests of the child; (2) To advise the relative that continued misuse of payments will result in substitution of protective payments (described above), or in seeking appointment of a guardian or legal representative; or Moreover, the imposition of criminal or civil penalties, under State law, upon determination by a court of competent jurisdiction that the relative is not using, or has not used, payments for the benefit of the child shall not be the basis for withholding of Federal matching funds.	No change.
H Limitation on number of children with respect to which the Federal Government will make matching payments.	There is no limit as to Federal participation in expenditures other than the $32 a month average maximum for all recipients of AFDC.	Provides that, for the purposes of Federal matching, the number of dependent children, deprived of parental support or care by reason of a parent's continued absence from the home, for any calendar quarter after 1967 shall not exceed the number bearing the same ratio to the total population of such State under age 21 on Jan. 1 of the year in which such quarter falls as the number of such dependent children with respect to whom such payments were made to such State for the calendar quarter beginning Jan. 1, 1967, bore to the total population of such State under age 21 on that date. No limit is imposed on Federal matching for children qualifying for AFDC based upon the death, incapacity, or unemployment of the parent.

II. OTHER PUBLIC ASSISTANCE AMENDMENTS

A. Partial payments to States	Provides that if a State fails to comply with its State plan under any of the titles of the Social Security Act, the penalty, after hearing, is suspension of Federal funds for entire title.	Provides that Federal funds may be withheld for only that part of the plan which is not being complied with.
B. Private grantees under demonstration projects.	Provides that grants and constracts for demonstration projects under sec. 1110 of the Social Security Act can be made only with respect to public and nonprofit agencies.	Would allow contracts to be with private profit agencies.
C. Social work manpower	No provision specifically to train social workers	Authorizes $5,000,000 for fiscal year 1969 and the 3 following years to meet the cost of expanding educational programs in social work. At least ½ of the funds appropriated each year must be used to support undergraduate training.

PUBLIC ASSISTANCE AMENDMENTS—Continued

OTHER PUBLIC ASSISTANCE AMENDMENTS—Continued

Item	Existing law	H.R. 12080
D. Home repairs	No provision	Provides that States may, under all federally financed assistance except AFDC, make payments for home repair or capital improvements for an owned home up to a total of $500 with 50 percent Federal matching. To do so would be more economical than paying rent in other quarters.
E. Demonstration projects	Authorizes $2,000,000 for fiscal year before 1969 for demonstration projects to support the objectives of the public assistance titles.	Sets authorization at $4,000,000 effective with fiscal year 1968 and for years thereafter. Also provides that the Secretary or Under Secretary of Health, Education, and Welfare must personally approve projects which are wholly funded through the Social Security Act and promptly notify the Congress about each of them.
F. Partial payments to States	Provides that if a State fails to comply with its State plan under any of the titles of the Social Security Act, the penalty, after hearing, is suspension of Federal funds for entire title.	Provides that Federal funds may be withheld for only that part of the plan which is not being complied with.
G. Puerto Rico, Guam, and the Virgin Islands.	Imposes dollar limitation of $9,800,000 each year in Federal funds for matching cash public assistance payments. Figure for Virgin Islands is $330,000 and for Guam is $450,000.	Establishes new dollar limits as follows: Fiscal year / Puerto Rico / Virgin Islands / Guam 1968 — $12,500,000 / $425,000 / $575,000 1969 — 15,000,000 / 500,000 / 650,000 1970 — 18,000,000 / 600,000 / 825,000 1971 — 21,000,000 / 700,000 / 960,000 1972 and thereafter — 24,000,000 / 800,000 / 1,100,000 In addition to these amounts, the Secretary is authorized to certify additional payments to be used for services related to community work and training and for family planning services in the following amounts: Puerto Rico — $2,000,000 Virgin Islands — 65,000 Guam — 90,000 Federal matching percentage would be 60 percent rather than 75 percent as for the States.
H. Incentives for reduction of hospital costs.	No provision	The Department of Health, Education, and Welfare would be given authority to experiment with alternative methods of reimbursing hospitals under medicare, medicaid, and the child health programs which would provide incentives to keep costs down while maintaining quality of care.

C 7.

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TO: League Affiliates

FROM: Jean Rubin, Consultant on Public Affairs

DATE: April 12, 1968

SUBJECT:

1) Time for action on AFDC freeze and AFDC-UP restrictions

2) Appropriations for Child Welfare Services

3) CWLA and National Council of Churches as "Amici Curiae" in the Supreme Court

1) Time for action on AFDC freeze and AFDC-UP restrictions

As you know, the President signed H.R. 12080 into law on January 2, 1968. (It is now PL 90-248, Social Security Amendments of 1967). As we predicted, the welfare provisions are already causing great difficulties in the states.

The freeze on federal funding of AFDC programs is perhaps the most harmful feature of the bill. Unless it is repealed or postponed the freeze goes into effect on June 30, 1968. This means the states must cutback on programs now, in preparation for the cut in federal funds which will occur as of that date, although the states' responsibilities are in no way lessened.

The Department of HEW now estimates that about 475,000 AFDC recipients will have to be assisted entirely from state and local funds because of the AFDC limitation. This represents a loss to the states of $125 million in federal funds.

You will recall that last year the League and many other agencies worked for the elimination in the Senate of the AFDC freeze and the other AFDC restrictions contained in the House version of H.R. 12080.* Although we were successful in the Senate, these improvements were lost in the Conference Committee on that bill, and therefore the freeze and other restrictions became part of the new law.

The Senate once again has taken action to repeal the AFDC freeze as well as to eliminate the restrictions on the AFDC-UP program which were two of the most negative provisions included in H.R. 12080. The Senate did this by adding amendments to an excise tax bill, H.R.15414, which had already passed in the House. These changes were proposed

* See Memoranda of Oct. 31, Nov. 9 and 30.

to the Senate Finance Committee by Senator Fred Harris and the Committee included them in the bill now passed by the Senate, and sent to a Conference Committee. Members of that Committee are: Representatives Wilbur Mills (Ark.), King (Cal.), Boggs (La.), Byrnes (Wisc.), Curtis (Mo.), and Senators Long (La.), Smathers (Fla.), Anderson, (N.M.), Williams (Del.), and Carlson (Kansas).

Unfortunately the importance of the welfare amendments has been overshadowed by other controversial Senate amendments also added to H.R. 15414, such as the 10% tax surcharge, and $6 billion required reduction in federal spending. As a result, on April 9 the Conference Committee on H.R. 15414 postponed further action on the bill until after the Easter recess. The Conference Committee will meet again on April 24th.

League Comment:

We regret that it has not been possible to advise you earlier about these developments because the Senate acted so quickly on these welfare amendments. Now, however, there is a short time in which your views may usefully be made known again on the AFDC freeze and the AFDC-UP restrictions. It would be helpful to express support for these Senate welfare amendments to H.R. 15414 before the Committee meets again on April 24th.

If your own Senator or Congressman is on the Committee your opinion should be made known to him - either while he is at home for the Easter recess or to his Washington office. Letters or telegrams to Senator Long and Congressman Mills would be useful. Other members of Congress should be encouraged to express support for the Senate welfare amendments to members of the Conference Committee. Communications to mayors and governors would also be useful in encouraging them to persuade members of Congress about the urgent fiscal problems caused by the AFDC freeze and AFDC-UP restrictions. Governors were extremely important in helping convince the Senate Finance Committee about the need for repeal of these restrictions.

The League, along with many governors, urban officials, welfare, labor and civil rights organizations, believes that repeal rather than postponement of the freeze is essential. A postponement would not relieve the states from pressure to restrict and cut back on the AFDC program in anticipation of the ultimate impact of the freeze.

The Report of the Advisory Commission on Civil Disorders included recommendations that the AFDC freeze and restrictions on AFDC-UP programs be repealed. In view of present concerns about how to help solve some of our pressing current problems it seems particularly timely to continue our efforts to eliminate welfare provisions harmful to needy children and their families.

2) Child welfare appropriations

As you know, in enacting the Social Security Amendments of 1967 Congress raised the authorization for appropriations to the states for child welfare services to $100 million for 1969 and $110 million

per year thereafter. (The previous authorization had been for $5 million). This raise was considered a forward step for child welfare. Despite this doubling of the authorization however, the Administration's budget request for child welfare appropriations for 1969 is limited to $46 million - the same amount as that which was requested and appropriated for 1968. Unfortunately, $46 million will provide less child welfare services in 1969 than it does in 1968 because of increased costs. States therefore will have to provide a greater proportion of funds than they did previously if they are to maintain even the same level of services, which are already considered inadequate. Wilbur J. Cohen, Acting Secretary of HEW, recently stated that the budget request for child welfare was small because of the financial pressures of the Vietnam war, and a view that AFDC services should have a priority.

State funding of child welfare services has been further imperiled by the new legislation which provides 85% federal matching for the cost of services to AFDC families and mandates many new state programs for which states will have to put up state funds. Therefore, state money will probably be less available for child welfare services because state funds will bring in federal matching funds for any money spent for AFDC, but virtually none for money spent for child welfare services provided to non-AFDC children. (Recent studies show that most children receiving child welfare services have been in the lowest socio-economic groups although they may not have been AFDC cases). It is vital therefore, that there be more adequate federal funding for child welfare services if child welfare services for non-AFDC cases are not to be entirely destroyed.

League Comment:

The failure by the Administration to request additional funds for child welfare services, after the authorization was doubled by Congress, raises serious question about the Administration's commitment to child welfare and is a serious matter for the future of public child welfare services. This is a matter of particular concern in view of the mandatory merger of child welfare and AFDC services under the new law.

The League, therefore, urges greater child welfare appropriations for 1969. If you wish to make your views known on child welfare appropriations, communications should be sent without delay to Congressman Daniel J. Flood, Chairman, Subcommittee on Labor, Health Education and Welfare, Committee on Appropriations, U.S. House of Representatives, Washington, D.C. 20510.

The League also urges continued support for legislation like the Burke bill which would provide matching federal funds for all child welfare services. Mr. Burke is reintroducing his child welfare services bill and we will inform you of the number as soon as possible.

3) CWLA and National Council of Churches as "Amici Curiae" in the Supreme Court

The CWLA and NCC have filed a motion for leave to file a brief "amici curiae" in the Supreme Court case of Smith v. King. This is a highly significant case challenging the constitutionality of a "substitute father" regulation determining AFDC eligibility in Alabama.

The regulation, affecting 16,000 poor children in Alabama, denies AFDC assistance to children if their mothers are suspected of "cohabiting" with a so-called "substitute father" despite the fact that the man may not be related to the children, owes them no duty of support, may never have seen them or even visited in the home. Nevertheless, under the Alabama regulation his alleged presence in the mother's life makes the children ineligible for AFDC.

You will recall that a "suitable home" provision denied assistance to 23,000 AFDC children in Louisiana in 1961. The League and other agencies presented briefs in the HEW Hearing on that matter which culminated in the "Fleming ruling" which prohibited such provisions. The "substitute father" regulation in Alabama was devised after that ruling in an attempt to accomplish the same purposes by a different method.

The Federal District Court in Alabama held, in Smith v. King, that the "substitute father" regulation is unconstitutional because it denies equal protection of the laws to these needy children. The Alabama District Court said "...the Alabama 'substitute father' regulation is an arbitrary and discriminatory classification which results in the denial of financial benefits to needy children who are clearly eligible and entitled to receive such benefits under both the federal and state statutes and constitutional regulations and that said children are denied for reasons unrelated to and in conflict with the purposes of these statutes."

The State of Alabama has appealed this decision to the U.S. Supreme Court and the case will be argued in Washington on April 22nd.

The Supreme Court's decision will affect the rights of thousands of needy children in many states which have similar policies with respect to eligibility for AFDC. On their behalf, the brief of the League and the National Council of Churches urges the Supreme Court to affirm the District Court's decision so that children will not be deprived of their rights to AFDC benefits because of parental conduct wholly unrelated to children's needs and to the purposes of the Social Security Act.

JR:rl

ADMIN 1000
80

STATE OF MINNESOTA

DEPARTMENT Public Welfare

Office Memorandum

TO : Statewide Organizations Interested in Child Welfare

DATE: April 26, 1968

FROM : (Mrs.) Shirley Zimmerman
Consultant to Statewide Organizations

SUBJECT: AFDC Rate Freeze and AFDC-UP Program
Adequate Funding for Child Welfare Services

Enclosed is a communication from the Child Welfare League regarding the AFDC rate freeze and the AFDC-UP program, as well as funding for child welfare programs. We thought this might be of interest to you.

SZ:mmv

Enclosure

THE MINNESOTA CHILDREN'S LOBBY INVITES YOU TO

"MINNESOTA'S CHILDREN"

A TWO DAY CONFERENCE DECEMBER 12 AND 13, 1974

THE HOLIDAY INN DOWNTOWN 1313 NICOLLET AVENUE MINNEAPOLIS

CONFERENCE SCHEDULE

THURSDAY, DECEMBER 12

8:00 - 9:30	Registration - Coffee and Rolls
9:30 - 10:00	Welcome and Introduction - Attorney General, Warren Spannaus
10:00 - 11:30	THE ART OF ACTION choice of panel presentation on "Techniques of Volunteer Lobbying" "Developing Position Papers" "Funding of Causes" "Leadership and its Use"
11:30 - 1:30	Free Time
1:30 - 3:00	WORKSHOPS choice of panel presentation on "Corporations, Labor and Children" "Care of Children in Juvenile Programs" "Early Childhood Legislation" "Let's Not Do It The Great White Way"
3:10 - 4:30	WORKSHOPS choice of panel presentation on "Issues of Training in Early Childhood" "A Reflection: Needs of Women in Today's World" "U.S.D.A. Food Programs" "Let's Not Do It The Great White Way"
6:30 - 7:45	DINNER
7:45 - 9:00	KEYNOTE ADDRESS: "Making It Happen For Kids" David Liederman, Director, Massachusetts Office for Children

FRIDAY, DECEMBER 13

8:30 - 9:00	Friday Registration - Coffee
9:00 - 11:30	CHILDREN'S LEGISLATIVE ISSUES IN 1975 choice of panel presentation on "Child Abuse - Its Legislative Needs" "Humane Services Concept and Children"
11:45 - 1:00	LUNCHEON
1:00 - 2:00	ADDRESS: "Getting It All Together For Children" Judith Helms, Executive Director, National Council of Organizations for Children and Youth
2:00 - 3:30	Semi-Annual Meeting of the Membership of the Minnesota Children's Lobby

CONFERENCE FEES

FULL CONFERENCE (Includes dinner and keynote address on Thursday, luncheon and speech on Friday)	$20.00
PARTIAL CONFERENCE - THURSDAY ONLY (Includes dinner and keynote address)	$12.00
PARTIAL CONFERENCE - FRIDAY ONLY (Includes Friday luncheon and address)	$ 8.00
KEYNOTE OR FRIDAY ADDRESS	$ 3.00
INDIVIDUAL WORKSHOP (Available only after full registrations are completed)	$ 2.50

If you have questions about the conference please call:

612-644-6815 - Janet Dieterich in St. Paul
612-825-4136 - Susan Johnson in Minneapolis

REGISTRATION FORM

"MINNESOTA'S CHILDREN"

December 12 and 13 — Downtown Holiday Inn, Minneapolis

Name_____ Telephone _____

Address_____
Street City ZIP

Organization Represented (if any) _____

_____	Full Conference (Includes Thursday Dinner, address, Friday Luncheon and address)	$20.00
_____	Partial Conference - Thursday Only (Includes Dinner and Address)	$12.00
_____	Partial Conference - Friday Only (Includes Luncheon and Address)	$ 8.00
_____	Thursday Keynote Address Only	$ 3.00
_____	Friday Address Only	$ 3.00
_____	Single Workshop (only after full registration is done)	$ 2.50
_____	Would utilize child care services (available at a fee)	
_____	Total Amount Enclosed	

Please list your choice of panel discussion in each session by preference first thru third

_____ Techniques of Volunteer Lobbying
_____ Developing Position Papers
_____ Funding of Causes
_____ Leadership and its Use

_____ Child Abuse - Its Legislative Needs
_____ Humane Services Concept and Children

_____ Corporations, Labor, Child Care of Child in Juvenile Programs
_____ Early Childhood Legislation
_____ Not the Great White Way

_____ Issue of Training in Early Childhood
_____ Needs of Women
_____ USDA Food Programs
_____ Not the Great White Way

Return to Minnesota Children's Lobby, 1430 Oak Grove, B-12, Minneapolis, MN 55403 By December 10, 1974 with the proper fee enclosed. No registrations will be accepted at the time of the conference.

DEC 2 1 1977

League of Women Voters Education Fund • 1730 M Street, N.W., Washington, D. C. 20036 Tel. (202) 659-2685

memorandum

December 9, 1977

THIS IS NOT GOING ON DPM

TO: Leagues With a Special Interest in Income Assistance, Employment, Health, Social Services or Day Care

FROM: Dot Ridings, Human Resources Chairperson

RE: Children's Political Checklist

Because of your League's involvement in some of the Human Resources areas explored in the recently published Children's Political Checklist, the Carnegie Council on Children has agreed to underwrite this special mailing, with the expectation that it will prove to be a useful tool in your community.

We are at this same time sending a memo to all Leagues about All Our Children-The American Family under Pressure, a Carnegie Council publication about child and family policy which already has generated discussion around the country.

All Our Children argues that the best way to help children is to help their parents, chiefly with jobs and minimum income support, but also through reforms in the social services and legal fields which would enable parents to exercise their own best judgments about raising their children. This approach is backed up with analysis and documentation.

All Our Children and a recent report of the National Academy of Sciences form the basis for the Children's Political Checklist, a handbook for discussion that covers key issues affecting families and provides examples, backup information and a list of questions that can help groups or individuals reflect on their own positions on these important questions. The Checklist should help you analyze human resources issues from the perspective of a national child and family policy.

A sample copy of the Children's Political Checklist, a discount bulk order form and a brochure describing All Our Children are enclosed.

You can order bulk orders of All Our Children at a special half price rate of $5.50 by sending prepaid orders directly to the publisher before February 1, 1978. (All copies must be sent to one address.) Write:

Institutional Sales Manager
General Books
Harcourt Brace Jovanovich, Inc.
757 Third Avenue
New York, New York 10017.

"This study is remarkable for its frankness. It is a beautiful example of how things can be done and should be done....We hope full use will be made of this study and similar studies in other nations." —John Grun, Director
Secretariat for the International Year of the Child*

"I must congratulate the Council. If the recommendations so passionately made get listened to by the right ears, as I hope they do, then this society might become wonderfully more humane."
—Jane Howard, author of *A Different Woman*

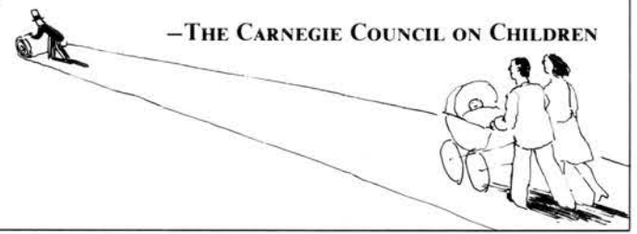
"Compassionate, far-seeing, and hard-hitting, this compelling perspective reminds us that major social challenges have not been forgotten. ***All Our Children*** will make it respectable to fight some battles on social policy issues again."
—Vernon E. Jordan, Jr., Executive Director, National Urban League, Inc.

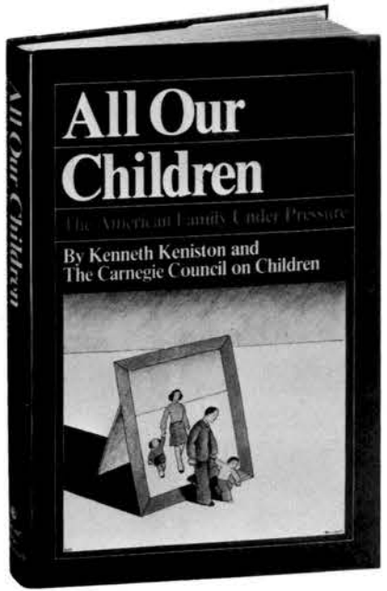
"Parents who have felt blamed for their children's failings and the erosion of the family by most (if not all) 'experts' will welcome the Council's report. Literate, clear writing...accessible to all readers....a virtual text book on instituting programs to shore up families and provide vital services...for all. The recommendations and findings contained here...are sane and logical."
—*Publishers Weekly*

"It is time for parents, citizens, private business, and public officials to face up to the many new shapes that are emerging for the old family and to bring our ideas and policies into line with reality....Our society needs the best adults we can make...
"Here in a brief review is the national program—the broad, integrated, explicit family policy—we believe public advocates should support for the sake of the children:

1) jobs for parents and a decent living standard for all families
2) more flexible working conditions
3) an integrated network of family services
4) proper health care for children
5) improved legal protection for children outside and inside their families"

—The Carnegie Council on Children





At your bookstore or:

HBJ

Harcourt Brace Jovanovich, Inc.
General Books, Department 10–BC
757 Third Avenue, New York, N.Y. 10017

Please send me _____ copies of *All Our Children* (1-046119) @ $10.95 each (HBJ will pay postage). I enclose ☐ check ☐ money order for $_____ total. (Please add sales tax where applicable.)

Name_____

Address_____

City_____State_____Zip_____

Council members are available for a limited number of lectures and consultations. For information, please write to: Christopher T. Cory, Director of Public Affairs, The Carnegie Council on Children, 1619 Broadway, New York, New York 10019.

The Carnegie Council on Children was created and supported by Carnegie Corporation of New York, an educational foundation. The principal author of this book and chairman of the Council is KENNETH KENISTON, Professor of Human Development at MIT and author of *The Uncommitted, Young Radicals,* and *Youth and Dissent. All Our Children* is the first of six books written under the auspices of the Carnegie Council on Children; forthcoming books will examine the effects of physical handicaps and social inequality on children, caste and minority education, child care within families, and other topics. All titles will be published by Harcourt Brace Jovanovich, Inc. or its subsidiary, Academic Press.

In 1972, the Carnegie Council on Children began to examine the way children grow up in America. The startling conclusions and resulting recommendations of their ground-breaking study are finally made available in

"A major contribution to the well-being of children."*

THE CHILDREN'S POLITICAL CHECKLIST,

companion to the Carnegie Council on Children's controversial report, All Our Children: The American Family Under Pressure, and to the National Academy of Sciences' report, Toward a National Policy for Children and Families,

is now available from: EDUCATION COMMISSION OF THE STATES, 300 Lincoln Tower, 1860 Lincoln St., Denver, Colo. 80295

single copies @ $3.00 incl. postage
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25+ copies @ $2.40 "

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The Children's Political Checklist

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Version 3
March 18, 2019

League of Women Voters Education Fund •1730 M Street, N.W., Washington, D.C. 20036 Tel. (202) 659-2685

memorandum

December 9, 1977

THIS IS GOING ON DPM

TO: State, Local and ILO Presidents

FROM: Dot Ridings, Human Resources Chairperson

RE: Publications Concerning National Child and Family Policy

National child and family policy is a topic under discussion throughout the country these days--in recent academic literature, in the media and among parents everywhere. The present Administration has stated that it is a high priority, and apparently there will be a major attempt to stimulate national discussion through a White House Conference on Families in addition to, or combined with, the decennial White House Conference on Children scheduled for 1979-80. Also, 1979 has been designated by the United Nations as the Year of the Child.

Many of you probably have read about a major new contribution to this discussion: All Our Children: The American Family Under Pressure, which is the recently published first product of the Carnegie Council on Children. You may have seen its principal author, Dr. Kenneth Keniston, on one of the many television shows or in public appearances he and other Council members have been making recently. All Our Children is a comprehensive and useful report which should help you make connections among a variety of human resources issues, including income assistance, employment and social services.

The publisher of the book has authorized a special half-price bulk-order rate* to non-profit organizations such as the League. To take advantage of this $5.50 price you must send prepaid orders (freight will be paid) for 10 or more copies before February 1, 1978, to:

Institutional Sales Manager
General Books
Harcourt Brace Jovanovich
757 Third Avenue
New York, New York 10017.

Another stimulus to discussion of child and family policy, The Children's Political Checklist, has just been published by the Education Commission of the States. Based primarily on the Carnegie Council report and on a policy statement produced last year by the National Academy of Science, the Checklist is a discussion handbook for parents, professionals, legislators and administrators. It covers employment and income assistance issues, social services questions, child health and safety and the politics of children. Single copies are $3.00 including postage,

*Single copies are sold in commercial book stores for $10.95

10-24 copies are $2.70, and 25 or more are $2.40; all must be prepaid. You can order directly from:

Education Commission of the States
Publications Department
300 Lincoln Tower
1860 Lincoln Street
Denver, Colorado 80295.

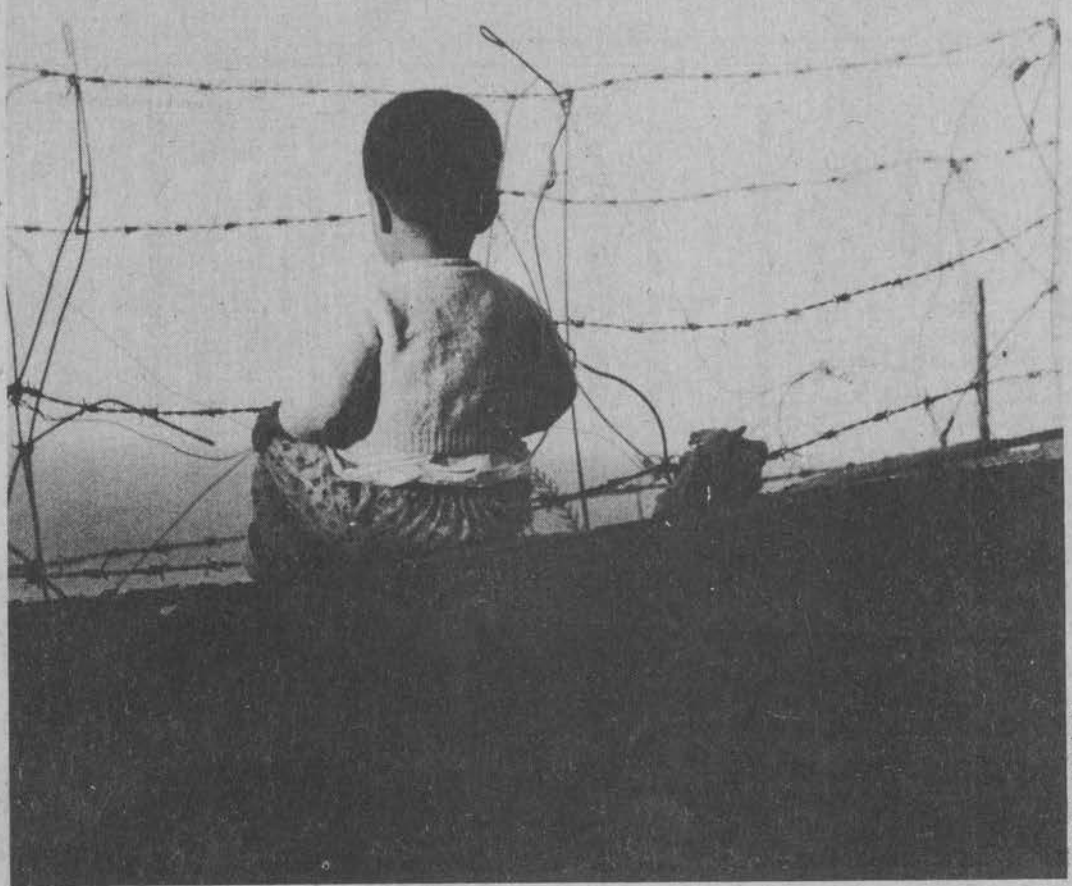
If your League named income assistance, employment, health, social services or day care as its top HR priority in its 1976 Annual Report, then you are receiving one complimentary copy of the Checklist in a special mailing made possible by the generosity of the Carnegie Council.

I urge you to share this information about the report and the Checklist with your membership, particularly your Human Resources chairperson.

MATCHBOX

Winter 1979

1979 International Year of the Child



UNICEF/L. Heeschutt

Refugee child of Algeria.

During the final days of World War II, a captured resistance member sat alone in a black prison cell, tired, hungry, tortured, and convinced of approaching death. After weeks of torture and torment, the prisoner was sure that there was no hope, that no one knew or cared. But in the middle of the night the door of the cell opened, and the jailer, shouting abuse into the darkness, threw a loaf of bread onto the dirt floor. The prisoner, by this time ravenous, tore open the loaf.

Inside, there was a matchbox. Inside this matchbox, there were matches and a scrap of paper. The prisoner lit a match. On the paper there was a single word: *Coraggio! Coraggio.* Take courage. Don't give up, don't give in. We are trying to help you. *Coraggio!*

Inside...

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Amnesty International is a worldwide human rights movement which is independent of any government, political faction, ideology, economic interest or religious creed. AI works for the release of men and women detained anywhere for their beliefs, color, sex, ethnic origin, language or religion, provided they have neither used nor advocated violence. AI advocates fair and early trials for all political prisoners and works on behalf of such persons detained without charge or trial. AI opposes the death penalty and torture or other cruel, inhuman or degrading treatment of all prisoners, without reservation. Founded in 1961, AI has consultative status with the United Nations, UNESCO, the Council of Europe, the Organization of African Unity and the Organization of American States. AI is financed by subscriptions and donations of its worldwide membership. To safeguard the independence of the organization, all contributions are strictly controlled by guidelines laid down by AI's International Council and income and expenditures are made public in an annual financial report.

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Version 3
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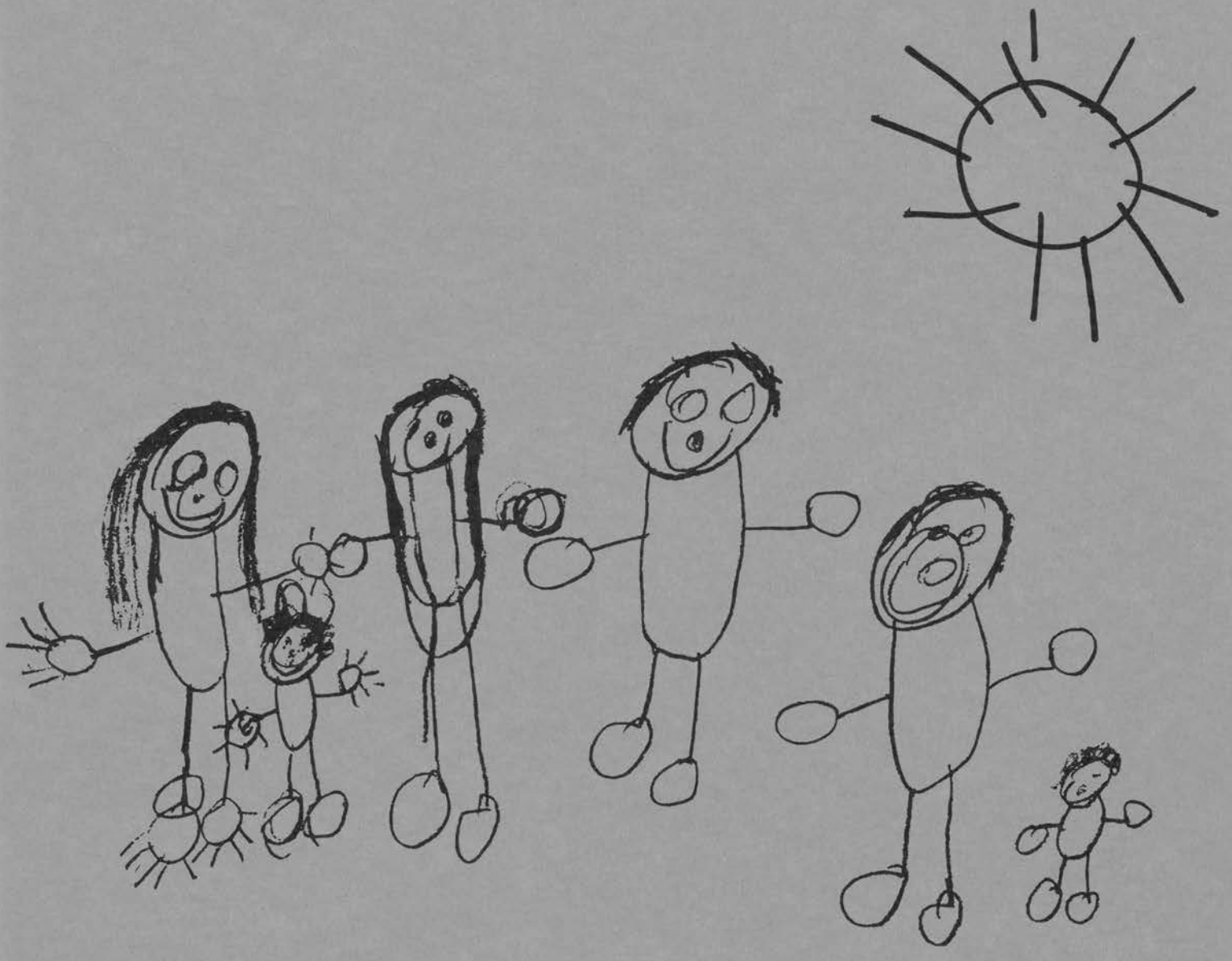
(1986)

Protecting Minnesota's Children:

Public Issues



League of Women Voters of Minnesota

Drawing by Rachael Schmieg, Kindergarten, Guardian Angels Elementary, Chaska, Minnesota

Protecting Minnesota's Children: Public Issues

Prepared by the League of Women Voters of Minnesota.
Published by the League of Women Voters
of Minnesota Education Fund.

For information about this publication or
the League of Women Voters contact:

LWV of Minnesota
555 Wabasha Street
St. Paul, Minnesota 55102
(612) 224-5445

Coordinator:
Polly Keppel

Editor:
Barbara Flanigan

Acknowledgments:
The League of Women Voters of Minnesota thanks those people listed under Resources who generously shared their time and knowledge in interviews and in answering requests for information. Recognition is also due to members of the local leagues listed below who assisted with the more than one hundred interviews conducted for this study. We are particularly grateful to Anne Tuttle and the members of the League of Women Voters of Shakopee for their special assistance.

LWV of Alexandria
LWV of Anoka/Blaine/Coon Rapids
LWV of Arden Hills/Shoreview
LWV of Austin
LWV of Bloomington
LWV of Brooklyn Park/Osseo/Maple Grove
LWV of Buffalo/Monticello Area
LWV of Cass Lake/Walker Area
LWV of Duluth
LWV of Eastern Carver County
LWV of Edina
LWV of Freeborn County
LWV of Fridley
LWV of Marshall
LWV of Minneapolis
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LWV of St. Peter
LWV of Shakopee
LWV of South Tonka
LWV of Stevens County
LWV of White Bear Lake/North Oaks
LWV of Wilkin County
LWV of Winona
LWV of Worthington

CONTENTS

FOREWORD

During its 66 year history the League of Women Voters has often served as an advocate for children. In the 1930's the league lobbied for maternal and child health programs and child labor laws. The league has supported policies ensuring that the basic needs of children would be met, that children would receive an education, that children with special developmental and educational needs would be served and that children would be protected from family violence.

At the June 1985 state convention of the League of Women Voters of Minnesota delegates voted to study Minnesota's policies affecting the health and safety of children as the major league program emphasis during 1985-87.

This report on the protection of Minnesota's children is the first in a series of three on issues affecting children in Minnesota. The second report will deal with children's health and the third with child care.

The national publicity surrounding the alleged cases of intrafamilial sexual abuse in Scott County, Minnesota, and the apparent flaws revealed in existing legal procedures to deal with them prompted a series of legislative changes and a great deal of public discussion. Controversy centers on the appropriateness, adequacy and effectiveness of legislation governing the protection of children in Minnesota. There is debate about the competing rights of the child and the adult in situations of alleged abuse and neglect and about the appropriate role for public intervention. There is concern about the availability and coordination of community resources and preventive services. There is argument about the desirability of court intervention and incarceration for offenders.

INTRODUCTION

Virtually all segments of opinion agree that society in general has an interest in the protection of children. The Minnesota Legislature recently passed a law requiring that infants and toddlers be protected by an "infant safety seat" while riding in a motor vehicle. Parents are required to have their children immunized against childhood diseases before they start school. Communities provide safety crossing guards at intersections near schools. These examples of protecting children are general societal responses. There is considerable difference of opinion, however, about the role of government in what have been traditionally regarded as private family matters.

This League report *Protecting Minnesota's Children: Public Issues* will direct particular attention to Child Protection Services (CPS), a specialized division of county social service agencies staffed by social workers. CPS is charged to intervene with families when there is reasonable cause to believe that parents are abusing or neglecting their children. The role of law enforcement officers, of county attorneys and of the juvenile and criminal court systems will also be described as they affect the protection of children. In addition to presenting the legal framework governing child protection in Minnesota, this report will attempt to present a picture of how the system works in practice and to discuss the major issues raised and changes suggested in the system.

Because the topic of child maltreatment is so broad, this report will focus on protection of the younger child. Although the laws, rules and practices apply to the adolescent as well, problems and treatment specific to teenagers will not be addressed in this report. Also excluded are instances of abuse by non-family members which go directly to the criminal court system and not through the system described here. (Under Minnesota Statutes, however, family is defined to include "persons who reside intermittently or regularly in the same dwelling" even if they are not related.)

Local leagues throughout Minnesota contributed to this study in substantial measure. Twenty-two counties representing urban, suburban and rural populations, ranging from Hennepin County with a population of 947,786 to Wilkin County with a population of 3,337, were investigated. League of Women Voters members interviewed more than ninety knowledgeable professionals including county social service directors, CPS supervisors and social workers, county attorneys, public defenders, judges, public health nurses, school social workers and nurses, law enforcement officers, social service professionals providing counseling and treatment in the private sector, educators and child advocates.

Neglect is the most frequently reported form of child maltreatment in the United States.

Child physical abuse, neglect and sexual abuse are defined in the 1985 version of Minnesota Statute 626.556.

Physical abuse means any physical injury inflicted by a person responsible for the child's care on a child other than by accidental means, or any physical injury that cannot be reasonably explained by the child's history of injuries.

Sexual abuse means the subjection by a person responsible for the child's care, or by a person in a position of authority of a child to criminal sexual conduct including "sexual contact" or "sexual penetration." Sexual abuse also includes activity involving a child in prostitution or as the subject of pornographic materials.

Neglect means failure by a person responsible for child's care to supply a child with necessary food, clothing, shelter or medical care when reasonably able to do so or failure to protect a child from conditions or actions which imminently and seriously endanger the child's physical or mental health when reasonably able to do so.

Child Maltreatment

The Nature and Magnitude of the Problem

The abuse and neglect of children are not modern phenomena. However, only in recent years has the issue penetrated society's consciousness as an appropriate concern for public policy. For many years, the belief that children were the exclusive property and responsibility of their parents was unquestioned and unchallenged.

In the late nineteenth and early twentieth centuries, societies for the prevention of cruelty to children (SPCCs) operated specifically to prevent the abuse, neglect and cruel treatment of children. The passage of the Social Security Act in 1935, shifted the major responsibility for child welfare from private agencies to the public sector.

In the early 1960s, the medical diagnosis of child abuse was recognized and advanced by C. Henry Kempe, M.D., and his associates, who introduced "the battered child syndrome" as a medical diagnosis for child maltreatment.[1]

In 1962, a conference on child abuse, convened by the Children's Bureau of the United States Department of Health, Education and Welfare, recommended the drafting of model child abuse legislation requiring that certain categories of professionals working with children report known cases of child abuse and neglect to social service agencies. As a result of this conference, an intensive effort was undertaken and by 1967 all fifty states, the District of Columbia and the Virgin Islands had enacted such legislation.[2] The first Minnesota law to require that physicians report suspected physical or sexual abuse of children to welfare authorities was passed in 1963.

In addition to what appears to be growing consensus that it is appropriate for society to intervene in cases of familial abuse and neglect, evidence is accumulating that failure to protect children leads to severe problems for them and, even, for future generations.

Child abuse and neglect contribute to "emotional disturbance, mental illness and anti-social behavior in children and adults." An Australian study showed that victims of child abuse lag in language development and self-esteem and these effects continue after the actual abuse has stopped. And it is not only the abused child who suffers:

"Accumulating clinical and research evidence indicates that all forms of abuse seriously damage the health of the general family environment, so that even those not directly abused are negatively affected. The level of family health in turn has its effect on neighborhood, community, and economic stability."[3]

The widely accepted premise that adult abusers were almost always abused as children leads to the logical conclusion that, without effective intervention, today's abused children may themselves become abusers. Unless abusing parents receive treatment and stop abusing, the pattern may well be perpetuated to the next generation.

The Problem Nationally

More than one million incidents of child maltreatment, involving one and one-half million children, were documented nationwide in 1983 according to reports published by the American Association for Protecting Children, the children's division of the American Humane Association. This represented an 8.4 percent increase over the previous year and an increase of 142 percent since 1976. The national rate of reported child maltreatment in 1983 (the last year for which national statistics are available) is 23.8 children for every thousand children in the United States.[4]

Neglect is the most frequently reported form of child maltreatment in the United States. Neglect alone, or

combined with abuse, accounted for 65 percent of the reports. Abuse alone, or in combination with neglect, accounted for 47 percent of the reports.

Type of Maltreatment Report	
Abuse	27.9%
Neglect	45.7%
Abuse/Neglect	19.0%
Other	7.4%

(Source: American Association for Protecting Children of the American Humane Association, "Reports of Child Maltreatment Increase Again," from *Protecting Children*, Vol. 2, No. 1, spring 1985.)

The average age of the children involved in abuse reports was 7.1 years old, compared to the average age of 7.5 for all United States children.[5]

Abusers are primarily those with whom the child lives—83 percent of the perpetrators were caretakers and 95 percent of these caretakers are the child's parents.[6]

Forty-seven percent of the households where child maltreatment was reported were receiving public assistance. Only fifty percent of the families involved had both male and female caretakers. Forth-three percent of the families in which children were abused or neglected were headed by a single female although this category accounted for only 19 percent of all United States families with children. The average age of the perpetrators was 31.3 years old; sixty percent were female.[7] Persons becoming parents at younger ages were also at greater risk in being involved in child abuse.[8]

There is a strong relationship between abuse and neglect, particularly neglect, and poverty. Although child abuse takes place in all classes of society, it is more prevalent in families of poorer economic status.[9]

Black children are reported as the victims of maltreatment slightly more than their percentage in the general population, 20 percent as compared to 15 percent. This higher percentage is attributed to the fact that more black children live in poverty. A higher proportion of black families have been reported for neglect only, 65 percent, than the rest of the population; fewer black families than the entire group are reported for abuse.[10]

Sexual abuse cases have a family profile very different from maltreatment cases overall. For one thing, besides the sexual maltreatment, there is little abuse or neglect. "Sexual abuse victims are mostly female, older than other victims, and are not more likely to be black. Families are much less often female-headed and somewhat less likely to be on public assistance." Most perpetrators are male, but they are much less likely to be natural parents of the victims than in other instances of maltreatment.[11]

While cases of severe physical abuse and sexual abuse have received a great deal of publicity, nearly two-thirds of incidents reported involved "deprivation of necessities" while acute physical injury is experienced by only one-quarter of the children.[12]

Data on maltreatment were available for 397,785 children nationally:

Type of Maltreatment of Children	%
Major Physical Injury	23.0
Other Physical Injury	23.7
Sexual Maltreatment	8.5
Deprivation of Necessities	58.4
Emotional Maltreatment	8.3

(Source: American Humane Society, "Reports of Child Maltreatment Increase Again.")

Approximately fifty percent of these reports resulted in CPS opening cases.[13]

Victims of major physical injury are most often very young children—60 percent of the major injuries were reported to children under the age of four. Forty percent of sexual maltreatment involved children over 12, but one fourth of these victims were under five years of age.[14]

Although no extensive national data are available, there is a strong suspicion that children with disabilities are particularly subject to abuse and/or neglect. This is borne out by several small studies.[15]

Child abuse and neglect reports to child protection services have increased significantly in recent years. There is agreement that much of this increase is a function of improved reporting rather than an actual rise in child maltreatment. Improvements in reporting systems, broadened reporting legislation, campaigns to increase public awareness and implementation of 24-hour hotlines have contributed to the increase.[16]

Some experts also believe that part of the increase in reported maltreatment is due to an actual increase in the incidence of abuse and neglect. The increase in the number of children living in homes headed by a single parent, especially in families headed by unmarried teenagers, and the greater percentage of children who now live in poverty are cited as explanations. Increased economic stress in some areas is also believed to contribute to more child maltreatment. Several studies have shown a relationship between child abuse and increased unemployment.[17]

Despite the increase in reports, informed professionals agree that many child abuse and neglect cases still remain unreported. The *National Study of the Incidence and Severity of Child Abuse and Neglect* completed in 1981, states that two-thirds of the cases in their sample were not reported to the appropriate authorities even though a professional source, mandated by law to report child maltreatment, had identified the child as maltreated. Incidents involving younger children were reported to CPS agencies much more often than those involving older children.[18]

Although the number of reported incidents has risen drastically, the federal funds available to deal with child maltreatment have declined. Between 1976 and 1982 the dollar amount appropriated to child abuse and neglect at the federal level under the Child Abuse Prevention and Treatment Program declined by 14 percent, not taking inflation into account. Cuts have also been made in other services used by many CPS families, including foster care, food stamps and maternal and child health. Title XX funds decreased 21 percent between 1981 and 1982. Title IV-B funding declined approximately 50 percent from 1981 to 1982. Eighty-seven percent of CPS workers responding to a survey reported that local funding for CPS had declined or remained the same in spite of increased reporting and 72 percent reported that support services had declined or remained the same.[19]

There is concern expressed that the great increase in reporting has created a volume of cases which CPS resources are unable to meet. County social service budgets frequently decline as unemployment rises, at precisely the time when there is also likely to be a rise in child maltreatment. Although the number of reports has leveled off in the last few years, some of this may be due to a failure to encourage reporting or to screening cases out. Some CPS agencies are imposing criteria and consciously serving only the worst cases. This may lead to a low number of "substantiated" cases as well as to higher caseloads, less thorough intervention and shorter followup.[20]

The Problem in Minnesota

Between 1978 and 1981 the number of child abuse and neglect reports documented by the Minnesota Department of Public Welfare rose from 2,589 to 8,003.[21]

More recent statistics and responses to league interviews from all parts of Minnesota also describe an increase in the reporting of child abuse. Reasons given for the increase include the media attention to the cases in Scott County, greater awareness of the problem on the part of the general public, strengthened reporting laws, more sophistication among professionals in recognizing abuse and an increase in self-referrals by families needing help. (In Hennepin County, for instance, the number of families asking for help has doubled in recent years and now accounts for nine to ten percent of all substantiated cases.)[22]

A sense of the magnitude of the problem of abuse in Minnesota is reflected in the following statistics from the Department of Human Services (DHS.) (This department succeeded the Minnesota Department of Public Welfare in July 1984.)

	1982	1983	1984
Reports of maltreatment	**9,941**	**11,411**	**16,676**
No. of children involved	14,408	16,196	18,621
Rate per thousand	12	14	16
Substantiated reports	4,134	4,740	6,466
% substantiated	42%	41%	39%

(Source: Interview with Dwaine Lindberg, DHS)

Department of Human Services figures for fiscal 1983, the last year for which they are available, show the following breakdown:

Cases reported	**11,411**
No. of children involved	16,196
% abused	52%
% neglected	32%
% abused and neglected	15.7%
% substantiated	41.2%
Child Abuse Perpetrators	
natural parents	59.9%
step-parents	10.4%
parent's friends	6.6%
siblings	4.8%
other relatives	4.4%
adoptive parents	2.1%
other	11.8%

(Source: DHS, "Compiled Child Abuse Related Facts," unpublished, undated, single sheet.)

Substantiated Cases of Sexual Abuse

1982 - 1,240
1983 - 1,573
1984 - 2,576

(Source: Interview with Dwaine Lindberg, DHS.)

Indications are that reports of abuse and neglect in Minnesota show an over-representation of poor families. League interviews showed that approximately 85 percent of all families who appear in juvenile court neglect/dependency proceedings qualify to be represented by the public defender or court-appointed attorneys.

More reports of child abuse and neglect involve minority families than would be expected on the basis of their proportion of the overall population. In 1981 an Indian child in Minnesota was four and one half times more likely to be reported as maltreated than a child in the rest of the population. Judge Allen Oleisky of Hennepin County Juvenile Court reported that 200 of the 900 cases he heard in 1983 involved Indian children. More than 400 children were involved.[23]

"Poverty compounded by chemical abuse is the biggest factor accounting for child abuse and neglect by Indian mothers," reported Bob Aiken of the Minnesota Chippewa Tribe.[24]

The over-representation of minority families served by child protection in Hennepin County indicates the effects of poverty. In an ongoing caseload of 1250 families, there are 279 black families, 195 Indian families and ten to fifteen Southeast Asian families.[25] Thus, minority families comprise more than one third of the caseload and less than ten percent of the total number of families in Hennepin County.

While statistics show that many abusing parents in Minnesota, as in the nation, are poor, a study of Minnesotans convicted of sexually abusing their children shows a somewhat different picture. The Minnesota Sentencing Guidelines Commission found that the 58 men convicted in 1983 of intrafamilial sexual abuse who had no prior criminal convictions were overwhelmingly white, more likely to have jobs and older than a group convicted of other serious crimes against people.[26]

The group of convicted sexual abusers were also better educated than the other criminals. Sixty percent had at least a high school education, as compared to 30 to 40 percent of the other criminals. Both groups of criminals, however, were less well educated than the overall Minnesota population.[27]

However, both groups of offenders were believed to be heavy users of or addicted to drugs or alcohol, 31 percent of those convicted of sexual abuse, 40 percent of the other criminals. Both groups were 91 percent male.[28]

THE LEGISLATIVE FRAMEWORK

Congressional legislation has imposed significant mandates for state child protection activities. To qualify for federal funds, states must comply with certain federal requirements. In 1962 Congress passed Title V-B, since retitled IV-B, of the Social Security Act requiring all states to create Child Protective Services.

The Child Abuse Prevention and Treatment Act of 1974 (P.L. 93.247), reauthorized in 1984, established a number of requirements. It mandated the appointments of a guardian ad litem (GAL) to serve as an advocate for child victims. It encouraged the use of multidisciplinary child protection teams. It required that each state designate an agency to receive reports of child maltreatment, that it provide immunity to mandated reporters, that it encourage voluntary reporting and that it comply with certain definitions of abuse and neglect. The statute also established the National Center for Child Abuse and Neglect (NCCAN) which allocates funds for use for projects within the states.

More recent federal legislation has addressed out-of-home placement and the particular difficulties of Indian children.

Minnesota Statutes

The major statutes and regulations governing child protection in Minnesota, however, result from state action.

In the last three decades, Minnesota has taken a number of steps to protect children from abuse and neglect. Reporting of incidents of child maltreatment is required. Sanctions against adults who abuse or neglect children in their families have been tightened. Although these developments may be regarded as intrusions by government into private family matters, Minnesota law and practices still stress the long-standing legal doctrine that the primary responsibility for the care and protection of children lies with their parents, guardians or legal custodians. It is only when the health or safety of children is jeopardized by inadequate or inappropriate care by these primary caretakers that public agencies should intervene. Stronger sanctions have been adopted to punish parents who abuse their children; a parallel development has been a greater effort to prevent out-of-home placement wherever possible.

Legislative provisions and regulations covering child protection are found in several Minnesota statutes. In 1950 the Minnesota Department of Public Welfare (DPW), now the Minnesota Department of Human Services (DHS), ruled that each county was responsible for providing child protection services. (Minn. Stat. Sec. 956.025.)

The Child Abuse Reporting Law

The major single piece of legislation governing child protection in Minnesota is the "Child Abuse Reporting Law." First passed in 1963 the law required physicians to report suspected physical or sexual abuse of children to welfare authorities. (Minn. Stat. Sec. 626.556.) As amended in 1985 the statute now requires:

> A professional or his delegate who is engaged in the practice of the healing arts, social services, hospital administration, psychological or psychiatric treatment, child care, education, or law enforcement (mandated reporters) who knows or has reason to believe that a child is being neglected or physically or sexually abused shall immediately report the information to the local welfare agency, police department or county sheriff. (Minn. Stat. Sec. 626.556, subd.3.)

The law also provides for voluntary reports of incidents of abuse or neglect and requires that abuse or neglect reports be assessed or investigated.

The original statute was strengthened in 1965 to require reporting of incidents of suspected abuse by physicians "and their agents"; for the first time protections were extended to those mandated to report and penalties were established for failure to report.

In 1975 the categories of professionals required to report child abuse were expanded to include all those listed above.

In 1978 reciprocal reporting of suspected neglect or abuse was required between the local police or sheriff's departments and the welfare department. Minor prostitutes were defined as abused children. Reports of suspected neglect or abuse were mandated in four areas: food, clothing, shelter and medical care. A new category called "neglected in foster care" was defined.

In 1979 the definition of neglect to be reported was expanded to include the "failure to protect a child from conditions or actions presenting imminent danger to the child's physical or mental health." Children who are subjects of pornographic materials were defined as sexually abused children.

Other statutes also shape the child protection system in Minnesota. Provisions in both the juvenile and criminal codes determine court procedures and jurisdiction in child abuse and neglect cases; they also list ways in which the state may intervene to protect children and to punish those who maltreat them.

The Juvenile Court

The first juvenile court in Minnesota was established in 1905 as part of a national trend of reform bringing under one jurisdiction cases of dependency, neglect and delinquency involving children.

In 1959 a new and comprehensive Juvenile Court Act (Minn. Stat. Chapter 260.) established legislation and court procedure. The basic philosophy of this act is stated:

> The purpose of the laws relating to juvenile courts is to secure for each minor under the jurisdiction of the court, the care and guidance, preferably in his own home, as will serve the spiritual, emotional, mental, and physical welfare of the minor and the best interest of the state; to preserve and strengthen the minor's family ties whenever possible, removing him from the custody of his parents only when his welfare or safety and protection of the public cannot be adequately safeguarded without his removal; and when, the minor is removed from his own family, to secure for him custody, care and discipline as nearly as possible equivalent to that which should have been given by his parents. The laws relating to juvenile courts shall be liberally construed to carry out these purposes.

Juvenile court is a civil court which rules on petitions of neglect and dependency; it protects the status of the child but does not prosecute the parents. It may, however, terminate parental rights or remove children from the authority of their parents.

Criminal Proceedings

The Minnesota criminal code has also been modified in recent years to address intrafamilial abuse, by including new categories of felonies and by modifying procedures to gain evidence and protect children.

In 1967 an amendment was passed allowing husband and wife to testify against each other in regard to what they know or have seen as it affects the child in cases of abuse or neglect. This differs from ordinary criminal procedure which does not permit spouses to testify against each other.

The criminal code was amended in 1981 to include intrafamilial sexual abuse as a felony. (Minn. Stat. Sec. 609.364.) In 1983 child abuse and neglect also became a felony when it results "from willful or malicious intent." (Minn. Stat. Sec. 609.377-.378.)

1985 Amendments

Responding to difficulties in child protection procedures revealed in the widely publicized cases of intrafamilial sex abuse in Scott County, as well as the Minneapolis Children's Theatre cases, the Minnesota Legislature adopted significant amendments to all statutes affecting child abuse during the 1985 session.

A number of the changes attempted to improve the reporting of child maltreatment:

• In response to a court decision questioning mandatory reporting of *"suspected"* abuse as too vague, a new reporting standard was adopted. A mandated reporter is no longer required to report all cases of *"suspected"* abuse; he or she is now required to report when he/she *"knows or has reason to believe"* that a child is being neglected or abused. Failure to report remains a misdemeanor. Voluntary reporters, who may be neighbors, friends, relatives, are still encouraged to report when they "know, have reason to believe or suspect" abuse or neglect have taken place. (Minn. Stat. Sec. 626.556, subd.3.)

• Mandated reporters must be provided, upon request, with "general" summaries of the outcome of reports they make of alleged abuse or neglect; voluntary reporters must be provided with "concise" reports upon request, unless the release of the outcomes would be "detrimental to the best interests of the child." This change was an attempt to encourage more reporting; mandated reporters had complained that they often had little information to guide them when making future reports or in their ongoing contacts with the alleged child victim because they had no idea of the outcome of their reports. (Minn. Stat. Sec. 626.556, subd.3.)

• The immunity from liability of both mandated and voluntary reporters was strengthened to encourage reporting. Previously, reporters were granted immunity from liability arising out of making a child abuse report only if they had acted "in good faith and exercised due care" in making the report. The 1985 amendment removes the "exercise of due care" from the immunity standard. However, a person who "knowingly or recklessly makes a false report" is liable. There is a stricter standard for investigators than reporters; investigators must still act "in good faith and exercise due care" in their investigations. (Minn. Stat. Sec. 626.556, subd.4.)

• A person conducting the investigation or assessment of a report of child abuse or neglect who intentionally discloses the identity of the reporter prior to completion of the investigation is guilty of a misdemeanor. (Minn. Stat. Sec. 626.556, subd. 11.)

• County attorneys, rather than city attorneys, will now exclusively prosecute alleged failure to report child abuse or neglect. Although city attorneys normally prosecute all misdemeanor violations, the legislative authors believed that county attorneys' offices could better handle failures to report abuse misdemeanors, since they are more experienced in child abuse prosecution. (Minn. Stat. Sec. 626.556, subd. 6.)

Other modifications were intended to strengthen CPS and to enhance smooth communication between different public agencies:

• A new job classification is established in child protection and all child protection workers or social services staff must receive 15 hours of continuing education or in-service training each year. (Minn. Stat. Sec. 626.559, subd. 1.)

• A law enforcement agency or local welfare agency receiving a report of child abuse or neglect must immediately, within 24 hours, notify the other agency both orally and in writing. Each agency must identify a designated person to ensure that this is done. (Minn. Stat. Sec. 626.556, subd. 3.)

• The Commissioners of Human Services and Public Safety are required to develop a multidisciplinary educational program on training child abuse professionals in appropriate techniques for child abuse assessment and investigation. $209,000 was appropriated for the program. (Minn. Stat. Sec. 626.559, subd. 2.)

Another set of changes were adopted to protect children during the interviewing process:

• Documentation of all interviews with alleged victims of child abuse must be kept and "unnecessary, duplicative" interviews are discouraged. (Minn. Stat. Sec. 626.559, subd. 1.)

• Each county attorney's office must develop written guidelines for the tape recording of interviews relative to child abuse. (Minn. Stat. Sec. 626.559, subd. 4.)

• If a child is interviewed by court order on school property, school officials may not disclose any information about that interview that may become part of the child's school record to the parents, at least until the investigation is completed. (Minn. Stat. Sec. 626.556, subd. 10.)

Some amendments addressed the concerns of parents in the Scott County cases:

• If a child is removed from home, the court must develop a reasonable plan for supervised or unsupervised visitation by the parents, unless it is judged this will endanger the child's physical or emotional well-being. (Minn. Stat. Sec. 260.191, subd. 1d.)

• Hearings shall be held within 60 days (rather than the previously required 90 days) of placing a child outside the home, if any party requests it, unless good cause can be demonstrated why this is not necessary. (Minn. Stat. Sec. 260.172, subd. 4.)

• Children taken out of the home because of alleged child abuse "may not be given mental health treatment specifically for the effects of the alleged abuse until the court finds that there is probable cause to believe the abuse has occurred," unless the child's parent or guardian agrees to this in writing. (Minn. Stat. Sec. 260.172, subd. 2b.)

• To guard against possible conflict of interest, the court may order that the diagnosing therapist not provide mental health treatment to the child if such an order is in the child's best interests. (Minn. Stat. Sec. 260.181, subd. 3.)

The purpose of laws relating to juvenile courts was amended to include: "to provide judicial procedures which protect the welfare of the child." (Minn. Stat. Sec. 260.011, subd. 2.) Specific modifications were introduced to accomplish this:

• Juvenile court procedures were modified to take testimony from child witnesses informally: children may be interviewed by the judge outside the actual courtroom, written questions submitted by counsel may be posed by the judge, and the child's parents or guardian may be excluded from the room while the child testifies. (Minn. Stat. Sec. 260.155, subd. 4a.)

• Juvenile courts must now give priority on the court docket (schedule) to any dependency, neglect or delinquency petition containing allegations of child abuse. (Minn. Stat. Sec. 260.156, subd. 1.)

The rules of evidence in child abuse cases were relaxed in cases of physical abuse in both criminal and juvenile proceedings. Previously out-of-court statements (hearsay) made by children under ten years were admitted as evidence only in cases of sexual abuse. This was expanded to include physical abuse cases as well in both dependency and criminal proceedings. (Minn. Stat. Sec. 595.02, subd. 3.)

Criminal court procedures were also modified in 1985 in the aftermath of the Scott County cases.

• The crime of "intrafamilial sex abuse" was merged with "criminal sexual conduct." This change means that the identity of the child victim will no longer be readily apparent from the name of the alleged perpetrator. (Minn. Stat. Sec. 609.341.)

• The law was clarified to state that the parts of records or reports relating to criminal sex abuse indictments or complaints that specifically identify child victims of criminal sexual behavior are not available to the public. ("Prohibiting Public Access to Data Identifying Certain Youthful Victims of Criminal Sexual Behavior." (Minn. Stat. Sec. 609.3471.)

• The penalties imposed in cases where the court stays the imposition of a prison sentence after conviction for single acts of intrafamilial sexual abuse are tightened. In such cases a professional assessment must now indicate that the offender has been accepted by and can respond to a treatment program *and* the offender must serve some local jail or workhouse time and must complete a treatment program. (Minn. Stat. Sec. 609.342-.345, subd.3.)

• Courtroom procedures were altered to allow a "supportive" person to be in attendance in the criminal courtroom during the testimony of a minor in a child abuse case, even if the supporting person is a prosecution witness. (Minn. Stat. Sec. 631.046.)

The "Baby Doe" Provisions

A separate but widely publicized legislative provision related to "medical" neglect. Consistent with the federal "Baby Doe" law the Minnesota Juvenile Code and the Child Abuse Reporting Law were amended to expand the definition of medical neglect to include the "withholding of medically indicated treatment from a disabled infant with a life threatening condition." Such treatment, which includes "appropriate nutrition, hydration and medication" must be provided except when "in the treating physician's reasonable medical judgment:

1) The infant is chronically and irreversibly comatose.

2) The treatment would merely prolong the infant's dying, or

3) The treatment would be virtually futile in terms of the infant and the treatment, itself, would be inhumane."

The county welfare agency is required to obtain an independent medical review of the infant after receiv-

ing a report of medical neglect. If an independent medical review of the records and an examination conclude that medical neglect has occurred, the agency must intervene on behalf of the infant in juvenile court. (Minn. Stat. Sec. 260.015, subd. 10.)

Specific Legislative Categories

Protection for Indian Children

A separate category of legislation has been enacted to deal with the special case of Indian children. The Minnesota Indian Family Preservation Act passed in 1985 (Minn. Stat. Sec. 257.35 to 257.357.) strengthens the participation by Indian tribes when placement of Indian children is being considered.

The law requires that the child's parents, the tribal social service agency and Indian custodian be notified within seven days of an out-of-home placement; that the tribal social service agency be notified whenever it is determined that an Indian child is in need of out-of home placement for more than 30 days; that the agency placing an Indian child make "reasonable efforts" to find extended family members; that child placement proceedings be transferred to the tribal court "unless either parent objects or the state court finds good cause for not transferring the case," and requires the Commissioner of Human Services to annually publish an inventory of all Indian children in residential facilities. The Commissioner of Human Services must be provided certain information regarding the child and family when a final adoption decree is entered; and Minnesota Rules are amended to provide that an agency placing an Indian child shall cooperate with the child's tribe in securing placement that is "consistent with the child's racial or ethnic heritage."

This state legislation is consistent with the Indian Child Welfare Act (25 USC Sec. 1901) passed by Congress in 1978 requiring that tribes be notified when a member is placed outside the home by a court. In addition to mandating notification of the tribe in decisions about out-of-home placement for Indian children, this federal legislation authorized programs aimed at helping families prevent the removal of children.[1]

Permanency Planning

In 1980 Congress passed Public Law 96-272, amending Title IV of the Social Security Act and adding conditions which states must meet to receive federal funding toward foster care and subsidized adoption. The purpose of the act was to help ensure "permanent families for children."

The act requires states to comply with numerous conditions to monitor out-of-home placement, return children to the home if at all possible, and, in cases where this is not possible, to expedite placing children for adoption.

To receive federal matching funds, states must review the status of each child placed outside the home "at least every six months." Other requirements were also included. Disposition hearings must be held for each child in foster care under state supervision within 18 months after the original placement and periodically thereafter. These hearings would determine the future status of the child:

1. whether the child should return home, *or*
2. should continue in foster care for specified time, *or*
3. should be placed for adoption, *or*
4. should be in foster care permanently or long term because of special needs.

In 1985 Minnesota passed similar legislation (Permanency Planning Grants to Counties Act, Ch. 9, Sec. 31, 69-75, 77, 1985 Special Session Laws of Minnesota.) Permanency planning is defined as "the systematic process of carrying out, within a short time, a set of goal-oriented activities designed to help children live in families that offer continuity of relationships with nurturing parents or caretakers, and the opportunity to establish lifetime relationships."[5]

Special "placement prevention and family reunification services" were established. They include:

1. family-based services;
2. individual and family counseling;
3. crisis intervention and crisis counseling;
4. day care;
5. 24-hour emergency caretaker and homemaker services;
6. emergency shelter care up to 30 days in 12 months;
7. access to emergency financial assistance;
8. arrangements to provide temporary respite care to the family for up to 72 hours consecutively or 30 days in 12 months; and
9. transportation services to the child and parents in order to prevent out-of-home placement or accomplish reunification of the family.

Funding

Funds for child protection services in Minnesota may come from federal, state and local sources.

Federal monies are appropriated to help implement Title IV-B of the Social Security Act. In 1985 Minnesota received approximately $3.6 million in Title IV-B Child Welfare funding to be used for any service on behalf of children. One million dollars of these funds are distributed to the counties; the remainder is used by the Minnesota Department of Human Services at the state level. Each county decides whether to allocate these funds to child protection programs.[6]

Another source of federal monies available to counties for child protection are some of the Title XX Social Services Block Grant monies. Minnesota anticipates $47 million in fiscal 1987. DHS retains some Title XX money to pay for staff and programs, but most is passed through to the counties which decide how to allocate it. Title XX funds are used for all social services, for children, families and adults. Child protection programs must compete with other programs for smaller amounts of Title XX dollars at the county level. Minnesota has also received approximately $120,000 annually since 1975 from the National Center for Child Abuse and Neglect (NCCAN) which has been used at the state level for staff positions and programs to treat and prevent child maltreatment.

NCCAN monies have funded a number of pilot programs. In recent years grants were made 1) to enable the Illusion Theatre to present their productions designed to educate children about sexual abuse to schools outside the metropolitan area in Minnesota; 2) to assist counties in the development of multidisciplinary teams of professionals to address child abuse cases; 3) to enable DHS to prepare a practice guide for CPS workers; 4) to fund a position of specialist in child sexual abuse identification and treatment in the DHS to assist local welfare agencies; 5) to prepare and make available to counties study materials to provide parenting education for first time parents; and 6) to enable Minnesota's health and education departments to work with health professionals and school personnel in preventing child abuse.

State funds are also available for child protection. Community Social Services Act (CSSA) block grants are the primary source for CPS activities. In fiscal 1985 the total CSSA monies granted to counties amounted to $49,325,615, but it is difficult to estimate how much of this goes to CPS in each county.

The county has the authority to use any mix of these funding sources to pay for CPS services and may also use county tax dollars.

THE CHILD PROTECTION SYSTEM

The Public Actors

Attempts to protect children, to end abusive practices and, if necessary, to bring families to court to achieve these ends always involve representatives from child protection services (CPS), and may also involve law enforcement agencies and the county attorney's office. All three agencies may also participate together in the process through multidisciplinary teams.

County Protection Services (CPS)

Under Minnesota law, all counties must provide child protection services. Each county welfare department has a separate child protection service. In sparsely populated counties there may be only one CPS worker; Hennepin County employs 129 social workers and supervisors in child protection.

Under DHS Rule 9560.0250, formerly Rule 207, Child Protection Services in each county have the basic responsibility to conduct an assessment of all child abuse and neglect reports received. An assessment "includes authority to interview the child, the alleged perpetrator, and any other person with knowledge of the abuse or neglect for the purpose of gathering the facts, assessing the risk to the child, and formulating a treatment plan. The definition is deliberately broad and should be construed to include investigating (i.e. fact finding)."[1]

When CPS receives a report of alleged child abuse or neglect it must determine if there is a need for "protective intervention." Protective intervention consists of providing or arranging for the help and resources necessary to assure an acceptable level of care and nurturance to abused and neglected children, preferably within their own families.[2]

The Role of Law Enforcement

Police officers and sheriff's deputies are involved in all cases of alleged sexual abuse of children, in cases of severe physical abuse and neglect and often in cases reported after hours and on an emergency basis. Law enforcement officials are charged with investigating the situation; investigation is defined as fact finding preliminary to possible criminal proceedings.

Actions to remove children from families or to mandate that parents participate in treatment plans go through the juvenile court system.

The police officer or deputy interviews the victim, the alleged offender, other family members and any other witnesses who can provide information. In most cases the child is contacted for information first and usually interviewed privately in a "safe" environment. Police officers and CPS workers may interview a child "without parental knowledge or consent" if the suspected abuser is a parent or another person within the family unit. If the parent refuses to allow the law enforcement officer or social worker access to the child a court order may be obtained permitting the interview.[3] If the report is substantiated, a tape recording is often made of the victim's statement after the initial interview. The officer must then evaluate the situation. In serious situations the officer must determine whether or not there is an adult who can protect the child from further harm from the abuser or whether it is necessary to remove the child from the home immediately. Law enforcement officers have the power to remove the child from the home temporarily, perhaps to an emergency shelter, to the home of a relative, or to an emergency foster home. If the child is removed, this decision must be reviewed by juvenile court at a "Hold Hearing" within 72 hours.

Since 1984 the police officer is also empowered to remove the offending adult, rather than the child victim, from the home to end the abusive situation. In such cases, however, the officer must always get an *ex parte* order from juvenile court pending a full court hearing.

The officer must also judge whether the child's physical injuries require medical attention, if a medical examination is needed to obtain evidence, if pictures need to be taken and if a search warrant must be requested.

Law enforcement must submit a written report on all incidents which is forwarded to the county attorney's office. Both law enforcement and CPS workers are now required to forward reports they receive separately to the other agency.

The Role of the County Attorney

The county attorney serves as an intermediary between the juvenile and criminal courts on the one hand and the social service and law enforcement agencies on the other.

All substantiated cases of sexual abuse and cases of severe physical abuse and neglect are referred to the county attorney for possible action in criminal court. (If the alleged offender is under 18, however, he or she will ordinarily be charged in juvenile court.) Cases where protective custody, supervision or termination of parental rights are judged necessary by CPS workers are considered for possible action in juvenile court. The county attorney's office must then decide whether, in their judgment, there is enough admissible evidence to bring charges in criminal court or to justify a dependency/neglect/termination petition in juvenile court.

Actions to remove children from families or to mandate that parents participate in treatment plans go through the juvenile court system. Actions charging parents with sexual abuse or severe physical abuse or neglect go to criminal court. The county attorney represents *the petitioner,* almost always the county welfare agency, when formal proceedings of neglect, dependency or termination of parental rights are brought in juvenile court. The county attorney represents the state if criminal charges are brought against the abuser; the *complainant* is almost always a law enforcement officer.

Although the role of the county attorney is understood not to include that of a therapist or social worker, the "child abuse victim, and especially the child sex victim, requires more attention from the prosecutor than victims of most other crimes."[4]

Multidisciplinary Teams

In addition to acting individually in child protection matters, reprsentatives from CPS, law enforcement and the county attorney's office may meet collectively in multidisciplinary teams encouraged by federal (1974) and state (1981) statutes.

The great majority of counties in Minnesota now have community-based multidisciplinary child protection teams, or participate in teams including several counties. Encouragement of the use of teams has been a priority of DHS.

According to league interviews, teams vary widely in size, participants, purpose and direction. Ideally, the teams function to coordinate the investigation of child abuse cases, thus eliminating duplication of effort by different agencies involved.[5]

Almost all teams include representatives from CPS, the county attorney's office, law enforcement, medical professions and social service agencies. Also included on some teams are representatives of schools, the clergy, mental health counselors and court services. Teams may meet as often as once a week or as little as "infrequently." The team reviews difficult cases selected by CPS and recommends treatment, providing mutual group support for difficult decisions and actions. Teams may also serve as inservice education providers among themselves and for the community. The Stearns County team, for instance, takes an active role in community education about child abuse by providing a speakers' bureau and arranging workshops for professionals working with children. The team has sponsored a yearly performance of "Touch" and "No Easy Answers" by the Illusion Theater with follow-up in school classrooms by child protection team members.[6]

The CPS worker alone performs the assessment in cases of less serious physical abuse and neglect which will not result in criminal charges.

The Process

Reporting

All counties are required to have services available to receive reports of abuse and neglect on a 24 hour basis. Calls during non-office hours are forwarded to local law enforcement, emergency social services or crisis hotlines. Reporters are encouraged to call their local police department directly when children are "abandoned or subject to a real or imminent threat."[7] Law enforcement and the child protection worker on call respond immediately to emergency reports.

For the years 1982-1984 in Minnesota, reports from voluntary reporters accounted for 48-50 percent of all reports of maltreatment; reports from mandated reporters comprised 41 to 43 percent of the total. Nine percent of the cases were reported by both.[8]

Reports By Mandated Reporters, 1984

medical	9.4%*
legal	11.1%
education	16.5%
other	17.0%

(Source: Interview with Carol Keuchler, Minnesota DHS)

*These figures total more than 43% because reporters from more than one category reported in some cases.

Investigation and Assessment

CPS workers and law enforcement officers are required to make an initial investigation and assessment of the situation within 24 hours when severe physical or sexual abuse is alleged. CPS workers must assess the situation within 24 hours in cases of physical abuse and within 72 hours when neglect is alleged. The CPS worker alone performs the assessment in cases of less serious physical abuse and neglect which will not result in criminal charges. Reports are classified as "substantiated," "false" or "cannot be substantiated."

When both CPS and law enforcement are involved, there is an effort to arrange the initial interview jointly, whenever possible, so that the child will not have to repeat the story.

The social worker is charged with assessing the safety of the child and the services necessary to remedy the situation during the assessment process. The CPS worker acts as primary case manager and coordinates services with other agencies, serving as the family's main contact person.

The law enforcement agency must determine if the child needs to be removed from the home immediately and if criminal charges should be filed.

When CPS workers establish that a report is substantiated, they must make critical judgments about the severity of the reported injury or neglect, the degree of danger to the child and the need for protective action, about individual and family dynamics, and about needed services and resources. Factors to be weighed include the age of the child, any previous history of abuse and neglect, the stress the family is experiencing, and available support systems such as relatives, friends and community resources.

The worker, ideally with the cooperation of the family, develops a comprehensive treatment plan. The plan generally includes regular home visits and counseling from the worker as well as assistance in receiving other services which might include help with child care, medical and financial aid, in-home services, parenting education and chemical dependency counseling. Public health nurses may also assist in providing support and education through home visits and clinics. Therapy groups for parents who have been abusive, groups for children in violent families, mental health services, homemaker services, and on-going individual, marriage, family or group counseling might also be provided by a community agency.

When specialized services are provided by other agencies the worker is expected to remain in touch to ensure that the family is getting the help it needs. CPS workers maintain contact with the family as long as the children are believed to need protection.

If the child, or children, are temporarily removed from the home, CPS coordinates services directed at correcting problems or changing circumstances to the point where the children can be returned.

Homebased (In-Home) Services
In response to recent federal and state mandates to reduce out-of-home placements for children, counties are increasing their efforts to offer home based services for families with abuse and neglect problems. Programs of in-home services are the most concentrated approach which counties use with families. Home based services are used in the most difficult cases; priority is given to those families where problems are viewed as so serious that it might be necessary to remove children from the family without the service. A paraprofessional, such as a home management or family service aide, is assigned to a family and, together with the social worker, teaches daily living skills, parent education, alternatives to physical discipline, money management and nutrition.[9]

The state guidelines requires that families should be given the opportunity to use services on a voluntary basis whenever possible. In keeping with this philosophy, some cases are closed where less serious abuse or neglect is substantiated if the families are cooperative and agree to accept referral to community agencies for treatment. In cases where families are cooperative but where they are judged to have chronic problems requiring lengthy treatment, the family is ordinarily referred to on-going protection workers to provide and coordinate the services they need.

In cases where the CPS worker judges that the child should be removed from the home for his/her protection or where the family will not cooperate, the worker notifies the county attorney's office and the case may proceed to juvenile court.

The Role of the Courts in Child Protection

Both juvenile and criminal courts may be involved in cases of child abuse and neglect. The juvenile court is involved when it is a question of monitoring or ending parental rights to protect the child; the criminal court is involved when an adult is charged with a criminal offense. In serious cases, therefore, a family may be involved in both court systems simultaneously.

Juvenile Court
Cases of child abuse and neglect are referred to the juvenile court system 1) where the danger to the health, welfare and emotional well-being of the child is so acute that it becomes necessary to involve the court; 2) where the case indicates a need for a more authoritative approach; and 3) when it is believed necessary to use the threat of removing the child from the home to encourage the parent(s) to use services, change behavior or take action to correct conditions which led to the original petition and which they are unwilling to do voluntarily.[10]

The juvenile court may act to protect a child from further injury as a result of abuse or neglect and/or to mandate services for the family in which abuse or neglect has occurred. The court also serves to provide a review of CPS decisions.[11]

Juvenile courts consider three types of petition in cases of child abuse or neglect:

Dependency proceedings involve children whose physical and emotional needs are not being met because their parents are *unable* through no fault of their own to provide the minimal standard of care. (Minn. Stat. Sec. 260.015, Subd. 6.)

Neglect proceedings address the needs of children whose physical and emotional needs are not being met because the parents are *unwilling* to provide the minimal standard of care. Cases of physical abuse or intrafamilial sexual abuse come within this definition. (Minn. Stat. Sec. 609.105, subd. 10.)

Juvenile court also deals with petitions to **terminate parental rights.** Parental rights may be terminated "voluntarily," with the agreement of the parents, (with good cause) or involuntarily. Involuntary termination of rights usually takes place after a prior adjudication of neglect or dependency and reasonable efforts to return the child to the parents have failed. (Minn. Stat. Sec. 260.221.)

In 1985 there were 2,635 dependency and neglect hearings in Hennepin County Juvenile Court, out of a total of 18,692 hearings. Each case may involve several hearings.[12]

Special Procedural Guarantees
Juvenile court hearings are designed to provide safeguards for the child and family not available in ordinary civil or criminal courts. Juvenile hearings are closed to the public. All evidence is confidential.

Parents and child are both entitled to legal representation.

Parents, either individually or together, have the right to be represented by an attorney. They may hire an attorney or, if the family income meets eligibility guidelines, a public defender or court appointed attorney will be assigned to represent them. The league survey showed that approximately 85 percent of parents who are represented by attorneys in juvenile court hearings for abuse and neglect are represented by court appointed attorneys.

Children in neglect or dependency hearings are assured of a person to represent their interests. The Minnesota Juvenile Code requires that a guardian ad litem (GAL) be appointed to "protect the interests of the minor when it appears, at any stage of the proceedings, that the minor is without a parent or guardian, or that his parent is a minor or incompetent, or that his parent or guardian is indifferent or hostile to the minor's interests, and in every proceeding alleging neglect or dependency." This may be waived when the child has counsel and "the court is satisfied that the interests of the minor are protected." (Minn. Stat. Sec. 260.155, subd. 4.)

If the parents have private counsel, a public defender may represent the child. The GAL, who may or may not be an attorney, is expected to be an independent and objective advocate whose allegiance is to the child and the court, not to the parents, the caseworker or any other party. GALs have access to all records bearing on the case, including the case file, medical, psychological and police reports and other relevant information.

There is a wide variation in the use of GALs among the 87 local courts in Minnesota which handle child protection matters. The frequency of appointment ranges from zero or "rarely" to appointment in every case that comes before the court. GALs are very frequently used in Hennepin and Ramsey Counties. According to a recent survey 49 percent of Minnesota courts appoint attorneys as GALs, 48 percent appoint non-attorneys and 3 percent appoint both. (64 percent of those courts which appoint non-attorneys pay them, 32 percent utilize volunteers and 4 percent utilize both.) Formal programs to train volunteer GALs have been developed in twelve jurisdictions to ensure that they can serve as independent advocates and effectively work for the best interests of the child.[13]

During the course of hearings in juvenile court all parties to the action are given an opportunity to present evidence and to bring witnesses to testify on their behalf.

Some experts in intrafamilial sexual abuse contend that, without the authority of the court, cooperation from the offender (i.e. admitting to the offense, halting abusive behavior or wholeheartedly participating in treatment) is unlikely.

Court Decisions
Since juvenile court is a civil court the standard for proof for dependency or neglect petitions is that the case must be proved by "clear and convincing evidence." At the close of the hearing the judge dismisses the petition if he/she decides it is not legally proven. If he/she decides it is proven, the judge may choose one of several orders to protect the children.

The court may order **protective supervision, legal custody** or **termination of parental rights.**

Protective supervision grants the local welfare agency the supervision of children placed in their own home under conditions prescribed by the court to correct the neglect or dependency. This has the practical advantage of providing the worker a "legal sanction" to be involved in the family. Such supervision may involve monitoring the home environment, perhaps through unannounced visits to check on the child's condition. Protective supervision encourages the parents to work on resolving problems and may be used as a last resort before removing the child. Protective supervision is commonly used when the CPS worker and the court are concerned for the well-being of the child, and the family is willing to participate in the treatment plan with the intervention of the court.

If the court determines that it is in the best interests of children to remove them from their homes the court may order **legal custody.** Then the child will be placed in another home deemed appropriate by the welfare department or agreed upon by the parties. Legal custody does not mean that the parents have sur-

rendered their rights; the worker must involve the parents in all major decisions regarding the child.

However, an order of legal custody places the burden on the parents to provide a safe environment for the child and to end abusive behavior before the child will be returned to their home.

Since 1984 juvenile court also has the power to order removal of the abusing adult from the home. A temporary restraining order is issued effective for a maximum of 14 days. A petition of neglect must be filed within five days following the order. Temporary visitation and support rights may be established and the abuser may be required to secure treatment or counseling services.

Although denying parents legal custody on a temporary basis is more common, the juvenile court may also **terminate parental rights** permanently. Ordinarily this is only done after extensive efforts have been made to try every other possible alternative. Planning procedures for terminating parental rights permanently attempt to expedite the decision, in the best interests of the child, when it appears that the alternative would be a long succession of out-of-home placements.

Every adjudicated case must be reviewed in juvenile court at least every six months. CPS is required to provide the court and the county attorney's office with a report describing the services delivered, the effect of the services and any change in the status of the family, whether or not the conditions leading to the original petition have been corrected and, in cases of out-of-home placement, whether or not this needs to be continued.

Special hearings are mandated on out-of-home placement.

Criminal Proceedings

Prosecution in criminal proceedings is pursued in child abuse and neglect cases when the purpose is to gain control over the offender for treatment or punishment. A criminal action supports the civil action in juvenile court and increases the options available for protecting the child. Some experts in intrafamilial sexual abuse contend that, without the authority of the court, cooperation from the offender (i.e. admitting to the offense, halting abusive behavior or wholeheartedly participating in treatment) is unlikely. Some treatment or counseling programs refuse any offender who is not participating as a result of a court order.

Moreover, many argue that if a child reports severe abuse and the offending parent or family member is not punished the child feels betrayed.

The 1985 amendment which will require some jail time for all those convicted of intrafamilial sexual abuse even if the sentence is stayed, in addition to evidence that they are participating in a treatment plan, was adopted as a response to the finding that very few men convicted of this crime in 1983 were actually sent to prison. A follow-up study by the Minnesota Sentencing Guidelines Commission showed that of the 58 men convicted, 33 (57 percent) were sent to local jails, 15 (26 percent) went to prison and ten (17 percent) did not go to jail at all. Fourteen of the sexual abusers who were not sent to prison were sent to residential treatment centers. Although the mandatory sentencing guidelines prescribed a minimum prison sentence, the statute permitted the judge to waive this "in the best interests of the family and the child."[14]

Criminal court procedures have been modified to permit more protection for child victims of abuse and neglect than for adult witnesses in ordinary proceedings. However, a higher standard of proof, "beyond a reasonable doubt," is required to convict in criminal proceedings than to prove a petition of abuse or neglect in juvenile court. Moreover, defendants in criminal proceedings enjoy the guarantees of the right to confront the witnesses against them and to a jury trial provided by the Sixth and Seventh Amendments to the United States Constitution. Unlike the juvenile court system, the criminal court system as a whole is not primarily dedicated to protecting children nor designed to take their particular problems into account. These factors play a large part in the reluctance of many prosecutors to bring some suspected child abusers to trial, particularly in cases which depend on the unsubstantiated testimony of young children for conviction.

ISSUES AND PROBLEMS

A number of problems are cited as hampering the effective working of current child protection services and procedures in Minnesota.

Inconsistency among Counties

Although state law mandates the protection of children and the provision of services to families and children who need help, wide variation exists among counties in child protection. Differences in staffing, in the availability of specialized services, and in local tax dollars for social services account for some of the variation. Differing priorities among counties on child protection services are also responsible.

League interviews and other information suggest that there is considerable variation among counties in the number of reports which they term "substantiated," in the aggressiveness of their intervention with the family and in the services they regard as essential in the treatment program. There is also a considerable difference in reporting rates from county to county.

League interviews revealed that in some counties, for instance, the CPS substantiates reports of physical abuse only if there is clear evidence of bruises and/or bleeding; other counties intervene with less serious cases.

Virtual Autonomy of Counties in Child Protection

Department of Human Services Rule 9560.0250 calls for the DHS to supervise, and county agencies to administer, protective services to children. In practice, however, Minnesota counties retain virtual autonomy in the field of child protection. DHS exercises little direct authority. Few sanctions are applied by DHS and the staff available to monitor the implementation of the rules at the local level is limited. DHS has no discretion in awarding the funds from state Community Social Services Act block grant monies or federal Title XX or Title IV-B monies to the counties.

The Department of Human Services can caution county child protection services that they are open to civil suits if they fail to comply with statutory mandates, but the county agency and the individual CPS worker are ultimately responsible for carrying out the provisions of DHS rules.

Variation in the Availability of Services

The availability of specialized services necessary to work effectively with families and children varies widely depending on the location, size and affluence of the county. Many counties have programs for child victims, but assistance for abusers and comsprehensive family sexual abuse treatment is hard to find outside large cities. Sometimes parents must drive long distances to receive treatment.

County mental health centers are frequently used for treatment referrals on a contractual basis. Nonprofit social services, such as Lutheran Social Services and Family and Children's Services, were often cited as valuable resources for individuals, families and children when they are available. But they do not exist in many rural counties. Private therapists are more often available in communities for treatment.

Parents Anonymous, a support group for parents who have abused, does not have chapters in all communities, although most professionals surveyed would like to see one established in their cities.

A number of highly regarded, specialized programs have been developed to meet specific needs, but they are often limited in the numbers they can serve and often located only in the Twin Cities metropolitan area. Programs such as the Crisis Nurseries in Minneapolis and St. Paul, which take children when parents are afraid they may abuse them or need respite; residential treatment centers for young mothers and children, child welfare workers available to work exclusively with high risk adolescent mothers and children and a comprehensive family sexual abuse treatment program, like the Family Renewal Center, located at Fairview Southdale Hospital, are few and far between.

When working in smaller communities with limited resources, CPS may be forced to establish a treatment plan for a family on the basis of what is available rather than on the services which the family really needs. The agency recognizes the limitations imposed by limited budget as well as distant services. The tendency may be to stay with what is available rather than to develop new resources or find new solutions.

Difficulties in Small Communities

In addition to the lack of a range of readily available services, child protection services in small or sparsely populated counties face other problems.

Professionals in smaller communities interviewed by league members reported certain advantages in protecting children. Staff of different agencies "get to know each other better and are more willing to and capable of sharing information freely."

Smaller communities make it more possible to supervise families closely. They reported better access to the court system and less discontinuity of services.

However, they reported more difficulties.

A number of problems arise because of the fact that families are well known in smaller communities: "It is difficult because a child can be so easily labeled. . . Anonymity is difficult, particularly for victims of sexual abuse."

In addition to problems of confidentialilty for the victim, small towns may pose problems for other actors in child protection. There is apt to be a loss of anonymity for the mandated reporter. One respondent reported that in some communities, "Everyone knows everyone else or else is related; sometimes investigators are related to those being investigated."

Some of the professionals required to deal with child maltreatment may be inexperienced or unqualified in this specialty. "Police officers are usually unaccustomed to dealing with these issues." The lower pay scale and higher caseloads of CPS workers in smaller counties make it "more difficult to get qualified people." Several counties reported that they were unable to find anyone willing to work at the available pay scale for a number of months, leaving CPS slots vacant.

The highest caseloads for CPS workers exist in the smaller counties. A survey by the attorney general's office in 1984 showed case loads of more than 100 child abuse cases in several rural counties.[1] Social workers may have CPS as only one part of their total responsibilities. Because of limited staff, CPS workers in small counties must often serve both as assessors/investigators and as ongoing case managers. Since they are the only workers in the communities involved with child maltreatment, workers are exposed to more pressure and receive less support.

Arranging training for CPS workers is also more difficult for sparsely populated counties. Courses and workshops on child abuse and neglect are available in the Twin Cities and in other large cities. In the rest of Minnesota, however, attending a program often involves considerable travel for the worker and expense for the local county agency. It also takes child protection workers away from what may be very heavy caseloads.

So we spend the time on the ones that really need help and we have to pick just a few.

Difficulties for CPS Workers

Another set of problems frequently mentioned are those which relate to the morale and efficiency of all CPS workers.

Conflicting Roles

The Department of Human Services and CPS workers themselves are concerned at the expansion of the worker's role to include serving as an investigator for the county attorney. This conflicts with the more traditional role of helper to the family. If collecting evidence is of primary concern, will the CPS worker have the time and energy to assess the level of family functioning and determine how best to help the family? If workers are viewed as investigators, at least partially responsible for bringing the family to court, can they maintain the trust of the family?

The mandated use of the "Tennessen Warning" is also criticised. CPS workers beginning an assessment must inform parents that they are not required to disclose information since it might be used against them in court. Although the warning is now only required in situations involving children over ten, the requirement is still cited as a problem. If the family elects not to speak freely, the role of the CPS worker in understanding the situation and providing appropriate services is undermined. In practice this requirement is frequently circumvented by workers and agencies.[2]

Caseload Size, Turnover and Burnout

Professionals throughout the state believe many CPS caseloads are simply too high to permit effective work with troubled families. There are no state guidelines recommending caseload size for CPS workers. However, the final report of a Task Force on Child Protective Services in 1984 recommended that a child protective services caseload "should be 15 cases or less, and in no event larger than 20 cases." CPS administrators in Hennepin County consider 17 the ideal caseload size for workers doing assessments/investigations and 19 cases the ideal for ongoing casework. They believe 25 should be the maximum caseload.[3]

Approximately half of the sixty-one Minnesota counties responding to a survey by Attorney General Humphrey in 1984 said that they needed more caseworkers. Caseloads reported in 1984 to the attorney general ranged from a low of ten or under to highs of 117 in Rice County and 119 in Marshall County. The average reported caseload was 31.[4]

All counties reporting in league interviews noted an increase in child abuse reporting since 1981, but most reported no corresponding increase in CPS staff. Hennepin County, however, has increased its CPS workers. The 1986 Hennepin County budget provides for an additional seven social workers, one supervisor and one clerk to CPS. Hennepin County has increased staff from 79 in 1980 to a proposed 161 in 1986. (These figures include clerks as well as social workers and supervisors.)[5]

The highest caseloads were reported in rural counties. In metropolitan counties, the greater volume of cases enables workers to specialize further either in intake/initial assessment or in ongoing casework with families, thus minimizing role conflict. In smaller counties social workers may take CPS cases as only part of their overall caseload.

It is extremely difficult for a worker to help a family become more functional if "the very size of the social worker's caseload only allows for investigating and surveillance or monitoring to see whether abuse or neglect continue."[6]

McLeod County's Carol Anderson reported her frustration at attempting to serve 90 substantiated cases of child abuse. She was only able to visit most families once a month or less, although they need to be visited at least once a week.

" 'So we spend the time on the ones that really need help and we have to pick just a few. . . We could prevent much of the out-of-house placements of the children if we could monitor the families.' "[7]

Large caseloads are listed as a major cause of the high turnover rates among CPS caseworkers. (Hennepin County CPS services experienced a one-third turnover rate of its workers between December 1983 and January 1985.)[8] High job stress and clients who are often resistant also contribute to high turnover. The high emotional level surrounding the whole issue of child abuse and neglect is even more important in workers leaving. CPS workers are often subjected to intense pressures from various parties; the person reporting the incident believes the CPS is not doing enough, while the alleged abusing parents accuse the worker of being intrusive. Low salaries in some smaller, rural communities were also cited as contributing to high turnover.

In Minnesota as elsewhere in the nation an increase in civil litigation against CPS agencies and concerns about liability and increasing legalism in the system have also affected worker morale.

High turnover itself is disruptive. Clients must adjust to new workers; it is difficult to achieve consistency in case plans. Staff turnover puts stress on remaining staff; they must carry extra cases. Supervisors must either leave cases uncovered, assign more cases to other workers or carry them themselves. All of these solutions lead to lower morale and effectiveness.

The junior status and inexperience of many child protection workers compounds the problem. Child protection service jobs have become an entry point in most local social service departments. Because of the pressure and stress associated with CPS responsibilities, workers often opt for other social work positions. A Hennepin County memo reported that a number of more senior workers preferred to take a demotion to transfer out of CPS to another position.[9] The high turnover and high proportion of junior workers means that more time must be spent on training new people. (In the past child protection workers were often the most senior, experienced social workers in the county social services department; now most of these individuals have transferred to other social work positions.)

This trend toward less experienced child protection workers means that social workers with the least experience and only a beginner's knowledge of effective community resources are expected to handle complex family problems and deal with children in crisis situations. The least experienced workers are assigned the most difficult cases that a county social services department may see.

Possible Solutions

What can social service agencies do to alleviate the strains on CPS workers and prevent or reduce burnout? Adequate staffing permitting manageable caseloads is important.

Clear and consistent procedures and guidelines to assist the worker in making difficult professional judgments would also help. The support of supervisors and their participation in the decision-making process is crucial.

Arranging for consultation (informal as well as structured) with fellow social workers, supervisors and members of a multidisciplinary team may help spread the burden of making difficult decisions and relieve some of the job pressure leading to CPS burnout. Ongoing opportunities for training and education are also important.

The 1985 amendment to Minnesota Statute Section 626.559 establishes a new job classification for CPS and requires that all child protection workers or social services staff with responsibilities for child protection

must receive 15 hours of continuing education or in-service training each year. The Department of Human Services has developed training programs and is making them available on a regional basis.

Such training should help workers develop new skills in case management and counseling, assist in identifying community resources, provide new ideas and also provide mutual support as well as updates on current laws and regulations.

The county attorney alone decides whether or not to bring a case to court.

Interagency Frustration

Still another problem reported in interviews is difficulties CPS workers encounter when they attempt to work with representatives of other agencies. Differences in goals and outlook may produce friction and misunderstanding among those who need to cooperate closely in the best interests of the child and family.

Multidisciplinary teams attempt to produce shared outlooks and cooperation among different agencies.

The DHS and professionals in league interviews cite numerous advantages of multidisciplinary teams: 1) enhancing communication between agencies; 2) providing more consistent and effective approaches to clients; 3) promoting coordination and more effective services to families; 4) providing focus on child maltreatment as a community problem and providing community education; 5) helping agencies develop policies and procedures; and 6) serving as a source of professional support and helping to prevent burnout.[10]

Most respondents agreed that the teams offer a valuable opportunity for improving members' knowledge and skills through education. Providing more complete and accurate information leads to more effective treatment plans and may prevent individual value judgments from inappropriately influencing decisions.

However, some CPS workers listed disadvantages to multidisciplinary teams: 1) it is difficult to assemble the team for crisis cases; 2) the CPS agency becomes accountable to professionals outside their system and may "lose control;" and 3) team meetings are time consuming.[11]

In addition to joint meetings, clear guidelines for procedures which delineate roles for different agencies are necessary. In the Scott County cases the absence of a clear understanding of agency responsibilities and appropriate roles appears to have been part of the problem.

Various schemes for interdisciplinary training are underway or in the planning stages.

The 1985 legislative changes require the Commissioners of Human Services and Public Safety to develop a multidisciplinary educational program for training child abuse professionals in appropriate techniques for assessment and investigation. Courses coordinated by the Bureau of Criminal Apprehension and the DHS have been scheduled. CPS workers and law enforcement workers who work together are encouraged to attend together. The current course curriculum emphasizes sexual abuse investigation.

A series of regional interdisciplinary programs is being developed by the Governor's Inter-Agency Task Force in Criminal Justice. To be funded by a $988,000 justice assistance grant from the federal government and local funds, this program will attempt to have entire multidisciplinary teams from counties attend regional sessions together on a regular basis. Aimed at preventing children and families from "falling through the cracks" because of lack of knowledge or skill on the part of professionals, the training will aim for uniformity and consistency in investigation, assessment, prosecution and treatment of child sexual abuse. The State Planning Agency is coordinating this effort.[12]

A particular source of frustration for CPS workers is the great power exercised by the county attorney. League interviews reported a number of instances where CPS workers believed court intervention was necessary to convince families to follow through on treatment plans or to remove children from dangerous situations, but the county attorney believed there was insufficient evidence to bring the case to court.

Although the CPS worker may have opportunities to discuss the case with the county attorney alone or in a multidisciplinary team, the county attorney alone decides whether or not to bring a case to court.

Gaps in Reporting

The 1975 expansion of the reporting law, increased in-service training for mandated reporters and more prevention and awareness programs in the schools have all contributed to a significant increase in reports of child maltreatment. However, many instances of abuse and neglect still go unreported.

Despite the fact that physicians were the first group to be named as mandated reporters of child abuse, there is agreement that they under-report incidents of abuse and neglect. The American Medical Association published guidelines for physicians dealing with child abuse for the first time in August, 1985. The guidelines alert doctors to the symptoms of physical abuse and say doctors should look for signs of neglect and sexual and emotional abuse. The guidelines also encourage doctors to remind parents that doctors are mandated to report abuse and urge doctors to become involved with community agencies trying to cope with the problem.[13]

In Minnesota very few reported cases of abuse or neglect originate with private physicians. In Hennepin County only 2.6 percent, in Ramsey County only 1.5 percent of reported cases were reported by private physicians.[14]

Responses to a recent survey by the Hennepin County Medical Foundation of 110 physicians attending two continuing medical education courses included the following reasons for physician resistance to reporting:

> (1) the risk of alienating and stigmatizing the family; (2) the belief that the physician can provide the needed services without a report; (3) the lack of trust and confidence in local officials and agencies; (4) uncertainty about how to proceed; (5) the incompatibility of the publicly-imposed police function with the physician's role as a professional; (6) the personal and legal risks to which physicians expose themselves by complying.[15]

Another study of 58 practising physicians revealed that one major reason for not reporting was the fear that physicians would lose patients. This study found "a greater willingness of young physicians to report cases which suggests that knowledge and attitudes may have been positively affected by the incorporation of child abuse training into medical schools and residency programs."[16]

The University of Minnesota Medical School now includes curriculum dealing with abuse and neglect and the Minnesota Medical Association offers continuing education courses for physicians which focus on the problems of identifying and dealing with child abuse and neglect.

Mandated reporters may attend workshops as part of in-service training or attend community presentations. Dr. Robert ten Bensel, professor at the University of Minnesota School of Public Health and expert in child abuse and neglect, believes all mandated reporters should attend an annual workshop training which would include a review of the law, the responsibilities of the reporter and the film "Cipher in the Snow."[17]

One of the main reasons cited to the Governor's Interagency Task Force for failure of mandated reporters to report was "peer group pressure." This was mentioned particularly with respect to teachers and workers in day care centers and youth centers. "Others are reluctant to report because of a lack of knowledge about how cases are to be handled and a lack of confidence in the social welfare or law enforcement systems to adequately deal with the problem."[18]

The frustration expressed by mandated reporters in the past at the lack of feedback from the CPS agency may be remedied by the 1985 requirement for reports of action taken to mandated and voluntary reporters upon request.

The 1985 legislative changes attempted to lessen the liabilities for mandated reporting and clarify the incidents to be reported. Reporters participating in good faith in making a report are immune from any civil or criminal liability.

Very few mandated reporters in Minnesota have been prosecuted for failing to report in the years since the requirement was first introduced.

"Neighbors are also reluctant to report suspicions."[19] In a survey by the Minnesota Poll in February 1985, only 55 percent of Minnesotans responding said they would report "someone they knew well" if a child told them he or she was being abused; 35 percent would first confront the person. In cases where a stranger was involved, however, 85 percent of those responding said they would call the police. (This was despite the fact that the respondents ranked sexual child abuse as a very serious crime, below murder, but well above armed robbery, and as serious as rape or kidnapping.)[20]

Liability

As the Scott County cases demonstrate, the increasingly litigious nature of American society carries over into the field of child abuse. Parents will sue if they perceive excesses or abuses by the system.

Lawsuits are being brought increasingly against CPS workers, as individuals and as agents of the county, and against psychologists, psychiatrists and other professionals as well. Mandated reporters express concern that they will be sued even if they eventually win the case. Insurance premiums for CPS workers and other professionals in the field of child abuse have risen. Because of national as well as state trends, liability insurance for all service providers has greatly increased. Minnesota's largest source for such insurance in the past, the St. Paul Companies, has stopped writing policies for some categories of service providers. Psychologists and other professionals who are unable to obtain insurance through ordinary means may now buy insurance from private insurers through a program set up by the Minnesota Department of Commerce.

Accusations against CPS workers "range from inadequately protecting a child and violating parental rights, to not providing adequate foster care services and leaving children in foster care 'limbo.'" A worker's failure to act may lead to a child's serious injury or death. On the other hand, intervening when a child is not actually in danger is damaging to both child and parents. Workers report they feel liable if they take action and liable if they don't.[21]

This fear of liability may lead to defensive social work. There is greater pressure to take no chances and to intervene whenever criticism might arise from not doing so.[22] In a league interview one worker reported closing a case which the county attorney was unwilling to bring to court to reduce her legal liability, even though she believed the family had serious problems.

Fear of liability contributes to lower CPS worker morale. It also reinforces the importance of supportive supervision and the need for clear and consistent policies and practices in family intervention and treatment.

Racial Insensitivity and Class Bias

National centers concerned with child protection services have expressed concern that CPS workers may misperceive the problems of poor and minority families. The 1978 National Conference on Child Abuse and Neglect focused on multicultural issues within the context of child protective services. Research studies have found problems with the "differences in caseworker's perception" in cases involving children from different ethnic and income groups.[23]

Most CPS workers are white and middle class. Families involved in child maltreatment, however, tend to be disproportionately poor and minority. Workers need to be knowledgeable about cultural and ethnic differences in minority communities rather than to attempt to impose their values on client families or to assume that families that are not just like an ideal American family (white and middle class) should be shoved in that direction.

The manual for CPS workers, *Child Protective Service Practice Guide,* emphasizes the need for sensitivity. Workers need to consider different family styles, the "role of the older person in the family, the source of ultimate authority, mobility of family, male/female issues and what the child rearing practices are." There is a need to accept cultural differences, but this does not mean that practices harmful to children should be condoned.[24]

Suggestions to help overcome insensitivity on the part of workers include in-service training to increase cultural awareness; recruiting and training minority social workers; support and development of minority resources and cooperation between the public agency and minority resources.

Hennepin and Ramsey Counties have tried to recruit social workers from ethnically diverse backgrounds. An effort is made to provide paraprofessionals to families whom they will feel comfortable with, often representatives of minority groups. Programs organized and staffed by minorities can often address specialized needs and relate more easily to those parents and children. Survival Skills Institute, which provides services including classes in parenting and groups to build self esteem to black teenage mothers, and Red Star Mothers, a program for Indian women, are examples.

Indians

Since the 1970s attention has focused on the large proportion of Indian children in Minnesota who have been placed outside their homes. In 1972 two out of every eleven Indian children under 21 in Minnesota was either in a foster or adoptive home. "In 1975, 98 percent of the adopting mothers were white."[25]

Between December 1972 and October 1981 "an Indian child was still eight times more apt to be placed outside the home than the state's other children."[26]

Procedures established under the 1978 Indian Child Welfare Act and the 1985 Minnesota Indian Family Preservation Act have increased the involvement of the Indian family, relatives and the tribe to ensure that the child is kept in his/her home if at all possible, and, if that is not possible, that efforts are made to place the child with an Indian family.

Even before 1985, the federal legislation had kept many children in the Indian community. Social work agencies are not more sensitized to Indian culture and there is an Indian guardian ad litem program. From 1977 to 1981 the average number of Indian children adopted was 51, "less than one-third of the peak of 151 adopted in 1972 (4 percent of all adoptions)."[27]

Reservations now have their own foster care standards, license and supervise homes and recruit and work with Indian families willing to adopt Indian children and provide foster care.

There are no exact figures on the costs of Indian child welfare cases. In 1981 twenty-four counties reported expenditures of $2.5 million for foster care. This accounted for 5.6 percent of total state expenditures for foster care but was only a portion of the full cost.[28]

Possible Class Bias

Child maltreatment is not limited to one particular group of families, but exists in all socio-economic levels of society, although there is a very strong correlation between neglect and poverty.

However, according to *Trends in Child Abuse and Neglect, A National Perspective,* by the American Humane Association, there is under-reporting of child abuse in affluent families.[29] A number of reasons for this under-reporting were given in league interviews:

There is less probability that the family will already be "in the system," receiving financial assistance or social services because of low income, unemployment, etc. and therefore in contact with a public agency. Middle class families are more apt to use private medical resources rather than public clinics or nursing services for children's care.

And when middle class families are reported, the system may intervene less effectively. Dr. ten Bensel, for instance, commented that social workers are more skilled at dealing with poorer and disadvantaged families than middle class families.[30] And, as one county attorney suggested in a league interview, it is often tougher to gain the cooperation of middle class families in participating in treatment.

If abuse is reported in middle class families, the families are often able to make a strong case for voluntary treatment plans, which their insurance will pay for, and thus to avoid extensive involvement with the courts. They may also be able to avoid the system with an articulate defense; they have the ability to hire private attorneys at the outset. In addition, they may be able to exert political problems on the CPS worker or county attorney. This may present particular problems in a small community when a middle class family is accused of abusing a child, because of the lack of anonymity.

The *Child Protective Services Practice Guide* devotes a section to "Assessing V.I.P. families." It suggests that it may be feasible to have another county provide the assessment because of confidentiality and possible conflict of interest.[31]

REFORMS AND FUNDAMENTAL QUESTIONS

In addition to criticisms of existing procedures which might be remedied by better funding, training or minor modifications of existing practices, several more fundamental reforms have been suggested to improve Minnesota's approach to child protection. In addition, serious philosophical concerns with the flaws in existing practices have been raised.

Negative Effects on the Child

Charges have been leveled at the system because of the injurious effects the whole process may have on children who have been abused or neglected. Children may be traumatized even in cases where their reports of maltreatment are believed and the system intervenes to protect their rights.

The child's situation may become worse in cases where the requirements of the system prevent effective intervention. If children report abuse to an adult professional and are not believed, if they report and are believed but the county attorney decides the evidence is not strong enough to bring the case to trial or hearing, or if intervention is attempted with the family but is inadequate or ineffective, children may be in a more unhealthy and embittered environment than they were before the maltreatment was reported.

In some instances where the system supposedly "works" the remedy may be almost as injurious to the child as the abusing environment. Children may be placed in foster homes for long periods of time and may have no assurance of any stable future. To quote one commentator, "Sometimes, the only resources available are hurtful. In many localities, children

reported as victims of neglect or abuse are placed in foster home care as the first, rather than the last resort. There, ironically and tragically, they may languish for years, often shuttled around from foster home to foster home, and their health and emotional needs are often cruelly neglected by the very system designated to serve them.''[1]

Despite the effects of permanency planning legislation, many children in Minnesota are still placed outside their homes.

> Perhaps the most influential factor for children is the reactions of those to whom they report the incident, whether they be doctors, police, attorneys, or parents. If those people are supportive and act as though they believe the child, if they offer a sense of security and reassure the child that he or she is not to blame, the child may stand a better chance of recovery. But children who are abused by a family member are in a ''no win'' situation. If they tell no one, the abuse is likely to continue. On the other hand, if they do tell someone, they are likely to be disbelieved. Once their cases reach the attention of authorities, these child victims are often pressured in ways that adversely affect the quality of their testimony. They may be blamed for having put Daddy in jail and forcing the family to go on welfare. Clearly, the pressure on these children to recant or change their stories is quite intense. Children who withstand the pressure and stick with the story face the continuing hostility of their families throughout, and perhaps beyond, the adjudication process.[2]

Children in Court

A particular set of problems surrounds the appearance of children in court situations, particularly in criminal proceedings. The issue of the reliability of the testimony of young children, particularly since trials involving sexual abuse often hinge on the unsupported testimony of children, and the possible trauma to young victims who must testify against their parents are both widely debated. The conflict between securing the constitutional rights of the accused adult on the one hand and protecting the emotional health of the alleged child victim on the other presents serious difficulties. The court system has long been characterized by the attempt to ensure due process to the accused; there is less experience in attempting to secure justice while at the same time protecting the child who serves as a witness for the prosecution.

The hearings on the 1985 Minnesota bill to amend judicial procedure and afford more protection to children occasioned nearly twelve hours of debate in the House-Senate Conference Committee. Senator Ember Reichgott reported: ''The legislature had to strike that delicate balance between protection of innocent victims of child abuse and protection of innocent parents who might be falsely charged and their children removed from the home. Testimony from law enforcement officials sharply conflicted with testimony by members of parents' rights groups.''[3]

The ''Summary Report on Criminal Justice Aspects of Child Sexual Abuse'' published by the Governor's Interagency Task Force on Criminal Justice Policy, November, 1984, reported widespread concern over the issue of children in court:

> Over and over again the Task Force heard about the difficulty of dealing with child witnesses. Speakers raised the concern about cross-examining children and the extreme difficulty of working with small children. Although the use of video tapes is now admissible, the right of confrontation becomes another problem. Statutes and case law are not clear on the use of expert witnesses and the admissibility of out-of-court testimony. These factors become even more complex in child sexual abuse cases. Again, the issue is how to balance a defendant's right to confrontation and cross-examination of a child victim or witness against the need to protect the child from emotional stress in the effort to elicit and verify the truth of statements or accusations.[4]

Juvenile court procedure offers considerable flexibility in an effort to protect the child while still hearing testimony; there is also a less rigorous standard of proof, than in criminal court. Children can be questioned in private by the judge or questioned by the judge with the attorneys present or questioned by attorneys. In Hennepin County, a one-way mirror is being used in some juvenile court proceedings so that parents can watch the testimony of the child but the child is not compelled to face the parent.

Although the child is now assured the support of a friendly person in criminal court, the defendant still has the right to be present while the child gives testimony for the prosecution and retains the right to cross-examination. Having to describe events of severe physical or sexual abuse while the abusing parent is in the courtroom may be very traumatic for the child. In addition, the greater formality of a criminal courtroom and the presence of a jury may be intimidating.

The need for a less threatening way for the child to testify in criminal proceedings was cited in a number of interviews. Anne Hyland, assistant Ramsey County attorney, asked ''Can we change the rules in criminal court so that the judge can question the child himself or remove the perpetrator, similar to the practice in juvenile court?''[5]

A survey of professionals who work with child victims in four jurisdictions across the country reported certain common fears expressed by children in the criminal court system. The fear most frequently mentioned was ''facing the defendant. That experience is frightening for most adults, but to a child who does not understand the reason for confrontation, the anticipation and experience of being in close proximity to the defendant can be overwhelming. This fear was mentioned by virtually all respondents, including police, social workers, advocates, therapists, doctors, and judges.''[6]

The survey found that children were also ''overwhelmed by certain physical attributes of the courtroom. Many interview respondents mentioned that the large size of the witness chair can be very intimidating to a child. As one therapist described the child's sense of helplessness, 'She can't even run away because her feet don't touch the ground.' ''[7]

Having to repeat their story so many times was also reported as ''difficult and confusing'' to the child. ''Endless continuances'' are also a problem since they prolong the process.[8]

Other frightening or disturbing characteristics reported include: ''cross-examination, the audience, being removed from home, the judge, retaliation or retribution by the defendant, general fear of the unknown, and the jury.'' One child reported being afraid that the judge would hit her with his gavel, which she thought was a hammer.[9]

Because of the constitutional guarantees to confront one's accuser and to a jury trial in criminal proceedings, however, there is considerable question as to how far the criminal code could be modified to protect child witnesses and still provide guarantees to the defendant. The 1985 legislation did not greatly change criminal court procedures as they affect children.

Until recent years Minnesota law stated that only children ten years or older were competent witnesses. Now, however, the testimony of younger children is admissible in most cases of alleged abuse and neglect. The judge may still exercise discretion in determining the trustworthiness and reliability of the child through a preliminary examination. Even though such testimony is admissible, however, an effective defense attorney may be able to discredit a child's testimony. In fact, because of the difficulty in establishing the credibility of young children as witnesses, some county attorneys do not attempt to prosecute abusers of very young children even when they believe the abusers are guilty.

The difficulty is to reconcile, in abuse cases, the defendant's right to test the child's testimony through cross-examination and society's right to prosecute alleged offenders effectively with the best available evidence and the child's right to be free from unnecessary trauma and other adverse effects arising from a witness role. While many would agree that children, simply because they are children, would benefit from modifications in courtroom atmosphere, such changes might have the effect of weakening the defendant's case. Providing a small child-sized chair for the child witness, for instance, may have the effect of emphasizing the greater strength and size of the adult defendant and the helplessness and vulnerability of the child.[10]

The difficulties surrounding children as witnesses are compounded by the inexperience of many attorneys and judges in dealing with children, a factor which is particularly serious in the sensitive area of child abuse. In smaller counties, juvenile court hearings are ordinarily only one responsibility of regular district judges and county attorneys. In larger counties the volume of cases permits more specialization by judges as well as county attorneys and public defenders.

Hennepin County District Judge Allen Oleisky, one of two judges who handles only juvenile cases, points to the particular need for judges to be trained in how children think and act as well as the practical skills of how to question and reassure them.

Alternatives to Court Intervention

There is an ongoing debate about the appropriateness of existing criminal measures against child abuse. Critics contend that the current court involvement in intrafamilial matters, particularly in the criminal court system, often does not serve to help the family in trouble. Although the relatively small number of intrafamilial sexual abuse cases are those most often mentioned in the court system, physical abuse and neglect are also frequently involved in the juvenile courts.

In Minnesota there has been a trend toward criminalizing family problems traditionally dealt with

by social services. The mandatory jail time now required for all persons convicted of intrafamilial family abuse is a clear indication of this tendency.

The increasingly adversarial nature of juvenile court proceedings is also cited as a factor which may lead the actors to lose sight of the goal of looking out for the best interest of the children involved, according to James Christiansen, program supervisor of CPS for Hennepin County.[11]

Opponents of the increasing involvement of child maltreatment with the courts have varying points of view.

One group of critics contend that the unreliability of child witnesses means that criminal court proceedings are often inappropriate in cases of child maltreatment.

Victims of Child Abuse Laws (VOCAL), was organized by 35 parents "personally affected by the Child Abuse Laws in Minnesota" in October 1984 to work for changes in the current legislative structure addressing child maltreatment in Minnesota. Composed partly of parents accused of abuse in Scott County, VOCAL focuses on alleged abuses of parents in the current reporting system, on the ability of the court to order out-of-home placement and on the dangers in believing the unsupported testimony of child witnesses. VOCAL successfully lobbied for some changes to protect the rights of parents in the 1985 session.

Other critics stress the fact that the possibility of criminal action and the involvement of law enforcement in cases of child maltreatment is simply not necessary or appropriate for the majority of cases.

An editorial in the *National Child Protective Services Newsletter* strongly criticises this tendency because of its harmful effect on many families:

> This preoccupation with legalism is out of tune with important realities and reflects a regressive trend to earlier days when CPS began as a campaign against parents. The fact is that most child neglect and abuse does not require emergency law enforcement intervention, does not require placement, does not require court action. What *is* needed is a helping, non-punitive intervention which protects children by assisting parents to resolve the problems which underlie abuse and neglect.[12]
>
> Experience has documented that child maltreatment is rarely a willful, deliberate act on the part of the parents. Most often it results from failure, inadequacy and inability to care for children. Each report must be assessed to determine the potential for change and to evaluate the risk to the child.[13]

The emphasis on the legalistic approach compromises the "emphasis and philosophy of help to families at the point of intervention," according to the editorial.[14]

Still another important group cites the need to find alternatives to the present criminal sentencing of most intrafamilial sexual abusers even when they are guilty of serious acts.

In Minnesota the debate centers currently on proposals for "creative leniency" which would allow a person who has allegedly sexually abused his or her child to be diverted from the criminal justice system in an effort to "treat" the problem. Responses to End Abuse of Children, Inc., a nonprofit organization originally funded by the Hennepin County Medical Foundation, is actively exploring alternatives to criminalization.[15]

One plan, suggested by Minnesota Assistant Attorney General Norman Coleman, would allow a parent who has sexually abused his or her child to be diverted from criminal prosecution by confessing and agreeing to treatment if such diversion was in the child's best interest. The choice of diversion would still be the county attorney's and a review board would assess the suitability of treatment programs and decide if treatment was in the family's best interest. At the successful completion of treatment, the defender would plead guilty to a nonfelony charge. This plan would be similar to programs established in Des Moines, Iowa, and Huntsville, Alabama.[16]

A second suggestion, offered by Paul Gerber of the Minnesota Bureau of Criminal Apprehension, would have the offender confess and be charged. However, abusers who submitted to treatment and long term probation would have prior assurance of no jail time.[17]

A third proposal from Anoka County Attorney Robert Johnson calls for team meetings among various professionals before the county attorney decides whether to file a charge.[18]

Supporters of these changes contend that while abuse and neglect are grave acts, the main consideration shosuld be the well-being of the child and the family. Moreover, they point out, many significant instances of child abuse are not currently taken to criminal court because of the difficulty of proving the case in criminal proceedings. The present system is not effectively intervening. And, they contend, the trauma involved in having abused children participate in criminal investigations or hearings may simply compound the damage they have already sustained. Criminal proceedings may also create even greater rifts within families rather than help them create a more healthy environment. They would work for a system in which only the small percentage of brutal abusers would serve prison sentences.[19]

Supporters of diversion from criminal proceedings stress that reporters would be more willing to report abuse and abusers would be more willing to ask for treatment if they knew that the family would not be drawn into the court system.

Opponents to these changes believe that abusers should not be immune from criminal charges. Hennepin County Attorney Tom Johnson is quoted as saying "the message will be that child abuse is 'something-less-than-a-real-crime.' Child abuse, he said, 'should be treated as a criminal act.'"[20]

The Governor's Task Force reported "almost complete consensus" among those it interviewed "that for child sex offenders both treatment and incarceration options are essential." They recommended maintaining "a Statutory Structure Which Includes Treatment and Incarceration as Sentencing Components."[21]

To quote another explanation of the rationale for criminal penalties:

> Psychologists and social workers involved with victims of sexual abuse are vocal advocates for charging and convicting the offender of a crime. By making an act illegal society tells the offender that his conduct is unacceptable and that he must bear the responsibility for his actions. This in turn tells the victim that it was not the victim's fault that the sexual abuse occurred. Punishing the offender may also help him to get rid of the guilt often felt as a result of a crime against a family member.[22]
>
> As mentioned earlier, many psychologists have found that child abuse offenders only continue treatment when they are under court order.

Prevention

Another set of suggestions for reform in present child protection services seeks a much more ambitious and comprehensive program for the prevention of child abuse.

While many of the circumstances and risks which produce child abuse and neglect in families are well known, generally the system only goes into effect after abuse takes place. To quote one CPS supervisor, "I feel that the emphasis on child protection has to be prevention—while we need to protect that child that is being victimized we need to support policies that will ultimately strengthen the family and contribute to the quality of life for our children.[23]

A strong emphasis on prevention would demand a much greater public commitment to teaching parenting skills, in the broadest sense, to children in schools as well as to young parents. Anne Harris Cohn, executive director of the National Committee for Prevention of Child Abuse, listed ten goals to a comprehensive approach to prevention when testifying to the House Select Committee on Children, Youth and Families on March 12, 1984:

> "1. Increase future parents' knowledge of child development and the demands of parenting
>
> 2. Enhance parent-child bonding, emotional ties, and communication
>
> 3. Increase parents' skills in coping with the stresses of infant and child care
>
> 4. Increase parents' skills in coping with the stresses of caring for children with special needs
>
> 5. Increase parents' knowledge about home and child management
>
> 6. Reduce the burden of child care
>
> 7. Reduce family isolation and increase peer support
>
> 8. Increase access to social and health services, particularly crisis or emergency services, for all family members
>
> 9. Reduce the long term consequences of poor parenting and break the cycle of abuse
>
> 10. Increase children's abilities to protect themselves from abuse."[24]

She recommended a number of specific programs including support programs for new parents, education for parents, and early, regular child and family screening and treatment.[25]

Funding early intervention services for high risk families is of particular importance. Teaching families how to link up with and use community resources and offering them support is important. More Crisis Nurseries which can take children at risk at very short notice are also important.

At present programs targeted at pregnant teenagers and teenage mothers offer early intervention for very high risk groups. The Pregnant Adolescent Continuing Education (PACE) program and Mothers and Infant Continuing Education (MICE) programs in the Minneapolis Public Schools and the St. Paul Central Day Care Center offer support, teach skills in parent-

ing through modeling as well as formal classes and provide good nutrition and care for vulnerable babies. The day care component offers young mothers the opportunity to complete high school, which will in turn help to reduce pressures, raise self-confidence and provide a better environment for the children concerned. Such programs are very few, however, and are only available to a small proportion of eligible families.[26]

In addition to parenting programs, various specific programs focus on teaching children how to respond to threats of abuse and how to report concerns. The Illusion Theatre offers plays on sexual abuse, especially written for children and adolescents. Social workers and police officers report that these presentations are extremely effective in educating and in encouraging disclosure of abuse. Touch education helps children, by use of discussion, educational aids and role play, to better distinguish abusive from benign physical contact. Permission is given to children to say "no" to adults and to ask for help from a dependable source. However, school districts in outstate Minnesota cannot all afford the $1,200 plus food, lodging and transportation to schedule the programs for children in their district.[27]

A more specialized program has been developed by Parents Advocacy Coalition for Educational Rights (PACER Center, Inc.), an organization dedicated to advocating for children with disabilities. PACER's "Count Me In" puppets teach children about the physical and sexual abuse of handicapped children. The program is directed at handicapped children where there is a reporting policy in place and a designated reporter to whom children can go with reports of abuse.[28]

CURRENT SPECIFIC PROPOSALS

Several proposals for new legislation or amendments to existing statutes have been proposed for the 1986 Minnesota Legislative session.

Children's Trust Fund

One proposal would establish a children's trust fund to support programs aimed at preventing the abuse or neglect of children. Voluntary contributions, mostly generated from refunds on the state income tax form, would provide an estimated $400,000 annually. Programs to be funded might include "programs for new parents, such as courses on basic parenting and stress management, family support services, including crisis care hotlines, nutrition counseling and programs for children with special needs."[1]

Local child abuse prevention councils would recommend applicants for the funds. Grants would be made to both public or private nonprofit agencies; applicants would be required to match the money awarded in grants through local funds or in-kind contributions. The fund would be administered by the state planning director.[2]

More than thirty states have similar trust funds now. The Governor's Council on Families and Children, now the Minnesota Council on Children, Youth and Families, also supports this concept.[3]

Although there is considerable support for the concept of a trust fund, the mechanism of a checkoff on the state income tax form is not so widely supported.

Testimony on Closed Circuit TV

Another proposal would amend the criminal code to permit children testifying in child abuse/neglect trials to testify on closed circuit television. The defendants would be allowed to observe the testimony and some sort of cross-examination would be permitted.

This has been urged by Senator Ember Reichgott and is proposed by the Attorney General's office.

Revision of the Minnesota Juvenile Code

An extensive revision of the Minnesota Juvenile Code is being considered in the 1986 legislative session. Although since substantially amended, the revision was originally developed by a special task force appointed in accordance with a directive from legislative committees to review problems relating to juvenile and child welfare legislation in Minnesota. Generally speaking, the revised code would establish more precise definitions and categories drafted in an effort to enhance due process and guarantee rights to children in the juvenile justice system. Some of the more controversial provisions address procedures in delinquency and in commitment for chemical dependency and mental illness.

Certain provisions, however, would affect child victims of abuse and neglect. Instead of submitting a neglect or a dependency petition to the court, the new procedures call for establishing that a child falls within one of 15 categories defining Children in Need of Protection and Services (CHIPS). The court could establish jurisdiction and intervene without a finding of fault on the part of the parent.

The new code requires more stringent procedures for out-of-home placement and mandates which placements are preferable. A finding that in-home placement would be inappropriate must precede any out-of-home placement for CHIPs children. If an out-of-home placement is made, the court must give preference to "the home of a relative," first, then to "a foster family home," then to a "foster family group home" and last, to a group home. (Revisor, XX86-3573, Sec. 70/260a/ subd. 1, (f).)

The current juvenile code lists no standards for juvenile court determination of when, whether or where placement of a child outside the home should occur for abused, neglected or dependent children.

The new juvenile code proposal has bipartisan support in the legislature. However, the Minnesota Association of County Attorneys and the peace officers raise a number of objections. They contend that the new definitions might limit the ability of the juvenile court to intervene to protect children. They question whether the court would be permitted to intervene effectively to bring abut a change in the conditions leading to maltreatment, whether the proposed definition of "children alleged to be in need of protection or services" that can be ordered by the court is too limiting, whether the ability of the law enforcement officer to remove a child from a threatening situation is reduced, whether the broadened definition of "relative" in whose home the child may be placed is so broad it would hamper the court, and whether the definition of "necessary care" is adequate to protect the child threatened by physical harm.[4]

Other Developments

1. The Attorney General's office has asked the Hubert H. Humphrey Institute of Public Affairs to study the effect of current methods of handling child abuse cases. There is very little information on the long-term impact on families and victims who have gone through the system. They also wish to determine how many cases are not prosecuted and why.

2. Attorney General Humphrey has formed a 20 person task force to focus "on the goals of intervention in intrafamilial sexual abuse cases." The task force has been charged to address the issue of child abuse "in an objective and thoughtful fashion—with sufficient time allowed for public reaction and future legislative consideration." The group will aim to complete its study by August 1986.[5]

APPENDIX

Notes

Introduction

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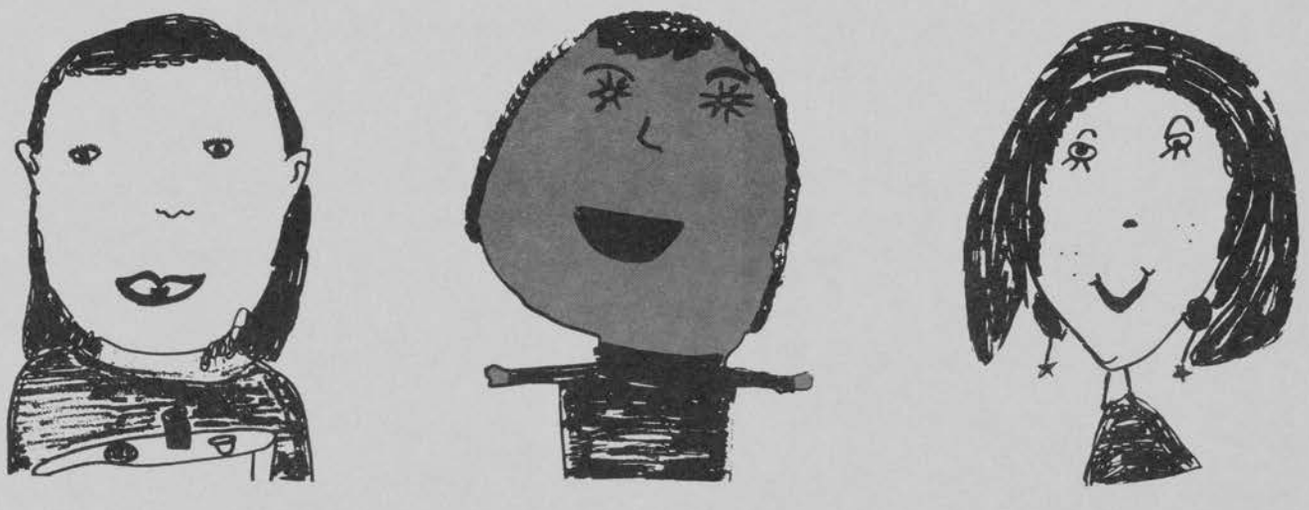
[1987]

Health Care for Minnesota's Children:

Investing in the Future

League of Women Voters of Minnesota



Child Health Plan Goals
Minnesota Chapter, American Academy of Pediatrics

Goal I:
All children should be wanted and born well to healthy mothers

Goal II:
All children should receive adequate and appropriate preventive health care which includes the prevention of death and disease and the promotion of physical, intellectual, social, and emotional health

Goal III:
All adolescents and youth should live in a societal setting that recognizes their special health, personal, and social needs

Goal IV:
All children with chronic handicaps should be able to function at their optimal level

Goal V:
All children should live in an environment that is as free as possible from hazards to their health and development

Goal VI:
All children should be educated about health and health care systems

—The Minnesota Child Health Plan, 1984

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HEALTH CARE FOR MINNESOTA'S CHILDREN: INVESTING IN THE FUTURE

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League of Women Voters of Alexandria
League of Women Voters of Bloomington
League of Women Voters of Brooklyn Park/Maple Grove/Osseo
League of Women Voters of Crystal/New Hope
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League of Women Voters of Fridley
League of Women Voters of Grand Rapids Area
League of Women Voters of Mid-Mesabi
League of Women Voters of Minneapolis
League of Women Voters of Minnetonka/Eden Prairie/Hopkins
League of Women Voters of Moorhead
League of Women Voters of New Ulm
League of Women Voters of Northfield
League of Women Voters of Owatonna
League of Women Voters of Red Wing
League of Women Voters of Robbinsdale
League of Women Voters of Rochester
League of Women Voters of St. Louis Park
League of Women Voters of Wayzata/Plymouth Area
League of Women Voters of Winona
League of Women Voters of Worthington

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CONTENTS

PREFACE

Members of the League of Women Voters of Minnesota voted at their 1985 convention to study children's issues. This study is the second in a series of three reports. The first, *Protecting Minnesota's Children: Public Issues,* was published in the spring of 1986. The third, on child care in Minnesota, will appear in early 1987.

Since its founding, more than 65 years ago, the League of Women Voters at the national, state and local levels has studied and lobbied on issues relating to children and to social welfare.

This report is based on interviews with more than 70 professionals and advocates concerned with child health services. Twenty-one local Leagues of Women Voters interviewed experts in their areas. We also benefit from a number of recent studies of health care in Minnesota. We relied particularly heavily on *The Right Start* by the Children's Defense Fund--Minnesota Project.[1].

Because of limitations of space and time, we must reluctantly exclude the important issues of adolescent health, chemical abuse and dependency and adolescent pregnancy, nor will we address the issues of mental health and out of home placement. Because of the crucial importance of prenatal care to child health, however, attention will be given to care available to pregnant women. The primary focus of this report is on low income and high needs children for whom public policy decisions are crucial.

INTRODUCTION

At first glance, concern for the health of children in Minnesota appears surprising. Minnesota, with the Mayo Clinic and the University of Minnesota Hospitals, ranks high among states in the level of sophisticated medical care. Minnesota's citizens are among the healthiest in the nation. Our life expectancy is second among the 50 states.

And, if we compare the health of Minnesota's children today with those of the early 20th century it is clear that we have made enormous strides. The development of vaccines against major infectious diseases, the spread of sanitation and the use of major miracle drugs have greatly increased the life expectancy of all children.

If health care for many Minnesota children is excellent, however, there is increasing concern about the adequacy of the health care delivery system to low income children. Of particular concern is the fact that deaths among black and Indian babies remain significantly greater than among white infants. Although Minnesota is a leader in high technology medicine for children—in liver transplants and in excellent neonatal intensive care—many low income women do not receive adequate preventive prenatal care. Professionals report unhealthy children who are not receiving regular well child care. The American medical system is geared toward acute care.

"The cost of giving one child all recommended child health preventive services from birth to age 20 is approximately equal to the cost of one day in the hospital. Unfortunately, too often children's health needs are addressed only when they are acutely ill."

—Dr. G. Scott Giebink
Chairman, Minnesota Chapter,
American Academy of Pediatrics,
***Minnesota Pediatrician,* Fall, 1986.**

Nationally, advocates for the health needs of children, particularly low income children, have not enjoyed the same strength as lobbyists for the elderly. The United States has never developed and funded a comprehensive preventive medical care system for mothers and children. Public health programs serving children have been inconsistent, fragmented and underfunded. In many cases, services for children have been included in or tacked onto other programs, without consideration to their unique needs.

Number of Poor Children Rises

In 1983 14 million American children lived in poverty; this was 22 percent of all children, the highest level in the past twenty years.[1] According to one study, the number of poor children tripled between 1979 and 1984. More families with children are headed by single parents, usually women, and such families are much more likely to be poor.[2]

The continuing effects of the recession of the mid-1980s, the poor economy on the Iron Range and the ongoing farm crisis all contribute to poverty in Minnesota. In 1979 more than 10 percent of Minnesota children lived in families with incomes below the federal poverty level.[3]

In 1984 in Minnesota one of every five Minnesota school children in 40 counties qualified for free school lunches because their families had low incomes."[4]

Programs for Low Income Families Weaken

As the number of poor children increases, programs supporting their quality of life have been cut or are increasing less rapidly than inflation. Federal budget cuts since the passage of the Omnibus Budget Reconciliation Act of 1981 (OBRA) have reduced services to poor women and children. Many families, especially the working poor, have been cut from the Aid to Families with Dependent Children (AFDC) program. The actual value of AFDC benefits has declined as costs have increased. Reductions in public and subsidized housing programs and the consequent rise in housing costs for many low income families cut into budgets that are already strained.

Particularly serious is the evidence of inadequate nutrition among low income families. The federal Food Stamp program now pays only 49 cents for each person per meal. Minnesota food shelves and congregate eating programs report increasing regular use by families with children, although both were intended as temporary measures primarily not for families with children. In July 1985 twenty percent of families with children who used food shelves reported their children had skipped meals in the last month because there was not enough money to buy food.[5] Professionals report anemia and other conditions suggesting inadequate nutrition among low income children.

The Health Care Environment Changes

As the poverty of children increases, and as the overall service system for low income families weakens, health care has become less available.

The number of low income families with children who lack health insurance or who are underinsured is growing. At the same time, economic pressures make it harder for health care providers to give uncompensated or charity care. The public system of health care for low income women and children has been reduced by inadequate funding in recent years. Although Congress has attempted to create some safeguards for maternal and child health, efforts have been inconsistent and poorly coordinated.

The more competitive medical environment, the continuing rise of medical costs and constraints on public funds lead to a growing concern that medical care for poor children may be reduced further.

* * *

There are good reasons to work for improvement in the delivery of health care to pregnant women and children even in an era of fiscal restraint.

First of all, a society is judged by how it treats its most vulnerable citizens. There is widespread agreement in developed countries that all children deserve basic services ensuring a good start in life.

Second, the funding of better preventive services would substantially reduce later costs, resulting in an overall gain for taxpayers. Not all savings would be felt directly in the health system. Welfare costs and education costs would also be reduced by less need for expensive later intervention.

Thirdly, children are important resources for the future which must be carefully protected.

* * *

This report will 1) discuss health care problems for low income women and children, 2) review medical insurance coverage for low income women and children, 3) describe major public programs affecting children's health and 4) present some of the current proposals for improving the maternal and child health system.

In keeping with League of Women Voters practice, this report will describe problems and programs and list proposed solutions. Recommendations for specific legislation, however, will only be arrived at after discussion and agreement by League members.

HEALTH PROBLEMS

Infant Mortality and Low Birthweight Babies

"Women who are poor, who are black or native American, who have no health insurance, who live in inner-cities or heavily rural areas—these women are much more likely to lose their children in the first year of life, simply because they don't have access to the proper health care or to the information telling them how to get it. In a nation that prides itself on equity and compassion, that is a crime."

—Senator Dave Durenberger
October 31, 1985

Infant Mortality

The infant mortality rate in the United States has declined dramatically in the last 80 years: from 124 infant deaths per 1,000 live births in 1910 to 10.6 deaths per 1,000 live births in 1984. However, the rate of infant deaths is lower in 16 other countries. Moreover, the overall rate of infant deaths in the United States masks a serious discrepancy between the health of white babies and those of many minorities.[1] In 1986 Congress created a Commission to Prevent Infant Mortality. The commission is charged with recommending needed changes in federal laws and programs in one year.

Infant deaths have declined more in other countries than in the United States. In 1950-54 the U.S. had the 7th lowest rate of infant deaths; and in 1982, the 17th.[2] In 1984 Minnesota had the fifth lowest infant death rate among the states.

Moreover, the decline in the American infant death

rate slowed markedly in 1984.[3] The Minnesota infant mortality rate actually rose in 1983 to 9.8.[4] In late 1984 an official of the U.S. Public Health Service acknowledged that the national goal established in 1979 of nine deaths per 1,000 live births would not be reached by 1990.[5]

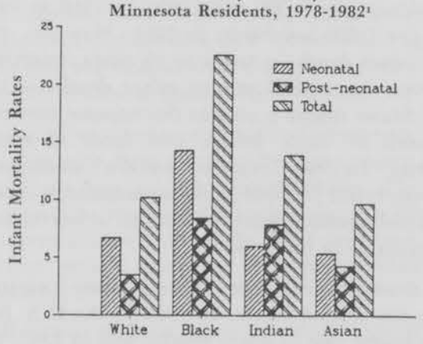
The main factor in reducing American infant deaths in recent years has not been an improvement in preventive care producing more healthy babies, but more effective treatment of the approximately six percent of American babies who are at high risk of death in new special high technology neonatal units.[6]

More Minority Infants Die

The infant death rate for white American babies is higher than those of similar socio-economic status in many developed countries, but the rate of infant deaths for several American minorities is almost twice that for white babies.[7] In Minnesota in 1983 the overall infant death rate approached 9.0 per 1,000 live births, but the infant death rate for black infants was 22.7 and for Indian infants 14.0.[8] It is unlikely that the U.S. Public Health goal set in 1979 to reduce the infant mortality rate to 12 or less per 1,000 for any racial or ethnic group by 1990 will be reached.[9]

As the following table from a recent Minnesota Department of Health report shows, black and Indian infants in Minnesota were more likely to die than white and Asian babies in the years 1978 through 1982. However, the patterns were different. A majority of Indian infant deaths occurred in the postneonatal period, between the first month and the first birthday, while most white, black and Asian infant deaths occurred in the neonatal period, during the first 28 days of life.[10]

Infant Mortality Rates by Race
Minnesota Residents, 1978-1982[1]



[1]Each rate is calculated using as the denominator total births by race which occurred during the surveillance period.

Source: Minnesota Department of Health, *Minority Populations in Minnesota,* p.30.

The discrepancy between infant deaths by race was also great in Minneapolis in the 1979-82 period. Infant deaths were 9.9 per thousand live births for white babies, 21.0 per thousand live births for black babies, 23.1 per thousand live births for American Indians and 13.6 for "other" who were almost all Asians.[11]

However, poverty offers a better explanation of high infant mortality than race. In Minneapolis 23 out of every 1,000 babies die before their first birthday in the poorer census tracts, but fewer than 9 out of every 1,000 infants die in the most affluent census tracts. The infant mortality rate for whites living in very poor census tracts was 14.3 per 1,000 live births, compared to 8.7 for whites living in wealthier areas. Blacks living in the poorest parts of the city had an infant death rate of 30.0 compared to only 11.4 among blacks living in the prosperous areas of Minneapolis.[12]

Indian babies whose mothers lived in the poorest neighborhoods in Minneapolis had an "astonishingly high death rate of 34.7 per thousand live births, almost three times as high as the rate among Indians living elsewhere in the city."[13]

Low Birthweight Babies

While infant mortality is a traditional measure, a more fruitful way to look at newborn problems is to examine the proportion of babies who are low birthweight (LBW), 2500 grams (5.5 pounds) and under at birth. Nationally the proportion of low birthweight infants declined from 7.6 percent in 1971 to 6.5 percent in 1983. In Minnesota, the proportion of LBW infants dropped from 6.0 to 5.0 percent.[14] However, twelve other countries, led by Sweden with 4 percent, report lower rates of LBW babies than the United States.[15]

Low birthweight babies are almost 40 times more likely to die in the first 28 days (the neonatal period) than normal-weight infants. During the postneonatal infant period, from the first month to the first birthday, low-birthweight infants are five times as likely to die.[16]

If they survive, LBW babies are at risk for a number of health problems including mental retardation, birth defects, blindness, autism, neurodevelopmental handicaps and respiratory tract conditions. Low birthweight babies are more likely to be rehospitalized during the first year than normal birthweight infants.[17]

Services to LBW babies are very expensive. "In 1984, cost of medical care for LBW babies provided through the state's Medical Assistance program alone was more than $6 million; the cost of care for all LBW infants in Minnesota was close to $60 million."[18]

More Black Babies Have Low Birthweights

The low birthweight rate among black infants is twice the rate among whites. In Minnesota, this ratio is growing. In 1979, 10.5 percent of black and 4.9 percent of white newborns were LBW; in 1983, 12.4 percent of black and 4.9 percent of white newborns were LBW.[19] Health Department data for 1978-1982 show that Indian babies compare favorably with white babies on a weight basis.[20]

The incidence of very low birth weight (1500 grams) is low for all racial groups in Minnesota but the rate is much higher for blacks. "One in 111 white births, one in 40 black births, and one in 100 Indian and Asian births results in an infant weighing under 1500 grams."[21]

As with infant mortality, however, LBW also correlates with poverty. In Ramsey County, more than twice as many LBW black babies were born to mothers in St. Paul, where one-fourth of the women were poor, than in suburban Ramsey County where only 4.2 percent of black women were poor.[22]

The disturbing reality in Minnesota is that not all groups share equally in the benefits of our health and social service system. "White and middle-class children in Minnesota are among the healthiest in the United States. . . while the poor and the minorities in Minnesota struggle to receive basic services and achieve a level of health that our society as a whole achieved over 20 years ago."

—Edward Ehlinger, M.D.
"A Strategy to Meet the Health Needs of Low Income Children."

Risk Factors for Poor Infant Health Can Be Reduced

The major risk factors associated with infant mortality and low birthweight have been known or suspected at least since 1912; most of them are factors associated with poverty.[23] The risk of low birth weight increases among all black mothers and among mothers who give birth when they are younger than 16 or older than 35. It is higher for women with poor prenatal care or none, whose diet is inadequate and who gain less than 20 pounds during pregnancy. Smoking, abuse of drugs and excessive consumption of alcohol are factors; so are stress, frequent childbearing and previous miscarriages. Babies whose mothers are unmarried are also at greater risk for survival, although the reasons are not altogether clear.[24]

Postneonatal deaths, after the first month and before the first birthday, are high among populations with low socioeconomic status, poor sanitation, unsafe housing and limited water supply. The rate is also high in households where the mother has had little education. The sudden-infant-death syndrome (the abrupt death of an apparently healthy baby) is the largest single cause of postneonatal infant mortality. Recent reports identify a particulary high rate of sudden infant death in households headed by unmarried mothers.[25]

Early and consistent prenatal care has been found to reduce the likelihood of infant death or low birthweight even in women with other risk factors. Although some commentators have tried to explain the United States infant mortality rate on the basis of the diversity of our population and/or inherent birth problems with black babies, there is strong evidence that inadequate preventive medical care to overcome conditions of poverty is largely to blame.[26]

Only 4.5 percent of women nationally, and 3.3 percent in Minnesota, obtain only late or no prenatal care. But a substantial number delay care until after the first trimester. In Minnesota in 1982, 71 percent of all pregnant women began prenatal care in the first trimester. But only 47 percent of black teenage mothers between the ages of 15 and 19 began in the first three months; 58 percent of white teenage mothers began early care.[27] Minority women were much more likely to be part of the small percentage of Minnesota mothers who waited until the seventh month or later for prenatal care in 1978-1982. "One in seven Indian and Asian mothers initiate care in the seventh month or later, as contrasted with one in thirteen Black mothers and one in 34 White mothers."[28]

Babies who are wanted are more likely to be born healthy. The American Academy of Pediatrics, Minnesota Chapter, stressed this in *The Minnesota Child Health Plan* in 1984: "Providing subsidized, effective family planning services to low income women should be a high priority objective for obtaining the goal of wanted, healthy children."[29]

Family planning services have been particularly useful for poor women and teenagers. In 1979 enrollment in publicly financed family planning programs prevented an estimated 417,000 unintended teenage pregnancies nationally.[30]

One study of the impact of all public health programs started between 1964 and 1977 reported that the increase in legal abortions and the use of organized family planning services by low income women was the most important factor in reducing neonatal mortality. Since then most states have stopped funding abortions. Family planning funding has been sharply reduced.[31]

Strong Programs Can Improve Infant Health

The 1985 Institute of Medicine Report, *Preventing Low Birthweight,* urges "a broad, national commitment to ensuring that all pregnant women in the United States, especially those at medical or socioeconomic risk, receive high quality prenatal care."[32]

Recent Minnesota Coalition on Health recommendations stress that greater investment in public prenatal care will prevent very high costs after unhealthy babies are born. "The estimated cost savings range from $2 to $11 in medical care costs for every dollar spent on prevention during pregnancy."[33]

"Nothing is as tragic as the unnecessary death or illness of a baby. To guard the lives and health of our infants, we can treat their diseases and handicaps after birth or we can prevent these conditions from occuring before birth. We have become extremely successful at treating ill newborns. We have been less successful in our efforts to assure babies are born healthy."

—Minnesota Coalition on Health, *Investing in Healthy Babies: Preventing Premature and Low Birthweight,* 1986

Governments in other countries which place a high priority on the birth of healthy babies by providing prenatal services have dramatically decreased infant deaths. Strong health policies adopted by Sri Lanka, a low income nation, greatly reduced infant deaths. Sri Lanka tries to provide basic services—education, nutritional supplements, family planning and prenatal care—to all. The programs are not elaborate or sophisticated, but they are available to everyone.[34]

The Scandinavian countries, the Netherlands, the United Kingdom and other developed countries with extensive welfare and health-benefit systems, have achieved even greater success. France has recently reduced its infant death rate by offering cash payments to pregnant women when they participate in prenatal care featuring early identification of risks and stress reduction.[35]

Some experts attribute the recent slowing of the reduction in U.S. infant mortality rates to the 1981 cutbacks in health and nutrition programs for poor women. Data for the 1981-82 recession show a decline in the participation of pregnant women in prenatal care in those states hardest hit by the recession, consistent with the loss of Medicaid and insurance benefits and with the curtailment of support for public clinics. There were also reports of less prenatal care in areas with large minority populations.[36]

The infant death rate in the United States showed the sharpest decline in the 1970s which saw the great expansion and creation of social-support programs and an increase in the number of American women receiving early prenatal care. Dramatic advances were made in medical technology for the care and improved survival of infants born at extremely low weight. Infant health rates in several states improved in the late 1970s when social services expanded even in states severely affected by the 1974-75 recession.[37]

Special Programs May Be Necessary For Low Income Women

According to the Institute of Medicine study pregnant women who need more prenatal care but who are unable or unwilling to use the private care system "may be better served by public facilities offering a range of services than by physicians in private practice, who traditionally provide only medical care. The poor and the very young, as well as those not yet part of the mainstream culture, such as recent immigrants, may benefit especially from the outreach activities, social work, and nutritional counseling often provided in such settings." They stressed the importance of a "personal, caring environment in which to offer services" to low income women and children.[38]

Such public programs can help ensure that the non-financial barriers to receiving health care are overcome. Transportation, child care, culturally sensitive professionals are all important. Accommodation to clients who cannot read is crucial in some cases.[39] Providing consistent outreach and followup may be essential in reaching low income patients, particularly for preventive care.[40]

"From a public health standpoint, people need to receive health care; it is not enough merely for health care to be 'available'."[41]

Poor Health Among Low Income Children

Many professionals working with poor children report conditions suggesting poor health and nutrition. Other indications show that some conditions which could be remedied become chronic in poor children because of inadequate medical attention.

Anemia (iron deficiency) is a condition related to poverty and malnutrition. Complete data is not available for all Minnesota children. However, data from screening for eligibility for the Special Supplemental Food Program for Women, Infants and Children (WIC) shows anemia in both low income women and children. In 1985 more than one in ten of the 47,400 low income women and children screened for the WIC program had some level of anemia. Among the 6,263 Ramsey County children screened, the incidence was 8.2 percent; among the 9,284 screened in Hennepin County the incidence was 9.3 percent. The incidence of anemia among low income pregnant and nursing women screened in Ramsey County was 21.9 percent.[42]

Lead poisoning, although less of a problem in Minnesota than in other urban areas, is heavily concentrated among the poor. Data from the Minneapolis Health Department show that almost all cases of elevated blood lead were concentrated in the same low income census tracts in the inner city since 1983.[43]

There is also concern about the effects of fetal alcohol syndrome, a condition of infants born to alcoholic mothers, in Minnesota children. It is reported as a particular problem in the Indian community. The syndrome can result in delayed walking and talking, learning disabilities and mental retardation.[44]

Acute otitis media, chronic middle-ear infections, among children is a major problem among Indian children in Minnesota. A screening of children at Andersen Elementary School in Minneapolis found that nearly half of Indian children showed evidence of chronic ear infections. Among similar, low income, non-Indian students, the incidence was only 20 percent.[45] Ear infections are now thought to lead to language lags, which may directly affect school performance.[46]

There are indications nationally that poverty correlates with accidents to children. Certainly the statistics of deaths among Minnesota minority children seem to bear this out.

After infancy the number of deaths of children in all racial groups is very small; most deaths are due to injury, but Indian and black children in Minnesota are much more than likely to die than white children.

Black and Indian children aged 1-4 were three times as likely to die as white children in 1978-1982. Homicide accounted for 17.2 percent (4 cases) among black children and for 30.2 percent, (5 cases) of all deaths of Indian children, and only 0.8 percent of all white deaths. Indian children aged 5-14 had a rate of death almost double that of white children, mainly due to injuries.[47]

MEDICAL INSURANCE FOR LOW INCOME WOMEN AND CHILDREN

Medicaid

Medicaid, also known as Medical Assistance (MA) or Title XIX of the Social Security Act, was created in 1965 to provide poor people financial access to the private medical system and do away with the two-tier medical system of private care for those who could afford it and charity care for the poor. MA is funded by federal, state and county funds. In Minnesota federal funds pay for 53 percent of all Medicaid costs. The remaining 47 percent is paid by the state, 42 percent, and the counties, 5 percent.

98,584 Minnesota children in families receiving AFDC and 10,850 other children were covered by Medicaid in 1981; in 1986 the figures had increased to 107,839 and 23,329. (There were 1,172,000 children under 18 in Minnesota.) In Minnesota, total Medicaid expenses for all services amounted to $1,020,449,602 in 1986, as compared to $321,575,493 in 1976.

Most Medicaid expenses, however, result from costs for nursing home care for elderly recipients in the Supplemental Security Income (SSI) program, serving aged, blind and disabled people, not from expenses for women and children. According to the most recent *Medicaid State Report* of the American Academy of Pediatrics, in 1984 Medicaid recipients in Minnesota under 21 constituted 50.5 percent of all recipients, but were responsible for only 14.5 percent of payments to vendors.[1]

Changes in Medical Assistance

In 1981 the Omnibus Budget Reconciliation Act (OBRA) reduced the federal Medicaid match to states for a three-year period, and eliminated nearly half a million families and 700,000 children from Medicaid coverage by modifying provisions of the AFDC "work incentive program."[2] An estimated 13,500 households lost Medicaid coverage in Minnesota following OBRA.[3]

However, since the 1981 reductions, Congress has broadened Medicaid coverage to include several categories of non-AFDC women and children who meet income eligibility levels, particularly pregnant women and newborn babies. As of January 1987, pregnancy and postpartum benefits will be extended for 60 days after delivery to all women who received Medicaid while they were pregnant.

In 1985 the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) allowed states to provide pregnant women with additional services through Medicaid even if these benefits are not made available to other Medicaid recipients.[4]

In the Sixth Omnibus Budget Reconciliation Act of 1986 (SOBRA), Congress authorized states to expand Medicaid eligibility for pregnancy related services and

to preschool children to 100 percent of the poverty line, considerably above the income levels for AFDC. For the first year children up to age one may be covered; another year of age up to age five may be covered each successive year.[5]

Because the Medicaid program has become increasingly expensive, Congress has gradually modified the traditional "fee for service" Medicaid model. By December 1985, 7,471 of Medicaid enrollees in Minnesota were enrolled in HMOs.[6]

Eligibility for Medicaid

"Even a small increase in family income or a few more hours of work which will yield enough additional income to finance needed medical care, can cost a family its entire Medicaid coverage. . . eligibility levels are so low in Minnesota that a single woman cannot work full-time at a minimum wage job and still qualify for Medicaid coverage for prenatal care. She must wait until her medical bills are large (usually after delivering the baby) before she can qualify for partial coverage as a medically needy beneficiary. And since it is very difficult to obtain medical care on credit, this means that she becomes eligible only after an emergency has occurred and the damage has been done."

—Luanne Nyberg, Monica Herrera and Dana Hughes
The Right Start

All states must provide MA coverage to everyone receiving cash benefits from the AFDC and the SSI programs. Minnesota has also extended coverage to many children and women who meet the income eligibility requirements for Medicaid, roughly 70 percent of the poverty level, but are not receiving AFDC. Children in Minnesota are covered up to the age of 21, rather than the mandatory 18. The Minnesota Legislature has elected to provide almost all optional Medicaid services. In 1985 the legislature increased coverage for families who lose AFDC benefits because the woman joins the work force from 9 to 12 months.

Medicaid also covers "medically needy" families whose medical expenses bring their income down to the Medicaid eligibility level. Families must first incur a certain amount of medical expenses and then spend down their income to the Medicaid eligibility level.*

*One exception to family income limits is the very small number of medically fragile children who would ordinarily require full-time hospitalization. These children are covered by Medicaid without consideration of parents' incomes even if they are maintained at home under the new waiver program (Community Alternatives for Children).

If Minnesota has extended coverage to families not receiving AFDC, however, it has failed to extend coverage to families whose incomes are up to the optional 133⅓ percent of AFDC eligibility levels permitted by federal regulation. Thirteen other states provide Medical Assistance to families with higher incomes than Minnesota.[7] In 1983, only 39 percent of Minnesota children with family incomes below the federal poverty level had Medical Assistance coverage.[8]

As the following table shows, only families whose incomes are less than 78 percent of the poverty line currently qualify for Medicaid health insurance in Minnesota.

1986 Federal Poverty and Minnesota Medical Assistance Eligibility Standards

(A) Family Size	(B) Federal Poverty Income Guidelines	(C) Medicaid Eligibility Standards	(D) (C) as a Percentage of (B)
1	$ 5,360	$4,200	78%
2	7,240	5,244	72%
3	9,120	6,384	70%
4	11,000	7,452	68%
5	12,880	8,364	65%

Note: Federal Poverty Guidelines are gross income. Medical Assistance levels are net, following allowable deductions.

Source: Minnesota Department of Human Services

The poverty line is established annually by the Department of Agriculture on the basis of the cost for a "thrifty/economy food plan" for a certain number of people. This figure is multiplied by three, on the premise that a family spends one-third of its income on food.[9]

There is substantial agreement that poverty extends to families with incomes up to 200 percent of the official poverty level.[10]

Problems with Medicaid Coverage

There are some difficulties with Medicaid coverage for women and children.

First, Medicaid is primarily a mechanism for reimbursement. Generally speaking, MA has not created delivery systems tailored to the needs of specific groups.

A second difficulty is the lack of coverage of special devices and equipment necessary for disabled children. Medicaid does not ordinarily cover equipment such as electric or modern light wheelchairs or modern communication devices. These items are frequently very expensive, but, advocates argue, crucial for quality medical care for this high needs group.[11]

Another problem with Medical Assistance is the relatively low level of reimbursement to physicians and hospitals. Legislators often argue that physicians' incomes are high enough to absorb some costs and that hospitals should become more efficient; physicians and hospitals contend that they should not be expected to deliver care at less than cost and subsidize what should be a public obligation. Part of the argument hinges on what hospital costs can be legitimately charged to Medicaid patients. Federal regulations restrict cost categories contending that Medicaid should not underwrite profits for providers; providers maintain that most ongoing costs should be charged against Medicaid, just as they would be against private insurers.

If physicians refuse Medicais patients, however, or if hospitals or physicians give MA recipients less complete care than other patients, society will effectively ration care to the poor. This is a particular worry when very expensive, high technology medicine is keeping more fragile children alive.

Payments to Physicians

Medicaid reimburses physicians for Medicaid patients at 50 percent of all "usual and customary charges" for specific procedures. Rates are not readjusted annually. Since November 1985 rates have been based on physicians' fees in 1982. An estimate places the Medicaid payment level to physicians for prenatal and obstetrical care at approximately 69-75 percent of Blue Cross and Blue Shield reimbursement.[12]

The American Academy of Pediatrics interviewed more than 814 pediatricians in 13 states (not including Minnesota) about Medicaid in 1978 and in 1983. The vast majority of pediatricians continue to treat Medicaid patients. However, in 9 states "one-third to one-half of participating doctors now limit their Medicaid patient load in some way, for instance by taking only emergency cases, newborns, or referrals."[13]

Refusal of Medicaid patients by physicians was viewed as less of a problem in Minnesota than nationally in the 1984 *Minnesota Child Health Plan.*[14] Although instances of some physicians limiting their Medicaid Practice have been reported, this does not appear to be a major trend in Minnesota, at least where women and children are concerned.

There is particular concern that obstetricians may be unwilling to treat Medicaid patients in the future. Medicaid participation of obstetricians has declined in other states. The combination of increasingly high malpractice insurance rates, inadequate reimbursement and the fact that many Medicaid covered pregnant women fall into high risk categories may combine to produce increasing refusals.[15]

Payments to Hospitals

Medicaid reimbursement for pediatric hospital costs is an issue in Minnesota. In August, 1985, Minnesota adopted a payment system for Medicaid patients based on 36 diagnostic groups (similar to the 474 Medicare Diagnostic Related Groups [DRGs].) Hospitals are paid a specific sum depending on the diagnostic category, not the actual costs for a specific patient. Under the system Medicaid payment for infants in neonatal intensive care units amounts to approximately $830 per day although hospitals contend that costs reach $1400. Hospitals may appeal in the case of very expensive cases, which are called "outliers," but this is a cumbersome process and relief is not always available. The legislature did provide, however, that payments for "outliers" in the neonate category would be proportionately higher than for other diagnostic groups.

The shortfall in Medicaid reimbursement for the three major Twin Cities children's hospitals, Gillette Children's Hospital, Minneapolis Children's Medical Center and St. Paul Children's Hospital, where Medicaid patients constitute from 20 to 25 percent of all patients, exceeded $2,000,000. At Gillette, which specializes in children with disabilities, patients whose expenses are largely paid by Services to Children with Handicaps (SCH) (discussed below), which uses the MA payment scale, constitute an additional 15 to 20 percent of all patients.

Following legislation in 1986, the Department of Human Services (DHS) and the Minnesota Hospital Association have hired a consultant to analyze pediatric reimbursement as a part of the entire Medicaid reimbursement picture and make policy recommendations. The possibility of adopting the special CDRGs for pediatric care developed by the National Association of Children's Hospitals and Related Institutions (NACHRI) will be reviewed.[16]

Lack of Adequate Insurance Coverage

Many low income women and children have no insurance coverage, either public or private, for medical expenses. Many children are underinsured for medical care.

It is estimated that the number of Americans who lacked health insurance increased 40 percent between 1977 to 1983.[17] An article in the American Academy of Pediatrics, *Child Health Financing Report,* for Spring

1986, estimates that as many as 20-25 percent of American children under 18 are uninsured for all or part of the year.[18]

More than 100,000 Minnesota children are uninsured; one-fourth of them are under six years of age.[19] Nearly one in five women between the ages of 18 and 24 have no medical or hospital coverage.[20]

In 1983, 43 percent of charity patients and 33 percent of "self-pay" patients (those with no health insurance) at Twin Cities hospitals, were admitted for services related to pregnancy, childbirth or newborn care.[21]

Two-thirds of uninsured children live in families with incomes below 200 percent of the poverty line. 38.0 percent of children below the poverty line are uninsured, and 27.3 percent of children between 100 and 200 percent of poverty have no insurance coverage.[22]

"My number one concern is with the families who are just above the medical assistance level. Because of the lack of money they don't take their children to the doctor unless it's almost an emergency and not for preventive care. Either you have to be very poor or have a good income (or good insurance) to receive adequate medical care."

—Jean Currier, Staff Nurse for Community Health Services, Maternal Child Health Coordinator, Goodhue County

Many Jobs Provide Inadequate Insurance

Forty-two percent of Minnesota's uninsured residents are jobless, but almost half of uninsured Minnesotans hold jobs for at least part of the year. Farmers are at great risk of being uninsured.[23] Increasingly people in part-time and minimum wage jobs receive no effective health insurance coverage through their employers. "Women are especially affected by this practice. A 1985 study of the working poor found that the occupations in which women tend to be concentrated have much lower rates of job-related insurance than those employing the working poor as a whole. Only 22 percent of persons employed in sales and only 24 percent of persons employed in the service sector were insured, compared to 40 percent of the working poor as a whole."[24]

Medical Care Too Costly for Most Uninsured

Health care is too expensive for most uninsured families on an out-of-pocket basis. Health care for a healthy baby may cost $400 a year and complete maternity care (prenatal plus hospital care) can amount to $4,000.[25]

"Ready access to medical care is especially important for poor children, since poverty itself has an adverse impact on their health status. Poor children are more likely to die before their first birthday and are more likely to suffer from one or more disabilities. They are twice as likely to be hospitalized and 20 times more likely to attend school irregularly because of ill health. Moreover, because of poverty and deprivation, poor children who are ill tend to be sicker for longer periods than non-poor children."

—Luanne Nyberg, Monica Herrera and Dana Hughes, ***The Right Start***

Nor can poor families afford to buy an individual health insurance policy if the employer offers no coverage or if the employer's family coverage plan is costly. "A woman earning the minimum wage, working full time, and supporting two children in 1985 would have had gross earnings of $6,432 for the year. . .An average health insurance family plan purchased privately would have cost her about $1,200. One year's enrollment in a health maintenance organization would have cost her about $2,000."[26]

Uninsured Use Health Services Less

A number of studies document the fact that families without health insurance often go without preventive health care. A 1985 Minnesota study found: "Insured children under the age of six make almost twice as many ambulatory visits as uninsured children during the year—4.98 visits to 2.77. The ratio is only slightly less among school-age children.[27]

Testimony at hearings held by the Children's Defense Fund--Minnesota Project indicates that a number of Minnesota children are going without preventive care:

- In northwestern Minnesota, untreated dental problems for some children have required hospitalization. One little boy had to wait three months to be admitted to the hospital because the family had no way to pay until the father was laid off in the fall and became eligible for Medicaid.[28]
- Five-year-olds coming in for school entry immunizations in rural Minnesota have not seen a doctor since they were six months old.[29]
- School nurses see kindergartners with permanent hearing problems because the family could not afford doctors' visits to treat ear infections."

Many children throughout the state coming for the Early Childhood Screening offered to all children by the public schools have not been regularly seen for well child care. 46 percent of the two-thirds of the approximately 2,500 prekindergarteners in St. Paul had not had a medical checkup in the last year. Officials predicted that the percentage might be even worse among the remaining one-third whose parents did not bring them to the screening. [31]

"The group I am concerned about is the working poor. I think this group is slipping through the cracks; there is not enough income, no health insurance, too much pride in some cases to seek public help. They just go without."

—Dr. Scott Jensen, Legislative Chair, American Academy of Family Physicians Minnesota Chapter

Free and Reduced Health Care

Low income women and children without insurance must rely on a patchwork of "charity care" services. It may be difficult to find providers who give free or reduced care; patients may have to visit several providers to meet all their needs.[32]

Some care is available on a sliding scale basis. Arrangements may be made for partial payment by a public agency, like Services for Children with Handicaps (see below). Providers may agree to extended payments, or perhaps to waive the fee entirely. They may also refuse to serve the patient, however, particularly if it is not an emergency.

Families in greater Minnesota may find it particularly difficult to obtain care. Transportation can present serious problems and pediatric resources are heavily concentrated in urban areas. Most of the more than twenty community clinics in Minnesota, which provide subsidized primary health care, are in the Twin Cities metropolitan area.

Uncompensated care is much more likely to be requested and offered when the situation is acute rather than on a preventive basis, especially from private providers. Low income families with very high medical expenses may eventually "spend down" and receive Medical Assistance. However, it may be difficult to arrange for relatively inexpensive preventive care. The greater willingness to grant free care in cases of acute problems is compounded by the stigma which many people associate with asking for charity.

Currently competitive forces in the health care industry make it harder for hospitals and physicians to offer free or reduced care. Insurers, government agencies and employers all demand that hospitals cut unnecessary costs, including charity care. Public hospitals and clinics, with a special mission to serve the poor, find it more difficult to compete for the business of HMOs.

The public teaching hospitals, subsidized by tax dollars, are major providers of care to low income people without insurance. St. Paul Ramsey Hospital and Hennepin County Medical Center receive county monies to care for low income patients. The legislature funds "University Papers" which, together with county funds, enable counties to send "poor people" to the University Hospitals and Clinics.

Public health clinics provided under the Community Health Services system as part of the Maternal and Child Health program (see below) are a particularly appropriate health care source for women and children; these offer preventive care at reduced cost at the county level.

The three private children's hospitals in the Twin Cities, Minneapolis Children's Medical Center, Gillette Children's Hospital and St. Paul Children's, provide a higher proportion of charity care than many private hospitals. All three have an "open door" policy for patients.

Shriners Hospital in Minneapolis, supported entirely by private dollars from the Shrine of North America, provides free care to a number of disabled children from a seven-state region.

One factor contributing to the relative scarcity of services available to the uninsured is the reluctance of large donors to support direct medical care. Although private donations help underwrite indigent care at private hospitals, it appears that foundations, corporate giving and the United Way in Minnesota do not generally support ongoing medical services. They "fund medical research, but not medical care, family planning but not prenatal care and delivery."[33]

Programs for Indian People

Indian mothers and children on reservations are eligible for free services from the Indian Health Service (IHS) of the United States Public Health Service. Federal monies are supplemented by Medicaid and other insurance reimbursement when possible.[34]

IHS clinics on the seven Indian reservations in Minnesota include family planning, prenatal and well child care. IHS administered hospitals on the Red lake and Leech Lake reservations offer general medicine, low-risk obstetrics and pediatric services. More extensive services are contracted from other health care providers.

A particular strength of IHS clinics is the Community Health Representatives who help to make medical treatment more acceptable and understandable to the community.

Some counties also offer special services to Indians on reservations, including staffing clinics and providing homemakers, through Community Health Ser-

vices. Hennepin County allocated $150,000 of county funds for calendar 1982 for Indian programs and provides an Indian advocate at Hennepin County Medical Center.

The extensive services available to Indian people on reservations do not follow Indians to urban areas.

The state helps fund urban health programs through the Special Native American Block Grant but the funds are too limited to serve all urban Indians. In 1982, $150,000 was divided among the St. Paul Urban Indian Health Center; the American Indian Fellowship Association, Duluth; and the Family Practice Clinic at Fairview Deaconnesss Hospital, the Community University Health Care Center, and the Indian Health Board in Minneapolis.

Indian Health Board clinics in Minneapolis serve more than 6,300 individuals annually, 55 percent are below the poverty level and only 4 percent are covered by private insurance.

Migrant Program

In 1986, 2,500 women and 3,000 children under 17 from migrant worker families used services provided by Migrant Health Services, Incorporated, located in Moorhead. This private non-profit agency provides health services to migrants in Minnesota and North Dakota from an overall budget of $800,000. Ten community based programs are offered during the two months when most migrants are in Minnesota. Interpreters are available at all clinics for the Latino workers. Funding is provided by federal allocations (80 percent) and from state health funds (20 percent). A voucher system is used for referrals to physicians.[45]

PUBLIC PROGRAMS

Maternal and Child Health Funds

The federal Maternal and Child Health Services Block Grant has been a major source for funding preventive health care for low income women and children in Minnesota. MCH funds have the potential for creating a comprehensive system of preventive health services, but they are inadequate to meet the needs of low income mothers and children in Minnesota.[1]

Federal MCH funding has remained virtually unchanged since 1981, despite inflation. MCH funds were reduced in 1981 as part of the Omnibus Budget Reconciliation Act (OBRA), but Congress provided additional one-time dollars in 1983 through an amendment to the Jobs Bill. However, unlike Medicaid, which was protected from the Gramm-Rudman budget cuts, the Maternal and Child Health Services Block Grant was not "held harmless" under Gramm-Rudman. Last year the MCH block grant to Minnesota cut by 4.5 percent.[2]

"Prevention is the only way we will ever be able to attempt to control public health problems and hold down the excessive costs of health care."

—Anita Hoffmann, pre-school nurse,
Brown County Public Health Nursing Service

In Minnesota for 1985 federal monies for Maternal and Child Health totaled $7,467,800. In 1985 the State Legislature for the first time allocated state funds specifically for maternal and child health. $1,450,000 from the cigarette tax was earmarked for a new formula funding program to make MCH services available to every Minnesota county.

In addition to MCH grants, separate funding allocations support other programs closely related to the health of mothers and children. In 1984 federal Title X family planning funds totaled $1,287,006. The Minnesota Legislature appropriated $2,010,128 for 61 Family Planning Special Projects for the two-year period 1984 and 1985.

Federal Maternal and Child Health Policy

Since 1912 when legislation created the Children's Bureau congress has demonstrated a concern for the health needs of mothers and children. However, until 1935 the expectation was that the states would play the major role in providing direct health services to women and children.

Title V of the Social Security Act of 1935 provided financial assistance to states to create maternal and child health programs and crippled childrens services. Federal regulations specified how these services were to be provided. During the 1960s and 1970s Congress amended Title V to establish separate categorical programs. As part of the 1960s' emphasis on programs for inner cities, the federal government contracted directly with local agencies to provide services. All state MCH programs were required to support projects in each of the Categorical program areas:
Comprehensive Maternity and Infant Care Projects
Comprehensive Children and Youth Projects
Comprehensive Family Planning Services
Newborn Intensive Care
Dental Health
Sudden Infant Death
Crippled Childrens Services

However, amendments to the Omnibus Budget Reconciliation Act (OBRA) of 1981 changed Title V to the Maternal and Child Health Services Block Grant and caused a major restructuring of the federal-state maternal and child health program:

1. The seven separate categorical programs were consolidated into a single block grant;
2. States were given more flexibility to establish their own priorities and develop their own programs;
3. States were required to prepare a report describing intended expenditures, a statement of assurances, and an annual report on progress towards the goals and objectives presented in the report.[3]

"If there is a catastrophic need, there are many services one can turn to, but not for the run-of-the-mill services a child needs. . . There is more for the dramatic things."

—Lynn Wetherbee,
Parent Child Activity Coordinator,
Division of Public Health, Bloomington

Minnesota Maternal and Child Health Policy

Minnesota legislation in 1982 authorized the Maternal and Child Health Advisory Task Force to create a state plan.

The end of categorical grants protecting the original maternal and child health projects as well as Services to Children with Handicaps (see below) led to concern that services to high needs urban populations would be reduced in an effort to spread funds throughout the state. There was a danger that neither urban nor rural low income women and children would be well served. Moreover, there was concern that the needs of disabled or chronically ill children might be pitted against those of low income children. However, the state cigarette tax provided funds for CHS agencies in greater Minnesota without depriving the original projects through fiscal 1987.

MCH funds in Minnesota are currently divided roughly in three parts. One third of MCH funds are allocated to the six special MCH projects which had been funded under the categorical programs before 1981, the largest of which serve at risk urban populations; one-third go to family planning, prenatal care and services to high needs children provided by Community Health Services (CHS) in counties in greater Minnesota, and one-third support services in the Minnesota Department of Health and Services to Children with Handicaps.

In 1984 and 1985 appropriations to the six MCH preblock grant projects were as follows:

$1,495,715 to the Minneapolis Health Department for maternal and infant care, children and youth, the Community University Health Care Center, and family planning;

$728,431 to the St. Paul-Ramsey Medical Center for maternal and infant care and adolescent health;

$36,816 to St. Mary's Hospital, Duluth, for perinatal intensive care;

$85,490 to Planned Parenthood of Minnesota for family planning services in the 12 counties in northwestern Minnesota;

$31,884 for dental health to the Goodhue-Wabasha Community Health Service, and

$58,652 to the Minneapolis Children's Health Center for a statewide Sudden Infant Death Syndrome (SIDs) program.

Community Health Services

In 1976 the legislature established the Community Health Services (CHS) system. CHS agencies provide maternal and child health services as part of "an integrated system of community health services operating within state guidelines and standards focusing on the prevention of "illness, disease and disability." Most of the 48 CHS agencies serve one or more counties, but city health departments in Minneapolis, Bloomington and St. Paul are also local CHS agencies. The Minnesota Department of Health coordinates and plans for the CHS services system, analyzes health needs for the legislature and provides technical assistance.[4]

MCH grants to local CHS agencies are allocated according to a formula based on the proportion of mothers under 20 years of age or over 35, the proportion of infants whose birth weight is less than 2,500 grams, and the proportion of children who are on public assistance. MCH grants must be used for 1) family planning, 2) prenatal care to high risk mothers, and 3) high needs children.

Currently, MCH funds are inadequate for full maternal and child health services for the low income population. Other funding sources available to CHS agencies for services to low income mothers and high needs children include CHS state subsidies, patient payments, and Medicaid payments. Counties may also appropriate local funds to fill gaps. However, those counties which are most economically derpressed and most in need of intensive maternal and child health services are also those least able to spare county funds.

Every CHS agency must prepare a plan providing maternal and child health services, but counties differ greatly in the priority given to this population, in the services provided and in the degree to which the target population is reached.

All 87 agencies employ public health nurses and/or registered nurses and provide services in child growth and development through home visit programs or through clinics held in the counties.

Most counties provide screening services to children in hearing and vision (68 counties), scoliosis (56 counties), Early and Periodic Screening (56 counties) and Preschool Screening (67 counties). Most counties also provide services to children through Home Health Programs for congenital anomalies (68 counties); services to families with abuse problems (52 counties), services to pregnant women (73 counties), mothers with new babies (84 counties), maternity clinics (4 counties) and services in family planning (34 counties).[5]

1985 MCH funds to the Minneapolis Health Department supported a Maternal Health Program and Child Health Program for populations "at risk" because of "economic, physical, psychosocial, or environmental factors." Persons with incomes up to 172 percent of the poverty line were eligible.

- *1,029 patients made 5,172 visits to the maternal health program.*
- *4,253 children made 13,579 visits to clinics, located at four sites.*

More than 75% of patients had incomes below the poverty level.

Clinics included nutritional assessment and counseling, social service assessment and developmental screening and evaluation in addition to medical and nursing services.

—Minneapolis Health Department
Maternal & Child Health Programs
Performance Report for Jan. 1, 1985-Dec. 31, 1985

CHS agencies also administer separate programs which impact maternal and child health including the Special Supplemental Food Program for Women, Infants and Children (WIC), Early Periodic Screening (EPS), immunizations and family planning services.

Since 1981 MCH funded projects in Minneapolis and St. Paul have been forced to reduce services. Income eligibillity for most Minneapolis Health Department Programs was reduced from 200 to 176 percent of poverty. The geographical target area was narrowed and child health clinics now focus on children birth through five and on adolescents. In 1985 the Minneapolis Health Department reduced the number of clinic sessions and eliminated one clinic site.[6] Minneapolis Health Department Clinics are so crowded that little outreach is attempted.

The Minnesota Health Department proposes for the next biennium to use $2.1 million accrued in Services to Children with Handicaps for SCH. This will free federal and state funds to ensure the same level of funding for the six pre 1981 projects and somewhat increase MCH funds for greater Minnesota counties. Because most of the SCH savings result from a one-time change in bookkeeping, and obvious economies in the state health department will all have been affected, it is not clear how this level of funding can continue beyond the next biennium unless federal and state appropriations increase.

"Something is wrong with society if we cannot feed the children."

—Dr. Henry Staub, Chief of Pediatrics, Unity Hospital, Fridley

Nutrition

The Special Supplemental Food Program for Women, Infants and Children (WIC)

WIC provides vouchers for the purchase of specific food products to pregnant women, nursing mothers, infants and children up to five who are income eligible and who are at either medical or nutritional risk.

In September 1986 WIC served 56,210 women and children in Minnesota: almost 47,576 infants and children and 8,634 women. The program was available in all 87 Minnesota counties.

Supported entirely by federal funds, the Minnesota WIC program received a grant of $24,731,193 in fiscal 1986. Unlike other programs, WIC funding has increased by 50 percent since 1981; WIC was specifically excluded from the Gramm-Rudman budget cuts.

However, current available WIC funds do not cover services to all eligible clients. The Department of Health estimates there are 110,000 women and children who would meet income eligibility guidelines for WIC, 185 percent of poverty level (the same as for reduced school lunch eligibility), but who are not being served. There is a waiting list of some 6,000 eligible applicants.

Particularly troubling is the concern that women and children at risk who would meet the income guideline, but who are not part of the welfare system, may not know about the program. Pati Maier, Minnesota WIC director, reports, "We're afraid that the woman working as a secretary for $15,000 a year and supporting two children may not have heard about WIC." A survey of food shelf users found some high needs pregnant women had not applied to the WIC

program because they were unaware of it. WIC is awaiting the recommendations of a marketing study to reach target groups, particularly pregnant women, who have priority for service.

The WIC program is available at most Community Health Service agencies and at private agencies. Each month food vouchers are distributed and nutritional information is offered. Health referrals are also often made.

Vouchers pay for milk, iron-fortified formula, cheese, legumes, iron-fortified cereal and juices. The supplements amount approximately to $58 a month for infants, $22 for children and $32 a month for women.

If nursing mothers and babies achieve good medical and nutritional health, they graduate from the program.

Persons interviewed for the study were uniformly enthusiastic about WIC; however, frustration was expressed at the limited funding. National evaluations of WIC show that it is cost-effective; WIC resulted in fewer fetal deaths, higher birthweight, and better nutrition among participants. The greatest dietary benefits of the WIC Program were among children of highest risk.[1]

It is ironic that WIC, serving the most vulnerable population, is less widely available than the reduced or free school lunch program which serves all income eligible children in schools where the program is offered.

"I've been hearing from mothers who have been cut off from WIC because their babies are healthy—this is ridiculous!"

—Rosemary Byrnes
Southern Anoka County
Community Assistance

School Lunches

The federal government has offered a subsidized school lunch program since 1946. 432 of the 435 Minnesota school districts serve approximately 420,000 school lunches daily; 31.2 percent of all school lunches are free or at reduced rate. Free lunches are available to students whose family income is 130 percent of the poverty line or below; reduced lunches are available, usually for 40 cents, to children from families from 130 percent to 185 percent of the poverty line.

All school lunches are subsidized both by dollars and by commodity foods. Free and reduced lunches are almost completely subsidized.

School Breakfasts

Approximately 28 Minnesota school districts serve some 12,000 breakfasts, sometimes only in targeted schools, with high concentrations of low income students. 83.9 percent of all breakfasts are free or reduced.

Programs for Special Needs Children

Chronically ill children and those with disabilities often require special health services. The number of handicapped and very ill children in the community is increasing, both because modern medicine saves more children and because young multiple-handicapped children are no longer routinely sent to state institutions.

Services for Children with Handicaps (SCH)

Since 1936 federal funds have helped Minnesota serve children with special medical needs and handicapping conditions through Services for Children with Handicaps (SCH, formerly Crippled Children's Services). Conditions covered include congenital heart problems, deafness, spina bifida, cerebral palsy, cancer, mental retardation and cystic fibrosis.

In fiscal 1986, $2,756,398 state dollars and $1,711,484 federal dollars from the MCH grant program provided medical services for 7,940 Minnesota children. An additional 4,218 received information and referral services.

SCH is designed to make services for high needs children accessible throughout Minnesota. SCH staff are located in eight different health districts, in addition to the State Department of Health. Staff perform case management functions for many families, offer counseling,and provide technical advice to public health nurses and other caregivers on special needs children.

SCH provides evaluation for eligible children with potential handicaps or disabilities at no cost to parents. Evaluation frequently consists of a referral to a medical specialist or clinic.

SCH also arranges and pays for approved medical procedures for children who meet income levels, 60 percent or less of the state median income ($18,000 for a family of four in August 1986.) Families with higher incomes pay 1 percent for every additional $1,000. SCH payment for each child may not exceed $10,000 annually. SCH is a payor of last resort, available after insurance funds are used.

In 1986 SCH offered 265 field clinics at more than 30 locations throughout Minnesota. Different clinics

include hearing and speech evaluation, orthopedics, and intensive school clinics for children who experience severe problems of school adjustment.

SCH is preparing to charge families whose children visit field clinics. SCH also now consistently applies the Medicaid reimbursement formula for providers; some providers were previously paid at a higher level.

The $10,000 ceiling for each patient each year for medical services is often insufficient to pay for complex medical procedures, like heart surgery and treatment for leukemia, even up to the MA level.

Average Costs of Care for Selected Chronic Childhood Illnesses in 1984

	Average Cost per Patient (yearly unless noted)
Cystic Fibrosis	$ 6,191
Congenital heart disease	13,000a
Hemophilia	10,238b
Chronic renal disease	6,729c
	16,520d
Leukemia	1,900
Spina bifida	10,850e
	22,405f

a Includes only first full year of care
b Average over three year period
c Home dialysis
d Medical center dialysis
e First six years with low lesion
f First six years with high lesion.

Note: These figures do not include full costs to the family. Excluded are rapid transport to special hospital at birth, special supplies, counseling, respite care, day care, etc.

Source: James M. Perrin, M.D., and Henry T. Ireys, Ph.D., "The Organization of Services for Chronically Ill Children and Their Families," Symposium on Chronic Disease in Children, *Pediatric Clinics of North America,* Vol. 31, No. 1, February 1984.

Minnesota Comprehensive Health Association (MCHA)

In 1976 the Minnesota Legislature created the Minnesota Comprehensive Health Association, an "assigned risk pool," to provide health insurance for persons who cannot obtain coverage elsewhere, usually because of chronic health conditions. In 1985 MCHA insured 1207 children and youth, 71 percent of whom lived outside the metro area. MCHA paid claims of $2,000,000 for children and youth.[1] Private insurance companies cover deficits incurred by MCHA.[2]

Applicants must show that they cannot find private insurance for a given condition and must wait six months before coverage for the condition begins. Each person covered is insured up to a lifetime ceiling of $200,000.

MCHA provides effective coverage for self-employed persons, including farmers, whose children have major inpatient hospital expenses or major ongoing expenses. It also serves families whose regular insurance puts caps on some costs. The somewhat higher premiums, the relatively high co-payment, 20 percent of services up to $3,000 each year; and the $500 or $1,000 deductible clause, make MCHA unaffordable for low income families.

School Based Programs

School Nurses

Ideally, school nurses monitor children's health, screen children for vision and hearing and refer students with problems to community resources, including private physicians. School nurses provide followup on known problems, meet with parents and persist until referrals are made.

During the 1981-82 Minnesota fiscal crisis the number of school nurses, counselors and social workers was reduced by 12 percent, compared to a drop in teachers of approximately 4 percent.Although the ratio has improved since, because the number of school nurses has remained constant and the number of students has declined, many school districts are far from meeting the ratio of 1 school nurse to 750 students recommended in the *Standards of School Nursing Practice of the American Nurses Association.*[1] Current Minnesota statutes do not require that school districts provide nursing services in public schools although they do mandate that school districts provide nursing services to non-public schools.

School districts vary widely, from $1.50 to $75 per child, in their spending on child health services. ($1.50 pays for the public health nurse to check vision and hearing.) Roughly half of the approximately 200 smaller school districts, with up to 550 students, contract with county public health nurses; one-half employ health aides without supervision or provide no regular service.

Many larger districts also provide sparse nursing services. St. Paul schools have a nurse to student ratio of 1-800, but in Minneapolis the ratio is more like 1 to 2,000. In some of the western Hennepin suburbs and larger districts in greater Minnesota, the ratio aproaches 1-6,000 or 1-10,000. Many districts have only one licensed school nurse who administers programs run by health aides in various schools.

Early Childhood Screening

Since 1977 Minnesota school districts have provided Early Childhood Screening for pre-kindergarten children. Intended partly to identify children with disabilities who may need special education services, this program also identifies other health and developmental problems.

Unlike the Early Periodic Screening Diagnosis and Treatment (EPSDT) or Early Periodic Screening (EPS), which provide periodic visits, the Early Childhood Screening program screens each child once at the age of 3 1/2 or 4. In addition to speech and hearing, and a developmental scale, the screening includes height and weight and a health history. In most districts, an interview with the parent also takes place. Until the 1981-82 legislative session, a physical, some lab work, a dental screening and a nutrition sample were also part of the procedure.

Originally, the state paid school districts all costs for Early Childhood Screening. Reimbursement rose to $28 per child in 1981. Reimbursement of $16.15 per child was appropriated for the scaled-down screening through the the 1985-86 school year. However in 1986 the legislature decreased funding to $8.15 per child; school districts are now expected to provide the remainder.

Although participation by families in the program is voluntary, 90 percent of eligible children were screened in some smaller school districts; average participation throughout the state was 80 percent. A number of conditions were detected and addressed as a result of the screening.

The Early Childhood Screening Program was originally criticised by physicians as duplicating the Early Periodic Screening Diagnosis and Treatment program (EDSDT) available to MA recipients and the Early Periodic Screening (EPS) for low income children, and as unnecessary for those children with private physicians.[2]

However, participation in Early Childhood Screening has been much higher than for either EPS or EPSDT and children were seen who had not been seen "head to toe" since infancy. The familiarity with schools and, possibly, the lack of any stigma attached to a screening program for all children may contribute to this success. Screening presents an opportunity to refer parents to local programs and resources and to provide counseling on parenting before the children begin school.

A third public school program addressing child health is the Early Childhood Family Education program offered through Community Education. Designed for parents and children birth to five, the program places major emphasis on teaching parenting skills, including child development and nutrition and health practices.

Other Programs

Early Periodic Screening, Diagnosis and Treatment (EPSDT)

Early Periodic Screening, Diagnosis and Treatment (EPSDT), is a federally mandated program for children who are Medicaid recipients. Legislated by Congress in 1967, EPSDT called for a "comprehensive child health screening on a broader scale than had ever occurred or been envisioned in traditional health coverage."[1] Checkups are scheduled for 0-6 months, 9 months, 1 year, 18 months, 2 years, 4 years, and every three years after 4, through age 21. Each examination must include a health history, an assessment of physical growth, a physical examination and a dental inspection. Other procedures including vision, hearing and developmental screening are specified at certain ages. EPSDT providers, including physicians in private practice, physician supervised clinics and nurse supervised clinics (created to offer the EPS screening program), are located in every Minnesota county.

Congress established higher reimbursement for EPSDT than for most medical services under Medical Assistance. Rates are readjusted more frequently than for regular Medical Assistance procedures; maximum reimbursement is currently at the 75th percentile of "usual and customary charges" of Minnesota physicians.

Participation by Medical Assistance families in EPSDT is voluntary. Outreach is a part of the program and notices are sent to eligible families reminding them of services. In fiscal 1986, 29,380 of the potential 132,527 children aged birth to 21 in Minnesota were screened under the program. This figure is considerably below the 54,000 eligible recipients set as the 1979 target capacity as part of the settlement of a Legal Aid lawsuit brought in 1975.

Underutilization of EPSDT may be due to the availability of other preventive health services to MA recipients in Minnesota. (In many states, EPSDT provides the *only* means of obtaining preventive health care for children.) Another factor may be a certain amount of confusion about the program among providers, potential recipients and welfare workers.

Early Periodic Screening

Early Periodic Screening (EPS) was established by the Legislature to reach low income children not covered

by Medicaid. It is supported entirely by state funds and administered by CHS. EPS is a nurse-run program; nurses are trained by the Minnesota Department of Health. Although developed primarily for children not covered by Medical Assistance, EPS clinics also screen MA children and are then reimbursed by Medicaid.

Fifty-six Community Health Services offer EPS clinics. Participating counties differ in their outreach efforts, in the sliding scale for fees and as to their willingness to waive the set fee.

EPS does not serve the total target population. In 1983 EPS clinics screened approximately 9000 children, about one-third of whom were Medicaid elibible.[2]

Immunizations

The Minnesota Department of Health receives vaccines each year from the National Center for Disease Control. In 1986 Minnesota received $200,000 in cash for the program and $571,000 in vaccines.

The vaccines are distributed to counties and are targeted for children who have no third party insurance coverage. Some counties allocate a portion of their vaccines to physicians for this target population, others dispense all vaccines through county immunization clinics. Private physicians generally purchase their own vaccines.

Counties may charge a small administrative fee, some charge $3, but this does not reflect the actual cost of vaccines or the differences between different kinds of innoculations.

The price of most childhood vaccines has risen dramatically in recent years. Because of past and potential liability litigation, the cost of the DPT vaccine, which protects against diphtheria, whooping cough and tetanus, has risen 3,200 percent in less than five years. The price of polio vaccine has almost quadrupled. The number of drug companies manufacturing vaccines has also been reduced which temporarily caused some shortage in the available supply; only two companies now manufacture DPT vaccine. The cost of immunizations charged by physicians has increased considerably.

Nationally the federal Childhood Immunization Initiative begun in 1977 to vaccinate children against the seven preventable childhood diseases resulted in more than 90 percent of kindergarten and first grade children being immunized each year in the United States. Since 1980 Minnesota statutes require that all children beginning in day care as well as kindergarten be immunized. The percentage of success is now in the "high 90's."

Immunizations are cost effective. It is estimated that for every $1 in federal funds spent on measles vaccine, an estimated $10 is saved 1) in hospital days and eliminated physician visits; 2) in cases of prevented mental retardation; and 3) in lives saved.

—American Academy of Pediatrics Government Liaison Office

The Gramm-Rudman Act eliminated funds for more than 65,000 children's innoculations in the 1986 fiscal year. This cut plus the higher costs caused fears that more parents would take their children to public health clinics "which are already overburdened, underfunded and understaffed" for their shots.[3] As yet, however, there does not appear to be a crisis in Minnesota.

The new 1986 Omnibus Health Bill provides for government payment for all medical expenses for vaccine-related injuries, although there is a cap of $250,000 on "pain and suffering" awards or death benefits. Parents may still sue in the court system. It is hoped that the bill will reduce the potential for liability to drug companies, result in lowering costs and eventually increase the supply.

PROPOSED REFORMS

National Proposals

Congress is awash with schemes to adjust the medical system. Most of these proposals would impact health care for children.

Some proposals, like that of the Council on Maternal and Child Health of the National Association for Public Health Policy, advocate a far-reaching reform of maternal and child health services. They urge the creation of a program of universal maternity care, similar to Medicare for the elderly, which would ensure nutritional supplements, prenatal and well child care to *all* mothers and children. They contend that our current fragmented system, even if better funded, is inadequate to solve the problem of maternal and child health care delivery.

Another suggestion is that insurance for low income women and children under Medicaid be separated from programs for the elderly. Not only would this enable a better focus on and understanding of maternal and child health programs, it would also result in less confusion for the elderly.

Some other proposals advocate reform of the current medical payment system to reward providers for preventive care rather than primarily for intervening at the acute stage.

The American Academy of Pediatrics (AAP) sponsored tax reform legislation—the Child Health Incentive Reform Plan (CHIRP)—would ensure that *all* children receive preventive health care. All businesses deducting insurance premiums as a federal tax credit, "must offer health plans that cover children's necessary preventive health care services."

A number of states have recently passed legislation, similar to the CHIRP proposal at the national level, which obligates private insurers to cover well child care.

Obviously, increased federal funds for existing programs, maternal and child health and WIC, particularly, would enhance service to target groups for good but inadequately financed programs.

Minnesota Proposals

At the state level, several legislative proposals would directly affect maternal and child health and, particularly, the problems of no insurance and underinsurance. In addition, augmented funding would obviously enhance a number of programs, like EPS and the adequacy of MA reimbursement. The Minnesota Association of Community Health Administrators (MCHA) advocates increasing Maternal and Child Health funds by $1 million in the next biennium.

Increase WIC

Two different proposals would add state funding to the federal grant to enlarge the WIC program:

- The Food First Coalition, led by the Minnesota Food Education and Resource Center, urges the appropriation of $22.2 million for the next biennium to provide WIC services to 50 percent of eligible households.

- The Children's Defense Fund-Minnesota Project advocates appropriating $3.1 million to enable WIC to serve all those on the current waiting list.

Extend Medicaid

Two formal proposals urge the extension of Medicaid benefits to 133⅓ percent of the AFDC level for all women and children, or to the newly approved 100 percent of the poverty level for pregnant women and preschool children. (The second option would be less expensive since fewer individuals would be covered.) The Minnesota Coalition on Health also recommends raising Medicaid eligibility.

The Department of Human Services, in its paper, "Report and Recommendations for Medical Assistance Prenatal Care Initiative," recommends:

- expanding the availability of Medical Assistance in Minnesota.

- risk assessment of all pregnant women receiving state funded prenatal care.

- making available additional services to high risk women including: case management; prenatal education, including pre-term birth, childbirth and parenting education; and nutrition education. These services would be billed in addition to regular prenatal care.

- Higher fees for providers of care to high risk mothers to encourage more visits if appropriate.

- Reimbursement for a second postpartum visit for all MA patients at approximately 3 to 6 months after delivery for health promotion.

A report by the Health Policy Analysis Group of the University of Minnesota's Division of Health Services Research and Policy also supports extending MA income eligibility. The report argues that such a policy could be budget neutral; the matching federal funds available for MA recipients would mean a cost saving for the state, since many of these people now receive state or county funded services, and many people covered would not be very costly since those with great medical expenses already qualify for Medicaid as "medically needy."

More Health Insurance

Two initiatives to address the problem of inadequate insurance coverage for the poor have been advanced.

- The *Right Start* initiative proposed by the Children's Defense Fund-Minnesota Project would provide health insurance coverage for uninsured and underinsured mothers and preschool children for preventive care up to 200 percent of the poverty line. The Right Start program would begin in 1987; by 1991 it would be extended to all children under age 18.

A fund would be established for those not eligible for Medicaid. This might be financed from general revenues, sin taxes, and/or special taxes on the health industry itself. The Right Start program would require $15,000,000 in state appropriations for the first biennium.

The recent recommendations of the State Welfare Reform Commission also urge providing insurance coverage for children up to 200 percent of poverty.

- The Right Start proposal might be coordinated with the *Healthspan* proposal recently introduced by the Financial Access Work Group and prepared by the Office of Health Systems Development in the Minnesota Department of Health. Healthspan would provide medical coverage to all uninsured persons under 200 percent of the poverty line. It would encourage enrollment in HMOs by administering agencies.

Healthspan would rely on new monies to insure families above Medicaid eligibility guidelines but not able to afford private insurance. A sliding method of payment for insurance coverage would be developed, paid for partly by government, partly by employers and partly by those to be covered, as their incomes rose above the poverty line.

The recent Governor's Commission on Poverty also recommends allocating $25 million for a sliding scale system to provide insurance coverage to families with children with incomes up to 200 percent of the poverty line.

CONCLUSION

It is clear that the patchwork of programs available to low income children in Minnesota are not the result of a carefully planned strategy to serve their health needs well. Funding levels are insufficient to cover medical needs, particularly to ensure preventive care. The lack of insurance coverage for many women and children, at a time when health costs require that persons be insured, is especially serious. However, insurance by itself will not meet all needs. Nutrition and programs incorporating education and outreach are also essential.

It is currently popular to blame Washington for all program gaps. In fact, however, Minnesota must assume some of the responsibility. The failure to provide Medicaid coverage to many poor women and children has serious consequences. The lack of support for the WIC program is also regrettable. Neither is consistent with a firmly held commitment to children and their future.

If we wish to create a system insuring the health and future productivity of our children, much remains to be done.

"Health care in America must be judged not only on its ability to cure sickness, but also on its capacity to keep people well. Nowhere is this more important than in the health of mothers and children. Preventive services for them will not only alleviate many deaths and much suffering, but more than pay for itself by giving these babies a fighting chance to grow up healthy and become productive citizens."

—Senator Dave Durenberger
April 17, 1986

APPENDIX A — COUNTY STATISTICS AFFECTING CHILDREN

	GENERAL					ECONOMIC HARDSHIP			HEALTH			
		Children[2]	Unemployment rate[3]			Single parent families[4]		K-12 students in low-income homes, 1984[5]			Percent no prenatal care in first trimester, 1983[8]	Percent of 1983 babies born under 5.5 lbs.[9]	1981-1983 infant death rate[10]
County	Population[1]	0-4	1984	1979	Percent change in 1982-83 farm income[6]	Number	Percent of all families	Number	Percent	Number of 1983 births[7]			
Aitkin	13,595	863	16.8	10.4	+6	260	6.8	477	32.0	200	29.1	3.0	8.4
Anoka	207,355	17,022	15.0	2.9	−265	4,943	9.7	3,911	8.2	3,544	18.4	5.5	8.6
Becker	30,972	2,328	13.4	8.2	+104	680	8.8	1,527	30.7	481	21.9	4.4	13.8
Beltrami	32,903	2,677	8.9	6.2	+25	840	11.3	2,141	30.2	583	22.4	3.9	15.4
Benton	26,434	2,512	8.4	5.6	−23	502	8.1	805	18.2	590	12.5	3.9	9.6
Big Stone	8,083	571	7.1	4.7	−42	106	5.2	436	29.2	111	22.0	5.4	8.3
Blue Earth	52,844	4,904	5.1	3.2	+24	1,124	9.1	1,354	13.7	805	16.7	4.3	11.9
Brown	28,617	2,394	6.6	4.0	−40	561	7.7	717	12.3	491	16.4	5.1	11.0
Carlton	29,342	2,377	11.2	6.6	+257	729	9.3	1,500	22.9	135	27.4	5.2	7.7
Carver	39,573	3,107	4.6	2.8	−23	748	7.8	489	5.9	645	14.0	5.1	11.3
Cass	21,344	1,593	10.8	7.0	+88	487	8.4	1,465	37.5	342	34.6	7.6	13.2
Chippewa	14,881	1,269	7.5	4.6	−16	247	6.0	433	16.8	203	27.0	4.9	12.4
Chisago	27,559	2,315	6.4	3.9	−54	439	6.4	794	14.4	464	32.2	5.0	11.6
Clay	49,203	4,262	5.5	5.0	−35	1,089	9.3	1,282	18.1	694	25.5	4.6	16.3
Clearwater	9,056	706	19.5	12.0	−25	201	8.6	752	39.0	134	21.2	3.7	4.7
Cook	4,286	280	11.3	6.9	NA	90	7.9	141	20.9	56	13.0	3.6	28.6
Cottonwood	14,178	1,014	6.9	3.9	−29	263	6.3	479	17.4	178	20.1	5.1	6.7
Crow Wing	42,287	3,343	10.2	7.1	−45	1,028	9.1	2,161	27.1	644	28.4	3.9	11.3
Dakota	208,308	18,206	4.6	3.2	−38	5,047	10.1	2,739	6.2	3,460	16.8	4.8	7.2
Dodge	15,744	1,502	8.4	4.6	−54	244	6.1	550	15.3	273	28.4	2.6	6.8
Douglas	29,505	2,372	6.9	5.4	−17	455	6.1	1,041	19.1	437	15.1	3.2	8.7
Faribault	19,218	1,332	6.2	3.9	−33	364	6.8	548	11.5	269	30.5	3.3	9.2
Fillmore	21,915	1,702	7.5	4.1	−38	383	6.4	772	21.8	317	28.3	2.2	10.0
Freeborn	35,398	2,727	8.0	4.8	−29	821	8.1	762	12.9	468	27.6	3.9	10.8
Goodhue	39,385	3,045	6.5	3.7	−9	752	7.2	900	13.1	598	21.1	3.7	12.2
Grant	7,209	525	6.7	4.2	+21	120	5.9	298	20.9	106	17.3	6.6	3.0
Hennepin	945,970	74,001	4.6	3.3	−31	33,143	14.0	20,405	15.5	14,614	19.0	5.8	9.5
Houston	18,774	1,618	6.0	5.0	−28	399	8.2	468	14.9	307	18.4	3.6	15.1
Hubbard	15,264	1,013	12.4	8.4	−11	296	7.5	1,012	37.6	235	27.2	4.3	13.6
Isanti	25,203	2,191	5.5	5.1	+55	410	6.9	748	16.8	416	32.7	3.8	12.3
Itasca	45,047	3,473	12.6	8.6	−27	972	8.3	2,247	26.1	633	20.9	4.1	9.8
Jackson	13,549	876	5.3	3.0	−47	226	6.0	320	14.4	190	17.3	4.2	4.8
Kanabec	12,366	1,153	11.4	6.8	+7	261	7.9	475	20.8	226	29.3	4.9	6.1
Kandiyohi	39,520	2,915	6.7	4.7	−162	714	7.5	1,197	18.5	606	24.8	5.3	12.9
Kittson	6,774	437	9.4	5.9	−31	121	6.5	269	23.5	92	30.3	3.3	0.0
Koochiching	16,759	1,430	10.3	7.2	−42	404	8.6	843	23.9	206	32.0	4.4	9.8
Lac Qui Parle	10,395	799	6.3	2.7	−7	150	5.1	366	21.3	133	22.2	9.1	6.1
Lake	12,740	936	16.4	4.0	NA	214	6.0	558	20.1	149	27.7	6.0	7.8
Lake O'Woods	3,925	290	9.3	5.0	+28	72	6.7	200	32.6	12	22.6	1.9	11.5
Le Sueur	23,585	1,994	9.1	5.0	−29	422	6.8	619	13.2	419	17.5	5.0	11.3
Lincoln	7,972	584	6.9	4.1	−48	110	5.0	467	34.2	106	31.1	1.9	2.8
Lyon	25,770	1,954	6.0	3.9	−33	470	7.5	1,051	19.7	403	25.8	4.2	9.8
McLeod	29,971	384	6.3	3.2	−27	534	8.8	500	11.3	494	11.7	5.3	11.9
Mahnomen	5,677	1,040	11.3	9.5	+25	121	5.3	833	47.7	97	19.6	4.1	9.8
Marshall	12,804	1,908	13.8	9.3	−27	187	8.1	910	31.1	179	23.0	3.4	8.5
Martin	24,669	2,049	6.3	3.4	−28	524	6.7	558	12.8	391	22.9	2.6	8.4
Meeker	20,920	1,727	10.0	5.3	−46	357	6.4	997	20.0	345	36.1	6.1	10.1

Continued

APPENDIX A — Continued

	GENERAL				ECONOMIC HARDSHIP			HEALTH			
					K-12 students in low-income homes, 1984[5]						
County	Population[1]	Children[2] 0-4	Unemployment rate[3] 1984	1979	Number	Percent	Percent change in 1982-83 farm income[6]	Number of 1983 births[7]	Percent no prenatal care in first trimester, 1983[8]	Percent of 1983 babies born under 5.5 lbs.[9]	1981-1983 infant death rate[10]
Mille Lacs	18,316	1,633	9.0	5.7	1,418	25.3	NA	314	15.5	7.0	14.9
Morrison	30,046	2,517	10.7	7.3	2,515	36.2	-21	548	15.7	4.8	11.4
Mower	39,816	2,858	6.7	5.1	1,125	16.6	-42	554	37.3	3.8	8.9
Murray	11,441	865	8.2	5.1	254	16.4	-28	162	15.8	2.5	3.9
Nicollet	27,976	2,380	5.0	2.8	310	13.7	-37	370	15.5	4.6	14.9
Nobles	21,934	1,630	6.8	3.4	755	19.2	-36	320	20.7	4.7	12.0
Norman	9,534	665	7.0	4.5	475	28.8	-19	106	26.4	2.8	2.7
Olmsted	95,791	8,475	4.6	3.7	1,765	9.9	-21	1,750	23.9	5.9	8.2
Ottertail	54,864	3,825	9.9	6.2	2,143	25.4	-19	771	16.6	4.0	6.3
Pennington	14,036	1,282	9.1	5.4	867	30.7	-8	226	27.5	5.8	5.8
Pine	20,576	1,676	11.2	7.5	1,239	30.0	+6	340	33.4	2.9	6.9
Pipestone	11,405	799	5.1	4.9	564	22.1	-67	182	18.6	7.1	10.9
Polk	34,562	2,667	8.6	5.6	1,653	25.2	-30	550	23.1	5.3	9.0
Pope	11,854	884	7.5	4.7	444	23.7	-30	200	21.2	4.5	10.5
Ramsey	457,123	35,778	4.8	3.8	13,262	19.9	-58	7,710	24.3	6.0	11.3
Red Lake	5,340	413	15.2	10.3	499	42.5	-18	88	24.1	3.4	7.1
Redwood	18,835	1,518	5.3	3.3	576	15.6	-28	324	13.7	4.3	12.5
Renville	19,685	1,393	8.5	5.1	591	15.6	-42	340	14.8	4.1	6.1
Rice	47,012	4,029	7.5	4.9	1,164	8.1	-33	700	27.2	5.7	8.5
Rock	10,728	893	4.0	2.9	349	18.8	-45	160	12.4	7.5	6.1
Roseau	12,845	1,099	11.0	6.2	660	24.5	-14	198	23.8	5.6	18.7
St. Louis	213,662	3,660	12.2	5.8	9,018	26.9	NA	2,835	16.8	5.3	8.7
Scott	48,885	3,040	5.3	2.8	737	7.3	-20	793	18.2	3.7	9.4
Sherburne	33,258	1,229	8.0	5.0	599	8.6	-306	539	16.0	6.0	8.4
Sibley	15,671	16,326	7.3	4.4	408	15.4	-42	217	12.4	4.6	6.9
Stearns	113,815	11,334	8.0	5.9	4,526	17.6	-15	1,952	17.8	4.4	9.7
Steele	30,498	2,711	6.6	3.7	678	10.9	-25	500	43.3	4.6	11.9
Stevens	11,191	859	5.6	3.7	311	16.6	-66	140	7.8	4.3	3.8
Swift	12,776	988	9.5	5.0	670	24.5	-38	174	25.7	6.9	8.8
Todd	26,034	2,048	8.2	5.4	1,822	36.0	-28	431	26.4	6.1	11.5
Traverse	5,402	370	6.3	4.5	208	28.0	-76	83	26.9	3.6	11.7
Wabasha	19,178	1,732	8.4	4.2	629	14.9	-8	332	22.8	6.9	16.2
Wadena	14,001	1,124	9.4	5.4	1,153	33.9	NA	213	24.7	2.8	17.3
Waseca	18,711	1,838	5.9	3.3	514	13.2	-38	301	20.9	5.3	14.2
Washington	120,502	9,334	4.4	3.0	1,595	6.4	-61	1,852	17.3	4.6	8.8
Watonwan	12,046	1,000	6.7	3.3	401	18.6	-25	199	24.2	6.0	8.0
Wilkin	8,348	701	6.3	4.1	311	18.5	+10	106	16.3	1.9	13.4
Winona	46,478	4,129	7.8	5.3	1,113	14.5	-37	702	16.5	4.9	11.3
Wright	62,199	6,353	6.1	3.7	1,502	11.3	-25	1,156	18.2	4.2	9.1
Yellow Medicine	13,095	918	6.2	3.5	609	23.6	-18	230	29.1	4.3	14.2
STATE	4,145,607	335,104	6.3	4.2	122,943	16.7	-29	65,559	20.9	5.0	9.8

	Single parent families[4]	
County	Number	Percent of all families
Mille Lacs	375	7.6
Morrison	560	7.5
Mower	865	7.8
Murray	174	5.5
Nicollet	507	8.0
Nobles	429	7.2
Norman	157	6.2
Olmsted	2,200	9.5
Ottertail	892	6.3
Pennington	389	9.7
Pine	431	8.3
Pipestone	195	6.2
Polk	793	9.0
Pope	183	5.7
Ramsey	17,001	14.8
Red Lake	87	6.2
Redwood	350	6.8
Renville	313	5.7
Rice	865	8.1
Rock	156	5.4
Roseau	209	6.2
St. Louis	6,451	7.7
Scott	850	6.5
Sherburne	485	5.5
Sibley	232	11.1
Stearns	1,995	8.2
Steele	575	7.2
Stevens	159	5.8
Swift	231	6.7
Todd	388	5.9
Traverse	103	6.8
Wabasha	350	6.8
Wadena	290	7.8
Waseca	352	7.3
Washington	2,408	8.3
Watonwan	226	6.6
Wilkin	170	7.8
Winona	1,044	10.1
Wright	986	6.6
Yellow Medicine	215	5.9
STATE	107,271	10.3

Source: Luanne Nyberg, Monica Herera and Dana Hughes, *The Right Start*, Children's Defense Fund, Minnesota Project, 1986.

NOTES

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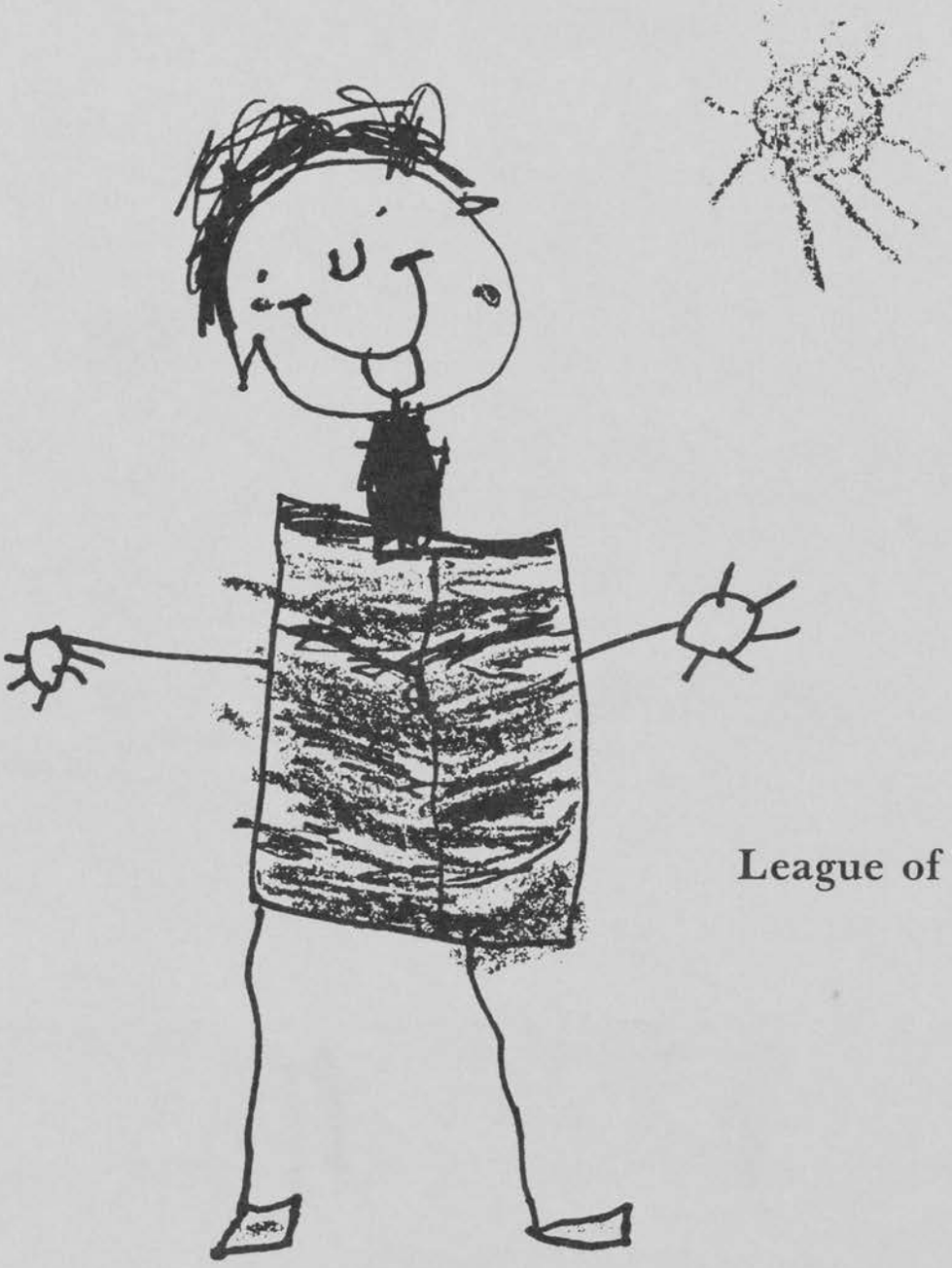
Child Care in Minnesota:
Public Issues



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League of Women Voters of Buffalo/Monticello Area
League of Women Voters of Detroit Lakes
League of Women Voters of Duluth
League of Women Voters of Freeborn County
League of Women Voters of Mankato Area
League of Women Voters of Marshall
League of Women Voters of Minneapolis
League of Women Voters of Minnetonka/Eden Prairie/Hopkins
League of Women Voters of New Brighton
League of Women Voters of Northern Dakota County
League of Women Voters of Northfield
League of Women Voters of Richfield
League of Women Voters of Robbinsdale
League of Women Voters of Rochester
League of Women Voters of Roseville
League of Women Voters of St. Cloud Area
League of Women Voters of St. Paul
League of Women Voters of Wayzata/Plymouth Area
League of Women Voters of White Bear Lake/North Oaks
League of Women Voters of Willmar

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CONTENTS

FOREWARD

Members of the League of Women Voters of Minnesota voted at their 1985 convention to study children's issues. This is the final report in a series of three. *Protecting Minnesota's Children: Public Issues* was published in the spring of 1986. *Health Care for Minnesota's Children: Investing in the Future* appeared in early 1987.

Since its founding more than 65 years ago, the League of Women Voters has studied and lobbied on issues relating to children and social welfare at the national, state and local levels.

This report is based on interviews with more than thirty-five persons knowledgeable about child care by members of twenty-one local Leagues of Women Voters.

"The availability of child care is essential to the welfare of the state. . . "

INTRODUCTION

Out-of-home child care has become a major business and an accepted part of American life. The Minnesota Legislature, in the 1986 Child Care Services Act, declared "the availability of child care is essential to the welfare of the state . . . It is the intent of the legislature that child care standards and regulatory methods facilitate the availability of safe, affordable, quality child care throughout the state."[1] Eighty-eight percent of those responding in a national Louis Harris poll released September 1986 approved of the government providing day care services for the children of poor working mothers. Fifty-four percent of these strongly approved, and another 34 percent said they somewhat approve. Seventy-three percent are willing to pay more taxes to enable this support.[2]

Both as a result of the women's movement and as a result of economic necessity causing women to work outside the home, there is increasing acceptance of the idea that young children may be cared for by persons other than their parents on a regular basis.

This acceptance marks a dramatic change from an earlier period when child care was widely resisted as a threat to the American family, typified by President Nixon's 1971 veto of a national child care bill. Currently the Archdiocese of St. Paul and Minneapolis, hardly an anti-family organization, has organized a task force to explore ways for churhes to particpate in providing child care.

However, perhaps because we are still in a transitional period, the support system, both public and private, is inadequate to create or sustain enough child care openings and programs of high quality to meet the increasing demand. Minnesota subsidizes care for many low income children but waiting lists are long. The absence of substantial grants, loans and technical assistance to providers and centers to help new programs start and good programs flourish is a serious gap. An additional problem is the lack of strong leadership for child care at the state level. At present, with the exception of staff in the licensing division of the Department of Human Services, there is no unit of professionals in state government to coordinate and plan for child care.

This is particularly worrisome because the situation promises to worsen before it improves. The percentage of Minnesota women working outside the home grew from 34.4 percent in 1960 to 54 percent in 1980. The projected percentages for the years 1990 and 2000 are 59.7 percent and 62.1 percent, respectively. Yet the number of openings in licensed day care in Minnesota remained static in 1986.[3]

Several issues are of particular concern. First, there is the question of quality. Licensing ensures certain minimal standards. However, many family day care homes in Minnesota are not licensed and some of them are of very low quality. And, so long as subsidies for low income children are inadequate, some parents are forced to choose cheaper unlicensed care or drop out of the workforce. While excellent programs exist, there is concern that some licensed programs may not adequately address the developmental needs of young children. This is particularly serious for low income children, because of the strong evidence that positive intervention in the preschool years is crucial.[4]

Second, there is the issue of helping women move off public assistance and into the workforce and of keeping low income women currently in the work force off AFDC. If this is to be accomplished, it is crucial that there be a consistent, substantial allocation fo public dollars to help cover the cost of child care for low income children.

Thirdly, there is the question of the low status, low pay and inadequate benefits accorded to child care providers and staff. Treating these workers, mostly women, as "only babysitters" and paying them accordingly contributes directly to the very high turnover rates among child care staff and the particular drain of experienced and well-trained workers. This high turnover, in turn, directly lowers the quality of care, since it makes impossible the consistency which young children need. To some extent child caregivers constitute a new economic underclass, an irony since they help make possible the fulfillment of many well educated working mothers. It will probably be impossible to raise their pay, however, without more support from government or business, because of the low wages many working women earn and their inability to pay higher child care fees.

Child care has gained acceptance, but the necessary supports for its effective functioning are not yet in place. Judged against the societal commitment to universal public education, and the salaries of school employees, child care has a long way to go. A greater commitment

is crucial if the optimal development of the many young children in child care is to be assured.

DEFINITIONS

For purposes of this report, *day care* or *child care* means care for children on a regular basis for less than 24 hours a day.[1]

Family day care and *group family day care* are provided in a home setting. A family day care home may care for "up to 10 children," a group family day care home for "11 to 14 children." A second adult is required if more than three of the children cared for are infants or toddlers.

Center-based day care is day care provided in a nonresidential setting. Day care centers can serve a larger number of children than day care homes. Daycare centers are required to have different classrooms, with children grouped by age.

Child care centers may serve infants, toddlers, preschoolers, and school age children before and after school. Most centers offer full-day programs, although some offer part-time care. Child care centers can be nonprofit, sponsored by a community group, school, welfare agency or church; or for-profit, proprietary centers, many of which have expanded into national chains.

Another form of child care, discussed less in this report, is *in-home care,* where a professional provider is employed by the parents to give care in a child's home. This "nanny" care is often very expensive, $50 per day, and out of the reach of most working women. However, it may be a practical alternative for families with more than one child.

In *shared-care* several families employ a provider to care for their children in one of their homes.

Another significant distinction is between *licensed* and *unlicensed* family day care. Licensed family day care providers are inspected to ensure they meet certain state requirements.

An additional category, *legal but unlicensed,* refers to family day care providers who care for the children of one family other than their own and are not required to apply for licensure.

Some working parents use *informal care,* relying on families, friends, and spouses to care for their children.

Experts estimate that there is one unlicensed day care home for every licensed home. The proportion of unlicensed to licensed caregivers is approximately the same in the metropolitan area and in greater Minnesota. Similarly, the proportion of informal to formal care is approximately the same throughout the state.[2]

Frequency of Different Kinds of Child Care

Nationally, the largest percentage of children are cared for in family day care homes, especially infants and children under three years old. About 75 percent of care is given by non-relatives, and about 25 percent is provided by relatives.[3]

Working parents in the United States use the following kinds of child care:

40.2% in another's home,
14.4% other arangements,
14.8% child care center,
30.6% in own home.[4]

In Minnesota, one expert estimates, one-third of children in child care are in licensed centers or homes, one-third are in unlicensed care and one-third are cared for by relatives.[5]

CHILD CARE IN MINNESOTA— AN OVERVIEW

The Need for Child Care Grows— The Supply Remains Constant or Declines

"While the need for more child care is growing rapidly, the present child care system is shrinking. Unless this trend is reversed, Minnesota will not have enough child care to meet the needs of working families with children." Thus begins the executive summary of *Making Child Care Work* the report of the Child Care Task Force of the Council on Children, Youth and Families to the 1987 Minnesota Legislature.[1]

Nearly half of mothers with children under one year are now in the labor force.

More Mothers Work

The number of working mothers continues to increase. The percentage of women working outside the home in Minnesota is the third highest in the United States. Two Twin Cities suburban areas, the Third and Sixth U.S. Congressional districts, have the highest percentage of families with two or more workers of all 435 Congressional districts.[2] The trend is not limited to the metropolitan area. The highest percentage of working women in Minnesota were in LeSueur, Olmstead, Dodge, Rice, and McLeod counties according to the 1980 census. The rate at which women join the labor force is expected to continue to increase through the year 2000.[3]

Between 1970 and 1980 the percentage of Minnesota mothers of preschoolers and school-age children working outside the home increased by 29 percent and 15 percent respectively. By 1980 half of the mothers of preschoolers and two-thirds of mothers of school-age children were in the labor force.[4]

Twenty-five percent of mothers in the workforce were the sole support of their families. By 1984, more than half of all mothers with children younger than six were working.[5]. Nearly half of mothers with children under

one year are now in the labor force.

Demand for Child Care Likely to Increase

The number of young children is increasing. Minnesota children under age six increased by 35,879, a 10 percent rate of growth, from 1980 to 1985. The number of Minnesota preschoolers is expected to continue to increase slightly between 1985 and 1990.[6]

The rise in the number of single-parent and dual-earner families also contributes to the need for more day care. The number of single-parent families in Minnesota increased by 85 percent between 1970 and 1980. By 1980, single parent families represented 14 percent of all Minnesota families with children under 18. 85 percent of these families were headed by women.[7]

Child care is also needed by many structurally unemployed parents who are undergoing training or retraining.

While some working women rely on informal arrangements with relatives and friends, 62 percent of working women with children under 6 reported that they needed to make child care arrangements in a 1977 survey.[8]

Child Care Openings Not Keeping Up With Demand

Child care has become an extensive business in Minnesota. More than 9600 licensed family day care providers and nearly 1000 licensed child care centers in Minnesota care for 147,000 children. Estimates are that 20,000 people are employed in direct child care services.[9]

While the demand for child care is increasing "the supply of safe, affordable, and quality child care is not." Available day care openings in Minnesota increased by 20 percent between 1980 and 1981, but the increase in 1982 was only seven percent. The growth rate slowed to three percent each year between 1982 and 1985. The number remained static in 1986.[10]

"In some part of this state, parents must take whatever they can get. . . because the supply of licensed care is very limited. And in other parts of the state, no licensed care is available at all."[11]

The shortage of child care is particularly severe for certain groups of children. There is a serious shortage of quality care available for infants and toddlers, school age children who need before and after school care (latchkey programs), sick children and children with special needs. Parents also have trouble finding care on a part-time basis (less than 40 hours a week nine to five). Parents who work nontraditional hours also have trouble finding care for their children.

Why the Shortage of Care?

First of all, the dramatic increase in the demand for day care would overwhelm the supply temporarily even if there were strong incentives for creating more day care. However, a number of factors make starting new day care programs or working in day care centers an unattractive proposition.

Potential Pool of Family Day Care Workers Shrinking

Many family day care providers care for children as a way to subsidize staying home with their own children until they reach school age, despite the relatively low pay. However, many women who would traditionally have provided family day care are themselves going directly into the work force while their children are preschoolers.

A recent article by David Allen of Resources for Child Caring, in St. Paul, published in the Citizen's League *Minnesota Journal* reports:

"In 1950, 14 women were potentially available to care for the children of every two women working outside the home. In 1990, the ratio of the potential pool shrinks from 14:2 to 1:2. As the demand for child care continues to increase, the traditional supply will continue to decrease."[12]

High Burnout and Turnover Rates

The rate of "burn out" and turnover among child care workers and providers is high. The U.S. Bureau of Labor Statistics reports that the national turnover of child care providers is comparable to that of gas pumpers and dishwashers. Almost 42 percent of all child care workers in centers left their jobs in 1980-81. Forty-three percent of all aides had less than one year's experience; 93 percent of all aides had less than five years experience. Eighty-five percent of all assistant teachers had less than five years experience, as did 69 percent of all head teachers.[13]

This high turnover is serious for child care because of the importance of continuity of care for young children. "Such a high turnover rate among a child's care providers can destroy the stable and continuous relationship a child needs from caregivers, negatively affecting the growth of a child's trust and independence, ability to cope with stress, and social and intellectual development."[14]

According to a report by the National Commission on Working Women, the high rate of staff turnover affects the entire industry. "Workers with education and training are siphoned off by other professions offering higher pay, better benefits, improved working conditions, and increased respect. This constant exodus of trained workers creates further stress for those who remain on the job."[15]

Low Pay and Poor Benefits

Low pay for both family day care providers and center workers is a major concern. Family day care providers and center-based child care workers are among the lowest 10 percent of all wage earners in the United States. Nor have the wages of family day care providers kept pace with the increased cost of living. According to one estimate, a family day care providers with a full complement of children would only make $11,000 per year *before expenses.*[16]

Two out of every three center-based caregivers earn below poverty level wages.

The Children's Defense Fund estimates that two out of every three center-based caregivers earn below poverty-level wages, regardless of their experience, training, or education.[17] According to statistics from the Child Care Workers Alliance, the average head teacher in a child care center has a college degree and makes $10,600 a year for full time work. Aides make an average of $7,600 annually. In addition benefits are often inadequate.

"•8 out of 10 child care givers *do not* receive even partial health care benefits.
•5 out of 10 *do not* have paid holidays.
•6 out of 10 *do not* have paid vacations.
•6 out of 10 *do not* have sick day benefits.[18]"

Wages are lowest at forprofit day care centers, although directors sometimes draw high salaries.

In effect, child care advocates argue, child care workers subsidize the child care system. If child care workers were paid on a scale comparable to public school teachers, the costs passed on to parents would be vastly greater. David Allen, in the *Minnesota Journal* article, reports, "Approximately $350,000,000 is paid out each year in Minnesota for child care services. Any attempt to assign comparable worth would easily value the services at half again or double that amount."[19]

Poor Self Esteem

The perception that family day care workers are babysitters and the problem of low pay and low status for a job society considers "women's work" contributes to this poor self image.

"In spite of strong contradictory evidence, the myths still remain that child care providers need no formal training; that providers are babysitters who love children or kindly grandmothers with time on their hands; and that caring for children is a job that requires few skills and comes naturally to most women. Even directors of child care centers are considered by some not to need special education or training."[20]

The Commission on Working Women attests, "In reality, child care providers are women and men who are required to have endless energy, creativity, patience, and skill; who work long hours in stressful conditions for pay that is often below minimum wage. They are faced with trade-offs between setting fees parents can afford, quality child care, and their own need for a living wage."[21]

Rising Liability Insurance Rates

Rising liability insurance rates are another deterrent to entering and continuing in the day care business. Child care centers in Minnesota report rises of 300 percent in liability insurance in the last few years. In a field with marginal profits at best, increased insurance rates make ventures even less financially attractive. A spokesperson for the Kiddy Karousel Child Care Center in Hibbing testified, at a child care hearing held by the lieutenant governor and the Minnesota Council on Children, Youth and Families, that their center's insurance had risen from $400 to $1,000 from one year to the next although they had never had a claim. A family day care provider reported that State Farm Insurance Company had raised the rates on the rider to cover a family day care home from $12.00 to $100.00 per year.[22]

Licensing Requirements

The costs and inconvenience of meeting licensing requirements and fire regulations are also cited as disincentives. Family day caregivers report spending from $300 to more than $3,000 to comply with requirements from the fire marshal, frequently involving fire doors between the garage and house and enlarging basement windows.

Centers for Low Income Children

Particular financial problems exist for centers where many children receive subsidized care. The limited sliding fee monies distributed by counties don't guarantee continued support for child care for all children. If a county exhausts its funds, subsidized children are forced to drop out. A current freeze on subsidies by Hennepin County, for instance, has greatly affected centers in Minneapolis. This pattern may also affect staff morale and tenure, because these centers also often lack funds for training and additional support. Staff may be forced to spend much time fundraising. Centers located in the inner city in Minneapolis and St. Paul have trouble attracting parents able to pay the full fee.

While counties must pay the median child care fees for children who are subsidized, and can go as high as 125 percent of the median fee level, this is not always sufficient to pay for high quality programs, unless the program is otherwise subsidized.

This is particularly serious since a number of low income children are referred to centers precisely because of special needs which make quality care particularly important. Hennepin County, for instance, funds care for children 1) if they have mild or moderate delays either developmentally or in social/emotional development, 2) if child care would facilitate the case plan of a parent, i.e., if the parent is in drug treatment or 3) if child pro-

tection believes child care would relieve stress in the home, possibly preventing out-of-home placement.

Greater Minneapolis Day Care Association (GMDCA) and the Child Care Resource Center on the Southside are working with a consortium of 14 inner city programs to help access foundation monies.

How Much Does Day Care Cost?

Although the wages of many day care workers and providers are very low, the cost of day care looms large for many working families. As the following table shows, costs are considerably higher for infant and toddler care.

Median Weekly Rates for Licensed Day Care in Minnesota, 1985

	Metro Area	Greater Minnesota City and Environs	Rural Minnesota
Preschool			
family day care	$55	$55	$45
center	66	55	47
Toddler			
family day care	$60	$55	$45
center	75	65	47.50
Infant			
family day care	$60	$56.25	$45
center	92	70	51.75

Source: Department of Human Services Survey of Day Care Providers, December 1985.

Unlicensed Family Day Care Ordinarily Costs Less

There is wide variation in the cost of before and/or after school (latchkey) care for school age children. Fees in the Minneapolis Public School Program, staffed by union members, are $67 monthly for before-school care; $67 monthly for after-school care ($134 if both are needed) and $102 monthly for the half-day that kindergartners are not in class. The St. Paul Public School program costs $24 weekly for afterschool care, $21 weekly for before school care. Care for kindergarteners costs $32.50 per week. The Edina Kids Club, however, costs $30 weekly, and $50 for kindergartners.[23]

Care for children who are ill costs much more. In-home sick care in the metro area ranges from $3.75 to $11.50 per hour for the mildest illnesses; the average is $9.00. Chicken Soup, a sick care center in Minneapolis, charges $35 per day, although there is a sliding fee scale. This is a heavily subsidized center.[24]

The cost of day care is so high that a single woman working full time even above the minimum wage often cannot afford to pay for care for two children and may be forced to stay on AFDC. Jeanne Raffesberger, quoted in an article in the *Minneapolis Star and Tribune,* found that, without some kind of subsidy, she simply could not afford to take a job. The job she was offered, at $6 an hour, would have provided no medical benefits or sick leave and with her day care expenses ($430 a month) she would not have cleared enough to pay the rent.[25]

High quality care also often costs more than the median rate. Although the most expensive day care centers are not necessarily those of highest quality, centers with a high quality program must ordinarily charge more than the minimum, unless heavily subsidized. A strong program means more expenses for equipment and supplies and higher pay and benefits for well trained staff to help ensure low staff turnover.

Who Pays for Child Care?

"The vast majority of fees paid, 80 to 90 percent, come from parents. Government is a minor partner, and employers pay less than one-half of one percent of the bill."[26]

A number of centers are subsidized in part by low fees or inkind contributions from schools, churches and other organizations. The National Council of Churches reports that up to 70 percent of all child care centers in the United States are in church buildings. Half of these programs receive free space, which involves multi-million dollar subsidies by congregations.[27]

United Way and the private sector also help support day care. In 1986 the Minneapolis United Way contributed $1,100,000 to child care in Hennepin County.

There are tremendous costs to poor quality care, some of which we won't see for 10-20 years.

Ensuring High Quality Child Care

Although protection from physical harm is the first priority in child care, there is widespread agreement that more than purely custodial care is necessary if children are to flourish and develop optimally.

Definitions of what constitutes high quality in child care vary, but experts on child development agree that certain determinants of care are necessary for good care:

"1. The size of the group of children
2. The ratio of adults to children
3. Caregiver qualifications
4. Planned program
5. Physical environment
6. Parent involvement."[28]

Shirley Moore, professor of child psychology, Institute of Child Development, University of Minnesota, stresses that studies of the effects of day care on young children report very different findings, due to varying quality of the programs.[29]

In addition to the objective criteria noted above, Moore states, "Centers rated high in quality appear to have children who are more contented, are more often occupied, have more time to talk with adults, and experience fewer directives, controlling statements and negative exchanges."[30]

Moore stresses, "Poor-quality environments do not adequately support the development of the children enrolled. Children who are already at risk for family stress, and then enroll in poor quality child-care environments, are quite possibly at serious risk."[31]

"There are tremendous costs to poor quality care," says David Allen of Resources for Child Caring, "some of which we won't see for 10-20 years, but the research on early childhood programs indicates that for each dollar we spend now to ensure that low income kids are in quality care we may save several dollars in the long run from reduced correctional, health, education and welfare services."[32]

Setting Higher Standards

One way to improve quality and help parents assess the quality of child care facilities is through an accreditation process which would recognize centers of high quality.

The report of the Child Care Task Force of the Council on Children, Youth and Families to the 1987 Minnesota Legislature recommends that the state allow "the establishment of differential payment schedules through its sliding-fee program that will recognize and reward child-care providers who have invested in education and/or training."[33]

However, some caution that differentiating between ordinary and high quality providers may cause the development of a two-tier system; a high quality system for middle class children and a lower quality system for poor children whose care is subsidized by public monies.

The Bush Foundation recently approved a two year grant of $144,000 for Resources for Child Caring to implement a new accreditation system for early childhood programs in Minnesota.

The National Academy of Early Childhood Programs, a division of the National Association for the Education of Young Children, grants accreditation to child care centers and early childhood programs that meet the highest standards of quality. Minnesota has the highest percentage of programs in the accreditation process of any state; more than 50 programs are now candidates for accreditation. A number of programs have already received accreditation.

THE ROLE OF GOVERNMENT

Public policy is key to the child care system. Funding and tax policies at the federal, state and county level are crucial to the adequacy and quality of the child care network and to parents' ability to afford care. Licensing requirements ensure minimal safety and health standards for child care facilities.

Public Funding

Public funding can support child care in two ways. First, public dollars may help communities develop and expand child care programs, through training, start up costs, and technical assistance. Second, public funds can subsidize care for individual children. Before 1981 most dollars for subsidies came from federal funds; states directed their child care dollars at developing facilities. Since the decline of federal subsidy dollars, however, Minnesota has shifted its child care support to subsidies, leaving little for helping providers and centers create new places and ensure quality.

The Federal Role

Title XX Funds

The major direct source of federal funding for child care comes through Title XX Social Services block grants.

Beginning in the 1960s child care was subsidized through Title IVA of the Social Security Act; in 1975 Title XX became the vehicle for funding child care for low income families. Before 1981 Title XX almost completely subsidized child care for children in families with incomes below 60 percent of state median income, including AFDC recipients. Since 1981, however, child care support must compete with all other social programs for children and adults for more limited federal dollars at the county level. Title XX was cut 21 percent in 1981 and subsequent appropriations have failed to keep pace with inflation. Minnesota received $48,263,400 in Title XX Block Grant Funds in fiscal year 1986; in fiscal 1987 Minnesota received $45,341,000.

Although counties may still use Title XX dollars for child care to non-AFDC recipients, they ordinarily apply them to AFDC recipients because the county saves money if these families become self sufficient.

Increasingly, state funds for the sliding fee program and local county dollars must bridge the gap.

Federal Child Care Food Program

More than 7000 family day care providers (81 percent of all licensed day care homes) and 330 child care centers (36 percent of the 900 licensed centers in Minnesota) participated in the Child Care Food Program of the U.S. Department of Agriculture in September 1986. The program reimburses each family day care provider an average of $185.00 per month, compared to the average $260.00 which providers spend per month for food for children in care. The food program was cut back in 1981 when a second snack was eliminated.[1]

Only licensed providers are eligible for the program.

A recent survey of family day care providers showed

great enthusiasm for the program which includes nutritional information and training for providers as well as money for food. Considerable paperwork is involved, however, since daily menus meeting USDA requirements and weekly reports must be completed.

The food program is more readily accessible to family child care than to child care centers; all family day care providers who complete the paperwork may participate in the program. All children in family day care are eligible. Child care centers, however, must demonstrate that 25 percent of the children they serve have family incomes eligible for Title XX funding and only food for those children is subsidized.

Federal Tax Policies Help Child Care

Dependent Care Tax Credit

The largest source of government support for child care is the dependent care tax credit on the federal income tax, used by 7.6 million families in 1984. Under this provision, parents may claim up to $2,400 for the cost of care of one child and $4,800 for two or more children. Tax credits range from $480 to $720 for one child and from $960 to $1,440 for two or more children from 20 to 30 percent of the claim, depending on income. In 1984 Minnesotans paid $36,000,000 less in federal taxes because of this credit.

The federal tax credit does not help all low income families. Although the tax credit is based on a sliding scale, there is no income cap and the rate is not sharply progressive. Moreover the credit is not "refundable." If low income parents pay for child care, their tax liability before the credit may be so low that they get little or no relief. This will be even more true after the 1986 federal tax reform since more poor families will have no income tax obligation. Very poor parents who cannot afford child care are not helped by the tax credit at all.

Salary Reduction Flexible Benefit Plan

An IRS regulation which helps to finance child care is the approval of the salary reduction flexible benefit plan whereby employers enable employees to pay for child care, up to $5,000, with pre-tax dollars instead of claiming the federal tax credit. Middle and upper income parents can save several hundred dollars a year. The plan does not benefit low income employees who would be better off claiming the federal tax credit.

Other Federal Programs Supporting Child Care

Earnings Disregard

AFDC recipients in the workforce qualify for an "earnings disregard" allowing families to spend $160 ($200 until 1981) of earned income per month for child care without reducing the family's AFDC grant. However, this support is inadequate to cover the entire child care cost.

Job Training Partnership Act

The Job Training Partnership Act (JTPA), a federal program for on-the-job training for income eligible people, includes child care for participants.

Community Development Block Grants

Federal Community Development Block Grants (CDBG) to cities are also a source of limited child care monies. (CDGB grants have a 10 percent limit for all social service funding.) Some municipalities allocate CDBG funding to child care in the form of provider support services and parent assistance funds. Minneapolis, for example, spent $683,809 on child care in 1986 while twelve suburban Hennepin County cities allocated $128,863 to child care. However, CDBG money is declining very rapidly.

A small federal grant addressed child care needs in Minnesota by allocating $40,000 for resource and referral systems in three counties and $32,000 for addressing the needs of care for school age children.

Child Care Funding for Post-Secondary Students

Limited Federal Student Financial Aid funds are available for child care costs for students, including AFDC recipients, attending postsecondary institutions, including AVTIs, community colleges and four year institutions. Some money goes directly to the institution. Other federal funding, from the AFDC Special Needs category, is also becoming available.

Federal AFDC Special Needs Appropriations were originally considered only as an emergency fund for AFDC families (for costs such as replacing a refrigerator or paying a utility bill to prevent a shut off). However, federal policy within the last two years has permitted the use of funds for expenses related to job search, training or education including child care. Funds cannot be used for child care when the parent works, however.

Special Needs AFDC funds are an open appropriation; the federal government will "match"as much in funds as the state is willing to commit.

In an effort to maximize available federal funds for child care and help move families off public assistance through training, Governor Perpich and his budget planning staff see AFDC Special Needs funds as an important potential source. They will attempt to provide state funds for every eligible recipient to maximize federal dollars.

An estimated 5,600 AFDC students are currently enrolled in postsecondary training statewide. Some use federal dollars to help subsidize child care now; some use funds the institution provides as part of their scholarship fund; some of them use county sliding fee or other available monies.

Minnesota Support for Child Care

The Minnesota Child Care Facilities Act, in effect from 1971 to 1979, was considered model child care legislation. Funded in 1971 with an appropriation of $250,000, by 1979 the act appropriated more than $2,000,000 for child care programs. It allocated matching state funding to counties to expand and improve the supply and quality of child care. Funds were used to meet the costs of licensing improvements, to enable new providers to get started, for training and for resource and support for child care providers.

However, this program ended in 1980 when Minnesota adopted the Community Social Service Act providing for social service block grants to counties and ending many appropriations for specific programs. With the exception of a pilot Child Care Sliding Fee Program, child care was folded into the block grant with all other social services.

If Minnesota lost some of the advantages of a model child care program with the end of the Child Care Facilities Act, however, it has recently made a considerable commitment to child care through the child care sliding fee program.

The Child Care Sliding Fee Program is the primary state source of child care funding in Minnesota.

Child Care Sliding Fee Program

The Child Care Sliding Fee Program is the primary state source of child care funding in Minnesota. 10,568 families with 16,265 children were helped by sliding fee funds in 1986. Before its establishment as a pilot program in 1979, sliding fee child care programs were only available in Minneapolis, Duluth and Rochester.[2]

Funding for the program has significantly increased over the last few years, from $3.1 million in the 1983-1984 biennium to $10 million for 1986-87. Only 27 counties participated in 1984; all 87 Minnesota counties were mandated to participate in 1986. Eighty-two actually participated.

Counties must provide a 15 percent match for sliding fee funds, which may come from Social Service block grant monies, federal dollars, or local tax levies. A number of counties contribute a higher percentage. In fiscal 1986, Ramsey County received $544,277 in state sliding fee scale monies, and appropriated an additional $1,611,889 to serve 1,435 families. Hennepin County received $915,989 and appropriated an additional $4,775,730 serving 3,182 families. Olmsted County, including Rochester, got $84,911 in state monies and spent an additional $327,054 to serve 309 families.[3]

Counties may use sliding fee funds to subsidize care for children from families receiving AFDC, for children from families eligible to receive AFDC but not collecting it, and for children whose families earn too much to qualify for AFDC but less than 75 percent of the state median income. Originally the program was targeted primarily to families above the cutoff for Title XX funds (60 percent of the state median income.) Since the reduction of federal Title XX funds in 1981, however, many counties use the sliding fee scale monies for children of AFDC recipients. In 1986, 39 percent of the families served by the sliding scale fee program were on AFDC; 61 percent were not.

The child care sliding fee is indexed to a family's ability to pay. More than 90 percent of the families on sliding fee scale are single parents. In fiscal 1986, the average spent per family was $1,545 or $1,018 per child. (This figure may be somewhat low because some counties only began to use the program partway through the year.)[4]

Substantial increases in funding are necessary to serve the 2,658 families in 43 counties now on waiting lists for sliding fee scale funds. An estimated $29,176,911 state dollars would be required for the 1988-89 biennium to provide child care subsidies to families now receiving child care assistance and those on the waiting lists as of October 1986. Nor do the waiting lists accurately reflect all those wanting the service. Many counties do not maintain waiting lists or have closed them.[5]

Minnesota Child Care Tax Credit

Minnesota's Child Care Tax Credit differs from the federal tax credit. First, it is targeted specifically to help low income working parents with child care costs; it is only available to families with incomes under $24,000. Secondly, it is "refundable" which means the claimant gets the credit regardless of whether she owes any taxes. Residents with incomes below $24,000 are eligible for a credit of up to 30 percent of their child care expenses to a maximum of $720 for one child and $1440 for two or more children. The maximum credit declines as income increases above $10,000, so that at $23,800 the allowable credit is only $10. Projections are that 48,000 people will save $22,000,000 through the Minnesota tax credit in the 1986-87 biennium.

The Minnesota Child Care Tax Credit was the only source of assistance for many families in counties which did not participate in the sliding fee program until 1986 and for families who would have met income guidelines for sliding fee support but for whom there were no funds. The tax credit is also the only source of government assistance for families whose children are in unlicensed care.

Other State Programs

The Minnesota Emergency Employment Development Act (MEED), which subsidizes portions of salaries of those hired by private employers, pays for child care for enrollees until they qualify for other funding sources or for six months, whichever comes first. (The MEED pro-

gram may not be renewed by the 1987 Legislature.)

Higher Education and Training

Ten percent of parents using sliding fee scale subsidies are students. Students may only use sliding fee dollars for two years. Counties ordinarily do not permit the use of sliding scale funds in four year institutions.

Governor Perpich proposes a new source of child care support to be coordinated through the Higher Education Coordinating Board for the next biennium. $10,600,000 of state funds would be allocated. He hopes to access up to $6,360,000 in federal funds for AFDC recipients.

State institutions have had some discretionary money (from student activity fees, etc.) to use for child care subsidy. A few state institutions and AVTIs have opened on-site child care programs, especially important because of the part-time nature of students' hours, and the difficulty of arranging part-time care in the community since providers prefer full-time children to fill their openings.

At the County Level

Counties support child care through a combination of federal, state and local funds. State sliding fee dollars accounted for 23 percent of all child care assistance funds spent by counties in fiscal year 1986 (July 1985-June 1986) and 30 percent of all county child care assistance funds in fiscal year 1987. Federal and state block grants, other programs and local monies made up the remainder. Counties are not able to furnish a breakdown of the exact amount from each source, but total expenditures by counties for child care from all sources other than the sliding fee funds totaled $12,675,867 in fiscal 1986; comparable expenditures for fiscal 1987 are estimated at $13,000,000.[6]

Expenditures by counties in fiscal 1987 did not increase appreciably over the previous year, due in part to declining federal dollars. Some counties experienced economic difficulties and had fewer local tax dollars to spend on child care, or other social services. Counties contend that if increased public support for child care is desirable, it must come from state rather than county monies.

Counties vary widely in their allocations for child care, partly due to differences in resources and to the priority accorded child care by the county board. Hennepin County passed a $6.6 million child care budget in October 1986, including an allocation of $870,000 to serve an average of 250 high risk and special needs children. In 1987 Hennepin plans to budget $200,000 in grants to eleven centers to add staff to help support high risk, special needs children. Hennepin has been lauded for its support of child care. However, there are approximately 1,000 Hennepin County families, representing 1,500 children, on a waiting list for day care assistance.[7]

Licensing

Family day care providers are licensed by county human services inspectors; day care centers are licensed by state licensors.

The licensing of child care programs cannot guarantee quality but "it does ensure that supervision is adequate, that centers and homes are safe and have adequate space, and that child-care providers have the needed qualifications to care for children."[8] Minnesota established the first standards for day care in 1956.

There is widespread agreement among most providers and experts that licensing for both family day care homes and day care centers is desirable, although some states have only a "registration" system for family day care. There is disagreement, however, on how stringent standards should be and on exactly what aspects of child care should be addressed through licensing. Currently, efforts are being made to reconcile the concerns of the state on the one hand, that standards be strict enough to ensure health and safety and address the developmental needs of children, and, on the other, the concerns of providers that regulations not be vague, burdensome or costly to fulfill.

Effective licensing means reasonable and clear standards, consistent enforcement, and supports and incentives for those licensed.[9] The present Minnesota system is criticised because licensors are often so overworked that they have time only to look for infringements and not to provide technical assistance and support.

The Minnesota Public Welfare Licensing Act provides for licensing of out-of-home care for adults and children in Minnesota, except for programs located in public schools and Montessori schools which are currently exempt. (The Department of Education is developing standards for school age children care, which will be comparable to Department of Human Services standards. It is anticipated that the exception for Montessori Schools will be removed in the 1987 Licensing Act.) A new draft of the Licensing Act is being prepared for the 1987 Legislature. Specific regulations governing family day care providers are contained in Rule 2; requirements for child care centers are listed in Rule 3. Both rules contain numerous specifications including a square footage requirement for each child, staff qualifications and training, ratios of staff to children, and special provisions for infants, birth to 12 months; and toddlers, 12 to 30 months.

Rule 2, governing family day care, was substantially revised in 1984-85. A major objective of the revision on the part of the Department of Human Services was to clarify vague language and to ensure comparable standards throughout the state. Another objective was to modernize the rule; a particularly serious gap was the absence of safeguards against child abuse. The department worked with an advisory committee and hearings were held. However, because of widespread opposition by day care providers, a new revision of Rule 2 was developed and circulated in 1986. Providers consider the new provisions "liberalized;" the Department of Human Services regards them as "watered down."

There were a number of changes between the drafts. Providers are no longer required to carry liability insurance, so long as parents are notified. More latitude is given in the ratios of infants and toddlers. Providers are given more discretion to define their policies for sick children. In addition, a section on "child development program" was amended; a list of necessary equipment was completely eliminated.

Rule 2 includes prohibitions against corporal punishment, limits on the time children may be isolated for disciplinary reasons, standards for indoor and outdoor play, and attention to the developmental and emotional needs of children. Training required for family day care providers includes six hours of first aid and CPR and six hours of training in child care and child development during the first year of operation and six hours of ongoing training each year in areas related to child care and child development. The new language reflects the concern about potential child abuse and disqualifies persons with a problem history.[10]

Although many day care providers are satisfied with the more recent version, it was challenged in court by family day care providers in Dakota County on the grounds that DHS had failed to comply with the requirements of the hearing process. The Minnesota Court of Appeals ruled in favor of the providers; the rule is in effect, however, pending action by the State Supreme Court.

Rule 3, governing day care centers, is currently being revised. Public hearings are scheduled for fall 1987. Two of the issues being closely examined are care for sick children and drop in care. Currently Rule 3 contains more specifics about physical requirements and also specifies more training and/or experience for staff than Rule 2. Teachers may qualify through various combinations of training and/or experience. Teachers must have degrees in child development or nursery kindergarten education, be certified by the Department of Education for nursery school or have training and/or experience and certification in a child development assistance program.[11]

Policymakers revising Rule 3 rejected a point system to rate centers. However, a plan which would set basic standards for education and training, but would also establish "advanced" or "model" standards, is being considered. Providers meeting the higher standards would be recognized by the state for their achievement.

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In addition to revising specific licensing provisions, the state attempted to meet concerns of day care providers through the 1986 Child Care Services Act. A task force was established to develop recommendations on licensing and safety standards and other issues affecting the availability of child care. The act required the Department of Human Services to summarize day care rules in language understandable to the general public and to provide a summary to all licensed providers. An information service to interpret the rules was mandated. Several provisions will "sunset" in July 1987 unless explicitly readopted by the Legislature: required expenditures of family day care providers to meet fire safety regulations were limited to no more than $100; conditional and restricted licenses were established for providers; a standard of "substantial," rather than "full or absolute," compliance, was established.

A particular concern to providers, still to be resolved, is the question of whether state licensing specifications, as approved by the state fire marshal, have priority over more stringent local requirements. Family day care providers report having to make expensive alterations to comply with local directives.

Technically, it is a misdemeanor under Minnesota law to operate an unlicensed family day care home, serving the children of more than one family who are not related to the provider. However, in fact, sanctions are almost never enforced against unlicensed family day care providers. If an unlicensed provider is reported to the county, a letter is sent notifying them that they are operating illegally and asking them to initiate licensure within 30 days. If there is no response, the provider is referred to the county attorney. However, since illegal day care homes are not assigned a high priority by most county attorneys, they are rarely prosecuted. Access to several programs provides incentives to family day care givers to become licensed. The Child Care Food Program and information and referral services are only available to licensed care givers. Title XX and state sliding fee monies can only be used in licensed programs.

IMPORTANT ISSUES AND UNMET NEEDS

Infant and Toddler Care

There is a serious shortage of child care for infants and toddlers in Minnesota.

A particular deterrent to providing more care for infants and toddlers is the required ratio of children to staff; there must be 1 adult for every 4 infants and 1 adult for every 7 toddlers. This high staff to child ratio means less compensation for the provider than for preschoolers, since the somewhat higher rates charged do not reflect the actual costs.

63 percent of Minnesota counties reported a shortage of infant care in a recent survey.[1] According to Child

Care WORKS, fewer than half of the parents who contact referral agencies are able to find satisfactory infant care.[2] Many family day care providers report receiving at least one call a week for infant care.[3]

The kind of infant day care available is not always what parents prefer.

"With more mothers going back to work only weeks after their babies are born, the problem is not expected to ease, day care officials say. Women are returning to work earlier, often out of economic necessity or because they are afraid to lose their jobs in companies that have no parenting leave policies."[4]

This shortage poses a particular obstacle to teenage mothers who are trying to finish their education. Ninety-five young mothers and babies were on the waiting list for places in the Mother and Infant Continuing Education (MICE) programs in the Minneapolis Public Schools in September 1985.[5]

"There should be choice out there," said Tom Copeland, director of consumer services for Resources for Child Caring, Inc. "We're finding more and more that there is little choice for many parents in many neighborhoods. In the last two years it has gotten significantly worse for infant care."[6]

Moreover, the kind of infant day care available is not always what parents prefer. Although for profit day care chains are opening infant and toddler care, most parents prefer family day care in a small setting. This is almost impossible to find according to Zoe Nicholie, of the Greater Minneapolis Day Care Association.[7]

A particular worry for infants and toddlers is concern about transmission of communicable disease in child care centers and regular group homes. According to the Journal of Pediatrics in 1984, infants and toddlers have "behaviorable characteristics that increase the risk of disease transmission. . . For these reasons. . . centers that care for infants and toddlers seem likely to be at greatest risk for transmission of infectious agents."[8]

Increasing Infant Care Options

Child Care Resource & Referral used a federal grant to establish a new model for infant care in the Rochester area in 1984. Individuals were trained to provide care in a shared care setting for a maximum of three infants of two or more families in one of the parents' homes. Parents share costs and benefits and provide somewhat better compensation to the caregiver. Nine base homes, with 18 infants, were operating by August 1985; five shared care homes continued beyond the funding period.[9]

Both caregivers and parents expressed satisfaction with the program. Infants in the project appeared to be ill less often than those in licensed family day care, unlicensed care, and child care centers.[10]

The Greater Minneapolis Day Care Association, assisted by a two year grant from the Bush and Gamble Skogmo Foundations, is attempting to improve the quality and availability of care for infants and toddlers through 1) metro-wide training, and 2) recruitment efforts in Hennepin County.

They are exploring a shared care model as well as expanded care for two babies, one of whom is the provider's child, the legal but unlicensed arrangement. GMDCA is also developing a handbook for parents and caregivers.

GMDCA is also using $50,000 in federal CDBG funds to help start family day care homes near Minneapolis high schools for the children of young student mothers.

Parental Leave

In Minnesota no law governs parental leave or disability leave for pregnancy.

A partial solution to the problem of infant care would be to expand parental leave policy, particularly since some experts now stress the benefits of parents staying with the baby when it is very young to established early bonding.[11]

"The U.S. is the only industrialized country in the world that does not provide some form of guaranteed maternity leave. More than 100 countries provide mothers with a paid maternity leave and job protection." Canada, for instance, includes maternity benefits in its unemployment coverage with up to 15 weeks of leave paid at 60 percent of salary. An additional 22 weeks of unpaid leave are available.[12]

No federal law currently requires employers to provide maternity or disability benefits, but five states require disability benefits for childbirth. Four states offer a specific job protection to female employees who have babies. In Minnesota no law governs parental leave or disability leave for pregnancy.

Most American employers do not provide extensive parenting leave. A 1984 Columbia University study found that 60 percent of working women had no paid maternity leave. Although larger companies tend to have more generous benefit policies than smaller ones, few of the Fortune 500 companies offered paid leave for new parents, except for disability leave granted to women for childbirth.[13]

Most companies offer paid leave only through the use of accrued vacation time.

More than half of the Fortune 500 companies give female employees some unpaid leave and more than one-third give males some leave time.

The pending Parental and Medical Leave Act, sponsored by Rep. Patricia Schroeder, (D. Co.) and Senator Christopher Dodd (D. Cn.), would provide workers up

to 18 weeks of unpaid, job-guaranteed leave for the care of a newborn, newly adopted, seriously ill child or dependent parent. It applies to employers with 15 or more employees.

Care for Sick Children

Regular child care is effectively closed to sick children. Licensed day care centers are prohibited by law from caring for sick children. Family day caregivers are allowed, but not required, to care for sick children under existing licensing regulations. Usually, family day care providers ask parents not to bring a child who is sick. Public schools provide no regular sick care services.

The alternatives are often for a parent to stay home with the sick child, to arrange for an in-home sick child care provider or to take the child to a sick care center, of which there are very few. A national survey reported that 2/3 of working mothers stayed home 1-5 days a year because of illnesses of their children; 17 percent stayed out 6-10 days and 5 percent stayed out for more than 10 days.[14]

There are wide variations in sick leave policy among employers. Some company policies permit parents to use sick days for children's illnesses. However, a number of companies refuse to permit the use of employees' sick days to care for a sick child. 68 percent of working mothers in the survey used their own sick or vacation days; only six percent had a "sick family day" allotment to use. 27 percent lost pay and 12 percent made up the time later.[15]

Services for Children Who Are Sick

The high average cost for in-home sick care services, $9.00 an hour, put them out of reach for all but highly paid workers.

Some special services have been developed for sick children. In Willmar, for instance, the pediatrics department of Rice Memorial Hospital provides care for children who are mildly ill. The service sends care providers, screened by the hospital and generally licensed practical nurses, to children's homes and can make them available in 45 minutes. Charges, on a sliding scale, range from $1 to $4 per hour, according to income. The service is subsidized by the Community Action Agency, Willmar United Way and other local foundations and businesses.

Chicken Soup, in Minneapolis, is a licensed day care center for moderately ill children. The center is subsidized by corporations and foundations and the United Way. Rates are $35 for a full day, $25 for a half day, although there is a sliding scale. The staff to child ratio is 1:4.

Sniffles Medical Day Care in Eagan, is a family day care home for sick children. Their ratio is 1:3.

Fourteen churches in south and southwest Minneapolis established the Trust Sick Child Care Service which gives parents names of trained caregivers. Charges range from $4 to $6 per hour, depending on the parents' income. Foundation grants help underwrite the program.

Before and After School (Latchkey) Care

In addition to child care for preschoolers, it is necessary to provide programming after, and sometimes before, school for many elementary aged children whose parents work. Called "latchkey" programs after the keys carried or worn around the neck by children who must let themselves into their homes alone after school, these programs are currently inadequate.

A survey by the U.S. Census Bureau in December 1984 found that, of the nation's 29 million children 5 to 13, only 1 child in 14 overall, and 1 in 7 when the mother worked fulltime, were regularly left unsupervised for any length of time. Even in families where mothers worked full time, the survey found that the proportion of latchkey children was only 13 percent in two-parent families and 15 percent in female-headed families.[16]

However, a recent study by Diane Hedin and associates of the University of Minnesota's Center for Youth Development and Research reports rates of children home without adult supervision "from two to 10 times higher" than other studies. The study concludes that about half of the children in grades K-3 and about two-thirds of fourth through sixth graders are home alone or with older siblings after school. The study was based on a sample of 1,212 parents of students in grades kindergarten through eighth and 1,281 students in grades fourth through eighth in Burnsville, Edina and Minneapolis.[17]

Hedin believes other studies may underestimate the number of unsupervised children because they relied on parents' reporting and "parents tend to underreport how much time their children actually are on their own, out of guilt or embarrassment." The Minnesota study is the only large latchkey study to survey children directly. There is also a higher rate of women employed in the Twin Cities metro area than in "any other metropolitan area in the country."[18]

Sheila Moriarty, executive director of the Minnesota Council on Children, Youth and Families, reports that children in rural areas are more likely to be left alone for longer periods. School superintendents in communities such as Mora and Braham have reported that many children in their schools are on their own from the time their parents leave at dawn until they return in early evening from commuting an hour and a half or more to and from jobs in the Twin Cities.[19]

Some Older Unsupervised Children Do Well

Not all children whose parents are not at home after school, at least grade four and above, *need* a formal latchkey program.

Hedin's study found substantial consensus on the age when children could be left at home on their own. Both parents and children agreed that 9½ year old children could be left for less than two hours. Parents agreed that children at 11½ could be left for more than two hours; children thought that children could be left on their own at 10½ or 11.[20]

The Minnesota study found that a strong majority of fourth- through eighth-graders like being home alone. However, fifty percent of "the lowest-income, minority, urban elementary children from single-parent families. . . said they did not like being home alone." They feared that someone would break into the home and rob or hurt them. This was particularly true of girls.[21]

Studies in other parts of the country show that many children do not appear to suffer without adult supervision. A study in Austin, Texas, concluded that there were no differences in the parents', the peers' or the children's own ratings on academic or social or general achievement, between children who went home to mother and those who were unsupervised.[22]

Laurence Steinberg of the University of Wisconsin found that children who went home to an empty house after school were only slightly more susceptible to peer pressure for antisocial behavior than children who went home to a parent.[23]

Programs in Minnesota

Many programs shut down in the summer just when children of working parents have the most time on their hands.

"More than 9,000 school age children, generally from ages five to 12, are. . . enrolled in extended day or "latch key" programs in Minnesota," according to a survey conducted by the School Age Child Care Initiative of the Minnesota Department of Education in November 1986. 6,500 of the 9,000 attend programs housed in public school buildings. This represents a marked increase in before- and after-school programs for school age children in Minnesota.

The survey was made possible by a federal grant of $32,000, which will also finance the preparation of a manual on latchkey services and workshops on establishing latchkey programs. The survey was sent to school districts, nonpublic schools and licensed day care centers.[24] (Family day care providers were not included)

But, according to Mary Jo Richardson, Initiative Co-director, "There are still many unmet needs in school-age child care. . . Many programs shut down in the summer just when children of working parents have the most time on their hands, and many areas in the state have very few programs available."[25]

Many parents report allowing their children to go home unsupervised because they can't find child care, or if they can, they can't afford it, according to an article in the *St. Paul Pioneer Press and Dispatch.*[26]

Several obstacles hamper the development of more programs. Problems cited most often in the Department of Education survey were "space," and "finances." "Marketing difficulties" were also listed as a problem by private centers.

Another substantial barrier to more and bigger programs is the difficulty of finding and retaining qualified staff because of low salaries and lack of benefits. The average hourly wage for child care "teachers" at public school sites is $6.15 per hour; hourly wages in private/non public schools and private centers are $5.87 and $5.57 respectively. (In contrast, the hourly rate paid teachers in the Minneapolis Public Schools is $16.56.)[27]

Transportation is also a problem for before and after school programs. Some families must pay an additional fee. Legislation has been introduced in the 1987 session allowing parents to list the child care location as a residence so that children may be transported to child care after school at no additional cost to parents.

Programs Use Variety of Models

In many communities the public schools, frequently though the Community Education Department, administer latchkey programs. "Minnesota is unique in the country with community education taking the lead in setting up school-based extended day programs," said Catherine Cuddeback, co-director of the School Age Child Care Initiative.[28]

The Minneapolis Community Education program illustrates some of the difficulties schools face in providing latchkey programs. In 1973 the Community Education Department of the Minneapolis Public Schools launched the School Age Child Care Program with federal, state and private funding. In 1981, the program served 1900 students, at 22 school sites, with various combinations of before school, after school, the "other half" day for kindergarteners, school release day and summer programming.

Since 1982, however, cutbacks from all funding sources, coupled with inflation, made it necessary to end the sliding scale fee program and to rely entirely on parent fees. In the 1986-87 school year, twelve sites will serve only 650 children and few of these will be low-income students. Since each site must now be self supporting a substantial pool of parents is required to keep it open; centers in poorer parts of the city were forced to close.[29]

Different Community Agencies Cooperate

The Robbinsdale Area Schools Adventure Club is considered a model program because of the excellent space,

the variety of available activities and classes and community support, according to Mary Jo Richardson.

In its tenth year, the program serves 600 children. The YMCA provides programs during the summer months.

Community education administers the program, working with the Park and Recreation Department on programming. The School board contributes space in two community education early childhood centers. Seniors from Armstrong High School volunteer as a social involvement project.

The St. Cloud Kid Stop program for school age children, begun in 1985, now serves 10 sites. The Boys and Girls Clubs administer the program which is generally housed in school buildings. A Community Education grant assists in funding. Many volunteers are involved, including the foster grandparents program, students from the work study program through area schools and early education students from the area's Vo Tech.

The League of Women Voters of New Brighton, with the Mounds View Community Education Department and the Ramsey County Child Care Council, was the key in mobilizing parents and community groups to establish "the Oasis" for school age children in the Mounds View School District. After two years under the New Brighton Parks and Recreation Department and one year with Mounds View Community Education, the program came under YMCA management.

In the Trimont School District high school home economics students help with the before school program and prepare a nutritious breakfast.

Resource and Referral

An important component of a strong day care system is a resource and referral system which can link parents and providers efficiently. In 1986 a $40,000 federal grant has helped establish resource and referral agencies for Washington, Dakota and Ottertail counties.

1986 Minnesota Child Care Resources and Referral legislation set minimum standards for child care resource and referral programs funded with state and federal money. No state funding was appropriated but the legislation made it possible for Minnesota to qualify for federal funds for resource and referral.

Resource and referral services offer information parents need on location of available care, current openings, licensing regulations, subsidy programs, types of care, ages served and costs. R and R services can also offer suggestions on how parents may evaluate child care facilities.

Resource and referral programs also benefit providers by facilitating recruitment and promoting licensed child care. R and Rs update their lists continuously so parents can be informed of which providers have openings and providers can fill them.

Currently only a fraction of Minnesota counties, mostly in the metropolitan areas of Rochester, Duluth and the Twin Cities, have child care resource and referral services.[30]

R and R services can be financed by a variety of sources. State funds can be used to leverage monies to support R and R programs. The new Dakota County Community Action Council Day Care Referral Program, for instance, combined a one-time $5,000 state "demonstration" grant with funds from several large businessess which contract for services for their employees, and $18,000 in county funds. Volunteers and a half-time staff person served 3,100 parents, 5,017 children, during the first full year of operation in 1986.

In greater Minnesota resource and referral systems may be most efficient at the regional rather than the county level. Recently a one-time state grant supported a new resource and referral service in Region 9, including Blue Earth and Mankato. The service shares space and a WATS line with the region's Council on Aging. The program received 71 calls in January 1987, the first month they were in service, without extensive publicity.

Family day care providers in the Hutchinson area have recently started an informal referral network.

Special Agencies

In Hennepin, Olmsted and Ramsey Counties, well established child care agencies offer a variety of coordinating services. The Greater Minneapolis Day Care Association, Resources for Child Caring in Ramsey County, and Child Care Resource & Referral, Inc., in Olmsted County, offer a variety of services, including resource and referral. They provide a variety of functions, such as administering the sliding fee program, administering separate grant programs and may administer the federal Child Care Food Program. They also provide training.

Nationally only 150 American companies provide child care facilities at the workplace or nearby.

The Role of Employers

Employers in the United States are very far from filling the gaps in day care. One recent study shows that employer-supported child care ranks as the least common of employee benefits. In 1985 only one percent of employees were eligible for child care and many fewer actually used them.[31]

A study by the Council on Economic Priorities reported that American corporations increased the number of child care programs they sponsored or paid for from 110 to 1978 to 2,500 in 1985. However, the report concluded that much more remains to be done by the 44,000 United States companies that have more than 100 employees.[32]

Company Day Care Centers

Nationally only 150 American companies provide child care facilities at the workplace or nearby. Hospitals house an estimated additional 400 child care centers.[33]

Some Minnesota companies provide model programs. Taylor Corporation in North Mankato built and supports the Golden Heart Child Care Center near its headquarters. The center enrolls 140 children, with a staff of 30 which exceeds the required state staff-to-child ratios. Although parents pay the going rate for child care in the Mankato area, the company subsidizes 40 percent of all center costs.

Miller and Schroeder, an investment banking firm in Bloomington, created a Safekeeping Korner in a nearby church for 22 employees' children. The company leases the space and provides a larger staff than required by state regulations.

Cardiac Pacemakers, Inc., in Arden Hills, provides on site day care for employees' children beginning at 15 months. They now serve approximately 30 children. All parents pay the full rate, but the fees are less than the market rate because the corporation provides the space.

A number of Minnesota hospitals also offer provide day care.

Some employers, including 3M, Cargill and the First Bank System, subsidize the cost of in-home sick child care for their employees. Cargill pays two-thirds of the cost of caring for employees' children who are mildly ill. A 3M pilot program reimburses employees on a sliding scale according to income. First Bank pays 75 percent of the cost of in-home sick child services.

Companies offer a variety of other child care services to employees. Cargill provides a list of licensed day care centers to employees. A child care information handbook is available and there are brown bag lunch seminars on day care.

Seventeen Twin Cities companies subscribe to resource and referral services for employees through the Child Care Information Network of GMDCA.

3M 1) offers a summer day camp for employee's children aged 5-12 for $42 a week; 2) makes available at no cost a computerized list of state licensed day care providers; and, 3) provides free seminars on childrearing.

A few businesses include child care as an option in a flexible benefit package.

Another way for employers to help with employees' child care is to set up a salary reduction flexible benefit plan. The cost to employers is minimal.

LEGISLATIVE INITIATIVES

Governor Perpich's proposed budget for 1987-1988 includes several provisions relating to child care. First, the budget proposes renaming the current Sliding Scale Fee Program the Child Care Fund and increasing appropriations from $10 million in the last biennium to slightly more than $18 million for the coming biennium.

Second, the governor proposes a total of $10,600,000 in state funds for child care to be dispersed by the Higher Education Coordinating Board as part of a larger effort to help people move off welfare and gain independence and assist low income students with child care.

The need for a professional unit able to plan and coordinate child care policies would be partly realized through the proposed creation of the Office for Children, to be located in the State Planning Agency. $200,000 is requested for the biennium.

Advocacy Organizations Name Priorities

Child Care WORKS, a statewide child care coalition of more than 150 organizations, is the major organization advocating for child care in Minnesota. The coalition represents child care agencies, labor organizations, employers', women's and religious groups, social service agencies, and community and civic groups. It supports access to high quality and affordable child care.

ChildNet, a statewide education and advocacy organization interested in a broad range of children's issues, endorses a similar child care platform.

Child Care WORKS places highest priority on three objectives for the 1987-88 legislative session:

1. A significant increase for the child care sliding fee program.
2. Funding of pilot programs to implement child care resource and referral services.
3. Funding small business grant and loan programs for child care providers.

Child Care WORKS also supports efforts to:

- Ensure that state child care policies promote increases in wages and benefits for child care workers,
- Continue the Minnesota Child Care Tax Credit,
- Guarantee employed parents the right to a leave, job security, seniority and benefits at the time of birth or adoption of a child,
- Provide the availability of insurance for child care providers at reasonable rates based on actuarial data,
- Fund child care services for post-secondary vocational educational institutions.

Community Education Approach

Legislation introduced by Senator Jerome Hughes (DFL, Maplewood) would allow school districts to levy an additional $1.25 per person through the Early Childhood Family Education Program in Community Education. Monies could be used for the development of any type of child care services the community chooses. Funds could be used for a variety of expenses, including start-up costs for centers and family day care and resource and referral services.

Parental Leave

Representative Peter McLaughlin (DFL, Mpls) and Senator Donna Peterson,(DFL, Mpls) are co-sponsoring the proposed Minnesota parental leave bill. The bill would provide an unpaid leave of absence for up to one year for the parent of a newborn or a newly adopted child. It applies to employers with ten or more employees. Upon return to work employees are entitled either to their former position or to a position comparable in duties, hours and pay.

The bill also permits an employee to use sickleave benefits for the illness of a child on the same terms as the employee may use sick leave for his own illnesses.

If this bill passed, 25.6 percent of Minnesota businesses employing 86.6 of employees in the state would be covered.

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Jim Korkki, program specialist, Minnesota Department of Jobs and Training
Peter McLaughlin, Minnesota House of Representatives
Carol Miller, supervisor, community resources/day care, Hennepin County
Dan Modeen, assistant director, child nutrition, Minnesota Department of Education
Beverly Moran, director, child care licensing division, Minnesota Department of Human Services
Sheila Moriarty, executive director, Minnesota Council on Children, Youth & Families
Jane Nelson, Appeals and Regulations Division, Minnesota Department of Human Services
Zoe Nicholie, director, Quality Infant and Toddler Project, Greater Minneapolis Day Care Association
Mary Ann Norris, elementary school coordinator, Catholic Education Center, Archdiocese of St. Paul and Minneapolis
Dru Osterud, Legal Services Advocacy Project
Mary Jo Richardson, co-director, School Age Child Care Initiative, Minnesota Department of Education
Barbara Roy, community affairs, First Bank, St. Paul
Maurice Sanderson, director, New Brighton Parks and Recreation Department
Tutti Sherlock, director, Child Care Resources and Referral, Inc., Rochester
Linda Sutherland, assistant director, Minnesota State Planning Agency
Larry Taylor, vice-president, Taylor Corporation, Mankato
Eleanor Weber, Appeals and Regulations Division, Minnesota Department of Human Services
Tom Wicks, director, Boys & Girls Clubs, St. Cloud
Sue Wilcox, Early Childhood Education, Detroit Lakes
Ruth Willius, director, Especially for Children, Minneapolis
Dorothy Zimmerman, community activist, Lincoln County
Faith Zwemke, governmental affairs coordinator, Child Care WORKS