

CASE STUDY OF FAMILY IMPACT ANALYSIS

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Write a 5- to 6-page analysis of one of the case studies (selections will be made in class) in the Ooms and Preister text using the following format. This assignment must be submitted by Class 21; **no late assignments accepted**. Use the family impact checklist in Appendix A of the Bogenschneider (2006) text.

Use the following format:

- Using the family impact principles, what are the supportive effects of the policy or program? What are the undermining or nonsupportive effects? List each principle and indicate if the principle is supported, nonsupported, or not relevant for the issue. Under each principle, use only those questions that seem appropriate for your case study. (10 points)
- Are there beneficial effects that might have been overlooked without family impact analysis? Are there harmful effects that a family impact analysis could help avoid? Summarize the conclusions of your analysis. (10 points)
- How well was the particular case study done? Are there family impact principles that the writer overlooked? Point out specifically the strengths and shortcomings of the analysis. (10 points)

Application 1

**SUBJECT: ADOPTION/FOSTER CARE POLICY AND PRACTICE:
A FAMILY CRITERIA ASSESSMENT**

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TO: Steven Preister, Chair
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Introduction

After reading through the finalized report, Family Criteria, I am providing some specific comments from an adoption vantage point as well as some examples of how these criteria might affect adoption practice or policy. I chose a broad focus on the basic legal framework of existing federal policy in adoption and foster care.

I read through the six sets of family criteria and family impact questions as if I were the head of a small private adoption agency or the head of a much larger public child welfare agency. I was struck by the fact that after a first read, an administrator of such a program may conclude that these criteria have little relevance to the type of program that he or she is administering. While I don't think this is true, I can easily see that such an administrator, who by definition is very busy, might read the criteria and file the document. The reason for this is that most of the family impact questions concern an already existing family structure and its relation to outside stressors. As adoption is about legally dissolving one family structure and constructing a new one, an administrator might conclude that these impact questions do not apply to such a transitional service. I don't think that is true; in fact, at its ultimate level, adoption impacts on at least two already existing family structures. We have addressed this fact in the Report; thus I think we will assist readers in seeing the family as a dynamic, not static concept.

Background

The Adoption Assistance and Child Welfare Act of 1980 restructured the federal role in the provision of foster care and adoption services. P.L. 96-272 spells out requirements for the provision of foster care services that states must meet in order to qualify for federal matching funds. The act also authorized for the first time the provision of federal subsidies to families who adopt certain children. The basic purpose of the foster care reform was to promote permanency planning: to encourage reunification with biological families and facilitate adoption, to counter the phenomenon of large numbers of children who remained in foster care.

P.L. 96-272 mandates that states must, in order to receive their full share of federal funds for child welfare services provided under Title IV-B of the Social Security Act, institute certain protections for all foster care children under the responsibility of the state (not just foster care children eligible for federal maintenance dollars). These required protections include: (1) an inventory of children in foster care more than 6 months; (2) a statewide information system of children in foster care; (3) a system for case review for each foster care child, including a case plan for each child, a 6-month review and an 18-month dispositional hearing, to assure placement in the least restrictive setting and to ensure procedural safeguards; and (4) a services program to assist children, when possible, to return to their homes from foster care. Child welfare services are

defined under the act as a range of services designed to protect and promote the welfare of children. Federal funding for such services under Title IV-B is authorized at \$266 million per year though actual authorizations have never reached this level.

P.L. 96-272 also created a new section, Title IV-E, of the Social Security Act. Title IV-E created two distinct entitlement programs. Title IV-E provides for federal matching dollars, based on the Medicaid matching rate, for foster care maintenance payments for children who were or would have been eligible for Aid to Families with Dependent Children (AFDC) at the time of their entrance into foster care. Foster care maintenance payments are designed to cover the cost of providing food, clothing, shelter, daily supervision, school supplies, personal incidentals, liability insurance for the child, and reasonable travel to the child's home for visits. Currently, Title IV-E foster care expenditures provide maintenance payments for approximately 100,000 children per year at an annual cost of approximately \$500 million, which includes administrative costs as well.

Under Title IV-E, a new federal program was created, the Adoption Assistance Program. Federal dollars are provided, again at the Medicaid matching rate, for subsidies to be provided to parents who adopt children who were or would be AFDC or SSI eligible and who are considered children with special needs. A child with special needs is defined as one with a specific condition, such as ethnic or minority background, age, membership in a sibling group, or a mental or physical handicap, which prevents placement in an adoptive home without providing assistance. Children receiving federal adoption assistance are also deemed eligible for Medicaid. Monthly adoption assistance payments may not exceed the monthly foster care board rate in that state. In FY 1986, \$41.4 million were appropriated for this program. An estimated 25,000 children received benefits in an average month during that year.

Principle #1: Family Stability

Policies and programs should encourage and reinforce family, parental and marital commitment and stability, especially when children are involved. Thus, intervention in family membership and living arrangements is justified only to protect family members from serious harm or at the request of the family itself.

Family Impact Questions Selected:

To what extent does the policy or program ease or hinder the family's decision to change its membership (for example, through divorce/separation; the decision to have children through birth or adoption)? What incentives or disincentives are provided to marry, have or adopt children, separate or divorce?

How does the policy or program recognize that major changes in family relationships, such as divorce or adoption, are processes that extend over time and may require continuing support and attention?

Is involuntary intervention in the family through placement of a child or adult family member in alternative care settings done only as a last resort after sufficient efforts to help the family stay together? What resources are allocated to help keep the family together?

What criteria are used to guide decisions that remove a child or a dependent adult from a family? What criteria (for example, permanency planning, family-like environment) are used to determine what alternative care will be most appropriate for that dependent member?

Both the principles and the family impact questions in this section were all quite relevant to adoption and foster care programs.

For this section, I chose to analyze the Adoption Assistance and Child Welfare Reform Act of 1980 (P.L. 96-272) as an example of how these criteria may relate to a program or policy concerning adoption.

On a paper level and in the offices of Capitol Hill this act would appear that it more than satisfies all of the family impact questions in this section. The problem is, of course, that these children do not live on a paper level nor do they live in the offices on Capitol Hill. While I would never argue that this act has not had a significantly positive effect on the foster care and adoption systems, I would argue that the sense of the "solution" provided to the reader—especially since it reads in a very sensible fashion—has lulled many into the mistaken belief that the problems such as foster care drift have been adequately addressed. P.L. 96-272 is filled with procedural requirements but has little if any enforcement standards. In other words, a state must simply prove that it has case plans, that it has administrative reviews, and that it has implemented "reasonable efforts" to prevent placement in foster care. Thus, a state that has one paragraph long case plans, 30 second administrative reviews, and whose "reasonable efforts" consist of a telephone call would be in compliance with the law.

To conclude, the Adoption Assistance and Child Welfare Reform Act of 1980 as written would pass this set of family impact questions with flying colors. However, as soon as one examines its implementation and looks for practice standards, enforcement procedures and activities, and outcome data, one quickly realizes that the Act as it is currently being implemented is insufficient to ensure that family stability is properly safeguarded by state child welfare systems.

Principle #2: Family Support and Responsibilities

The first presumption of policies and programs should be to support and supplement family functioning. Services that substitute for families should only be provided in situations where it is clear the family will not be able to function sufficiently even with support, or when the burden on the family is excessive.

Further, policies and programs need to vigorously enforce and support parents' responsibility to provide economic support and adequate protection for their children; similarly, family members' responsibility to care for other adult family members in crisis or in chronic sickness, disability, or frailty should be encouraged, facilitated, and supported.

Family Impact Questions Selected:

How does the policy or program help families perform their responsibilities and prevent government activities from inappropriately substituting for that responsibility?

Does the policy or program provide incentives for other persons or institutions to take over family functions? How does the policy or program provide resources which help to supplement family roles and so strengthen families' own abilities to provide support for their own?

What effect does the policy or program have on families' ability to provide financial support for their dependents?

Does the policy or program build on or ignore informal support networks and mediating structures (such as community/neighborhood organizations, churches) that are so essential to families' daily lives?

This principle and its family impact questions go right to the heart of a current debate in the field of adoption, and anyone involved in adoption practice who honestly looks at their practice would be forced to bring this debate home. There are those involved in adoption who see the adoption practitioner's role as ending upon the legal finalization of the adoption; those who hold such a view believe that there should not be nor need not be an ongoing relationship between the

adoption practitioner and the adoptive family. Certainly this is the view held by most of those persons, primarily lawyers, who are involved in independent adoptions. On the other hand, there are those who believe that the actual adoption process should signify the beginning of a potential long standing relationship between the adoption agency and the adoptive family. This relationship involves the adoption agency providing supportive services to the adoptive family when requested, and acting as an always available resource.

The Principle of Family Support and Responsibilities makes it clear that an adoption agency has a responsibility to act as a lifetime "friend"—though a friend of a professional nature—to adoptive families and children. To the extent that an agency administrator finds that his or her program scores poorly on these family impact questions, such would be the extent that his or her program is failing to meet its responsibility to act as this "friend."

When looking at these family impact questions as they might apply to a specific program, I would conclude without going into detail that the service delivery of a good adoption program prior to finalization of the adoption would score highly. However, this is not the case if one assesses services provided to adoptive families post-finalization. This is the area that has been termed Post Legal Adoption Services. Only recently have we developed the recognition that families who adopt children, especially special needs children, must have available to them a ready and appropriate resource for support and information. In the area of special needs adoption, to be succinct, we have failed miserably in providing this support. In practically every state, the service delivery and funding systems are set up to facilitate the actual placement of a special needs child, but little if any service delivery and funding goes toward maintaining these families after finalization. The situation, more often than not, is that a special needs child is placed into an adoptive family and this new family is "set upon the world" with little support. Several factors are currently contributing to this situation: (1) the area of post legal adoption services is still being developed with, quite frankly, inadequate and/or inappropriate services being termed post legal adoption services; (2) funding is not readily available for these services, and funding which is available is usually not released by the states to private adoption agencies even though it is often the private sector that has direct contact with many of these families. The need for Post-Legal Adoption Services for families who adopt non-special needs children, that is, healthy infants, has not been addressed by many funding organizations.

Thus, if one looks at the ability of the average adoption agency to provide support to the families that they have helped to create, especially when these families have adopted children with special needs, one concludes that the average agency will not do very well on these family impact questions. From helping families perform their responsibilities, to preventing inappropriate government interventions, to strengthening the family's own abilities to provide support for their own, to involving informal support networks, to improving linkages with community resources for families after the actual adoption, the field is still in its infancy. Certainly this is not true for all agencies. One agency that has developed an excellent post-adoption program, ACT (Adoption Counseling Team), is Spence-Chapin Services in New York. Other agencies, severely hampered by lack of funds and by a public policy that does not recognize in its funding decisions that the private sector is the most used and most efficient service delivery system, are unable to provide the quality and quantity of services needed.

Principle #3: Family Involvement and Interdependence

Policies and programs should recognize the strength and persistence of family ties, even when they are problematic, and the influence family members have upon each other. In general, the most effective and efficient way to help a person in need is to involve the other members of the family so that the family reinforces rather than undermines the the goals of the program.

Family Impact Questions Selected:

How does the policy or program consider whether there are competing needs within the participating family? When two or more family members' or families' (for example, birth parents, adoptive parents, children) needs or rights conflict, on the basis of what principles are policy or program decisions made (for example, the best interests of the child)?

How does the policy or program help individuals and families anticipate and deal with changes the service to the individual may have on the family as a whole?

How does the policy or program facilitate the families' own mediating processes in resolving family conflict? How does the program promote the family as a mediating structure between its individual members and social institutions?

This principle and its family impact questions would be applied differently to infant adoption as opposed to special needs adoption and services to biological families. Here I will focus on the child welfare system as it provides child protective services and subsequent adoption proceedings.

When one looks at this principle and the Federal policy governing the area of child protective services, i.e., the Adoption Assistance and Child Welfare Reform Act of 1980, one would conclude that the policy is very much in line with this principle. However, when one goes beyond the principle to the family impact questions, it becomes quite clear that policy and practice have not delineated specific criteria for when and how to become involved with families. These family impact questions should require, for a program to do well, that clear operating procedures for making decisions regarding intervention and removal of a child, and possible subsequent termination of parental rights, have been developed and implemented. In other words, a program should have agreed upon rules that guide practice.

Unfortunately, child protective services have few such rules. This bill is hampered by a ubiquitous vagueness regarding decision making. This vagueness is further exacerbated by the usually tenuous relationship between social work and the judiciary; it is the judiciary which has the final say in these matters. Neither the judiciary nor the field of social work has made any substantial strides toward developing criteria upon which decisions regarding removal of a child, involuntary termination of parental rights, etc. are made. The federal policy mentioned above only requires that a case plan be developed for every child. The assumption is that within this case plan, such criteria relevant to each child will be developed. The truth is that few such criteria exist.

Principle #4: Family Partnership and Empowerment

Policies and programs should treat all families with trust and respect as partners when providing education, health, and social services to a family member (for example, a child, spouse, or adult parent) and should offer a range of levels of involvement depending on the family's wishes and situations. Families need to be empowered by providing them with information and a maximum degree of choice and decision-making.

Similarly, policies and programs should take into account the complex responsibilities of families, and enhance their ability to manage their dealings with multiple human service institutions.

Family Impact Questions Selected:

To what extent is family autonomy respected by the policy or program and the family left to make their own decisions and lead their lives the way they wish? On what principles is family autonomy breached and program staff intervene and make the decisions? How does the program protect the family from unwarranted intrusion and allow parents' choice?

What are the program professionals' concepts of their role with the family in providing the service, meeting the need? Do they see themselves as healer, expert, consultant, enabler, mediator, or resource provider?

In what specific ways does the policy or program seek to involve participating families in the planning, implementation, and evaluation of the service or program?

How does the policy or program recognize that some families can and will be more involved in this partnership than others? How does the policy or program provide the opportunity to all families for at least some level of involvement?

In what ways does the policy or program prevent participating families from being subject to humiliating circumstances and suggest that they have an inferior status, thus devaluing and stigmatizing them?

This is a principle that also would be applied in a much different fashion to infant adoption services and maternity services than it would be applied to child protective services (CPS) and special needs adoptions. Here, I will apply this principle to CPS and special needs adoptions.

This principle goes to the heart of the matter in CPS. It delineates the difficulty in determining when to remove a child from a potentially dangerous home situation and then when to return that child to the home or when to terminate parental rights and seek an adoptive home for the child. It is extremely difficult for a caseworker to determine what degree of the decision making to grant a family when there exists an apparent potential for child abuse. Child protective services caseworkers and supervisors are in the middle of countervailing pressures. Child welfare is experiencing a preventive services move, that is, a move to maintain families and avoid inappropriate foster care. On the other hand, it seems routine for reports to be published on the number of children killed at the hands of their parents in a given year in a given jurisdiction. Invariably, these reports contain recommendations for quicker action on the part of CPS. So the question for the child welfare field is: Where is the appropriate point of practice between the preventive services move and the reports that point to "x" number of children killed by their parents? Not surprisingly, this question has not been adequately answered. There have been recent attempts to develop paradigms for identifying this point. It is safe to say that these paradigms have not been put into widespread use. Perhaps one day they will be, but in most child welfare systems, no such paradigms are in place. Exacerbating the situation are large caseloads and the lack of adequate foster homes.

The fields of special needs adoption and foster care are hampered by the fact that the child welfare system and the judiciary have not achieved efficient mechanisms for assessing and terminating parental rights. The result is that children who should be moved into permanent adoptive homes sit in foster care with parental rights intact when these should be terminated. Thus, it seems appropriate when discussing the Principle of Family Partnership and Empowerment to examine these impact questions in relation to child protective services.

I believe on a theoretical level that child protective services would be seen as scoring quite well on these family impact questions. Allow me to explain. We have all heard horror stories of child protection workers either acting too slowly or too hastily in removing a child. The theory of CPS is not to blame, however. The guiding principles of the best interests of the child, appropriately maintaining biological families, developing objective case plans to help families achieve appro-

priate levels of functioning, etc. are generally well thought out principles. It is in practice that these guiding principles go awry. Lack of trained and experienced staff, much too high caseloads, inefficient methods of supervision, poor relations between the judiciary and child welfare systems, etc., all act to create the horror stories we read in the newspapers.

Principle #5: Family Diversity

Families come in many forms and configurations, and policies and programs must take into account their different effects on different types of families. Policies and programs should not discriminate against or penalize families for reasons of structure, roles, heritage/values, or life stage which differ from the perceived or desired norm.

Family Impact Questions Selected:

Is there an explicit or implicit preferred family structure in the policy or program? Does the policy or program build in rewards or penalties for families of a particular structure (for example, one-earner versus two-earners; single versus married; married versus divorced/separated)? If it does, are these preferences and incentives justified?

Are there any explicit or implicit assumptions in the policy or program about what is considered "normal" or desired family functioning? How are these expressed?

Is the program or service equally accessible to families with different structures, life stage, or cultural expectations and values (for example, employed parents/homemaker parents)?

I found this principle and its family impact questions to be the section that most readily cut to the quick, so to speak, concerning adoption services. If I were administering an adoption agency or if I were simply looking at the field of adoption and I read the principle, I would conclude that the practice of adoption does not *unreasonably* discriminate against any family type or structure.

However, if I were to proceed to the family impact questions, I would quickly realize that more than likely my adoption agency had failed to explicitly examine implications of our practice and to articulate guiding principles for making determinations regarding the placement of children. In other words, the entire basis for adoption practice is determining whether or not a family will be an appropriate placement for a child. Obviously, inherent in such a decision making process will be a myriad of values and perceptions regarding what is the appropriate family structure, roles, values, etc. Clearly it is neither possible nor appropriate that these values and perceptions be eliminated. Rather, in order to provide adoption services in an equitable and consistent manner it is necessary that an adoption agency articulate the underlying values that should guide the judgements of the personnel. The truth is that many agencies have not done this sufficiently. The result is that personnel in adoption agencies are too often making decisions regarding the suitability of potential adoptive parents without any guiding principles on which to base these decisions.

For example, there continues to be a debate in the field of adoption regarding the appropriateness of interracial adoption, and the appropriateness of placing a child with a family of quite marginal income or even on welfare. In many child welfare agencies, both public and private, many adoption workers are making these decisions based on their individual values, perceptions, and misconceptions. Agencies will serve adoptive applicants and children in a very appropriate fashion if they articulate those guiding principles upon which all decisions should be based. While final decisions regarding an adoptive applicant are often not made by an individual worker alone, decision making that is not based on articulated policies can and does occur. What strikes me as positive about this set of family impact questions as it relates to adoption practice is that they would force any agency administrator to drag his or her personnel kicking

and screaming through the process of articulating these policy guidelines. To me, there is no question that there should be an explicit preferred family structure that should guide the placement of children into adoptive families. This is not to say that this is the only family structure, only the preferred. Adoption practice would be failing its responsibility if such value judgments did not exist and were not made.

Thus, it is not because adoption agencies may, to put it one way, score highly or lowly on these questions that I would see this principle as relevant to adoption practice. Rather, they are relevant because they would lead any agency through a very necessary and appropriate task.

Principle #6: Targeting Vulnerable Families

Families in greatest economic and social need, and those determined to be most vulnerable to breakdown, should have first priority in government policies and programs.

As a corollary, policies and programs should seek to prevent serious family crises rather than targeting all resources on remedial/band-aid services.

Family Impact Questions Selected:

What efforts are made to identify and target those families who are the most vulnerable and the least likely to have other sources of support?

To what extent is the policy or program specifically directed toward low income families?

Are efforts and resources targeted on preventing family problems before they become crises or chronic situations? Are these sufficient?

In relation to this principle and family impact questions, I have chosen to examine them in light of the public foster care and child protective services, given that this is a government program and the principle specifically applies to government programs.

Certainly the child protective and foster care services programs grant special priority to families in greatest economic need and those determined to be most vulnerable. The result is, of course, that the lower-middle and lower socio-economic classes disproportionately reap both the benefits and the negatives of these programs. Many would hold that the negatives easily outweigh the benefits, hence the lower socio-economic classes are being victimized by these government programs due to their socio-economic status. For example, preventive services designed to keep biological families together and to preclude inappropriate removal of children have never been developed on any large scale in the public child welfare system. Thus lower socio-economic class families, when facing a crisis that threatens the stability of their family, can only avail themselves of, or are forced to respond to, a public child welfare system that, due to a variety of staffing and financial pressures, is geared toward dissolving families. (This is of course not to say that some families should not be dissolved; rather it is to say that our system can dissolve families too quickly.) Middle and upper socio-economic class families, however, often have the resources and wherewithal to take advantage of non-public interventions that are geared toward resolving crises and maintaining a family. It should be noted that at the same time that preventive services are only beginning to be institutionalized, the numbers of children in need of foster care are rising. This is held to be due to the increases in such social problems as drug abuse, teenage child bearing, and so forth, especially in urban areas.

Certainly this is not a call for dismantling our public child welfare system. However, it is made clear by examining this system in light of these family impact questions that the system needs to be regeared so as not to accidentally punish some families solely because they lack economic resources.

Conclusion/Findings

It is clear that the intent of P.L. 96-272 is addressed to a real need in child welfare: i.e., to keep children in the foster care system for as short a time as possible. Its other intentions are also laudable: to work with families in order to return children to their birth parent(s) whenever possible, to require permanency planning and regular reviews of children in foster care, and to support and subsidize the adoption of children with special needs.

It is also clear that the problem with P.L. 96-272, from a family perspective, is not the intent of the law, but its implementation. Implementation can, in fact, subvert the purpose of the law.

Finally, examining the foster care and adoption systems with the family criteria specified in this Report, it is also clear that a number of important issues still remain to be addressed, specifically, support of families who have adopted special needs children, the development of clear guidelines and operating procedures for making decisions regarding intervention and removal of a child and termination of parental rights, articulation of the values which guide the practice of placement of children with certain kinds of families, and so forth.

This concludes my discussion of adoption and foster care services in light of the Family Criteria Principles and Family Impact Questions. I hope that this will provide some insight into how these principles and questions may or may not be relevant to adoption and foster care.

Application 2

SUBJECT: A FAMILY PERSPECTIVE ON CHILD CARE: H.R. 1572

FROM: Theodora Ooms, Director
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TO: Steven Preister, Chair
Family Criteria Task Force

As an application of the family criteria in this Report, I provide this excerpt from the draft of a chapter in the monograph I co-author with A. Sidney Johnson, entitled, *Taking Families Seriously: A Challenge for Social Policy*. For your information, we use a slightly different set of family impact questions than appears in the Family Criteria Report.

Background

While it is difficult to obtain national information about the demand for and supply of child care, parental survey responses, and center waiting lists, much anecdotal evidence points to a substantial unmet need (Select Committee, 1985). A new study by the U. S. Department of Labor (1988) finds no evidence of a general national shortage, but clearly there are shortages of certain types of care in particular communities. Some studies document the costs of different types of child care—costs that range from \$1500 annually for family day care to \$4000 annually for center care—but much less is known about what families actually spend on child care. Some pay a great deal, others pay little or nothing. An analysis of national expenditure data suggests that employed mothers spend on average between 2% and 6% of their total expenditures on child care, but this estimate includes those who reported no child care expenditure (Schwenk, 1986). Other studies suggest that for those who pay at all, 10% of income is a closer estimate (Caine & Hofferth, 1987), although some poor families, especially single parents, may expend 25% of their income on child care.

What about the patterns of child care arrangements that families use? Studies indicate that although the majority of children are cared for in their own or others' homes, a substantial shift has occurred in the last two decades from in-home to institutional, center-based care (O'Connell & Bloom, 1987). The U.S. Census Bureau (1987a) reported that in the winter of 1984-1985, 23% of children aged 4 and younger (1.9 million children out of 8.2 million) were enrolled in day care or preschool facilities during most of the time their mothers were working; about 31% were supervised at home by their parents and 37% were cared for in someone else's home. Large numbers of lower income parents are employed in shift work which enables them to split caring for their children between them and avoids child care expenses. Others use relatives to whom they pay little or nothing (Presser, 1988). Only 8% were able to care for their children at their workplace. Group care in child care centers—the most discussed because it has generated the most controversy—is, as just noted, the least used. Studies also show that older children are more likely to be enrolled in center care than are infants, and that unmarried, and well educated and higher income mothers are more likely to place their children in center care than are other groups of mothers (U. S. Bureau of the Census, 1987b).

What about the children who are receiving no child care at all and are left unsupervised after school? Commonly known as latch key children, estimates of their numbers, based on a handful

of state and local studies, vary enormously, with figures ranging from 2 million to 15 million children and have often simply been inferred from the numbers of employed mothers (Cain & Hofferth, 1987). In 1987, the U. S. Census Bureau published the results from the 1984 first national study of latch key children that suggest that other studies may have considerably overestimated the number of children involved. In 1984, parents reported that only about 1.4 million children were left unsupervised after school (U. S. Bureau of the Census, 1987b). This study also reports that white children are more likely than black to care for themselves after school (or to be cared for by non-relatives), as are children whose mothers are better educated or in white collar occupations. Yet another study of 1984 national census data confirmed these lower estimates and found that self care is used most by middle/upper income white mothers living in suburban or rural areas with no other adults in that household, for older children, and for only a short time each day (Cain & Hofferth, 1987).

After a relatively quiet few years, child care once again has been placed on the top of many people's policy agendas. Most people now agree that government has a legitimate, indeed vital, role in the provision of child care, especially for low-income families. While past debates focused on whether or not government had any role in the provision of child care, the debate today is not whether the federal government should play a role, but what kind and how large government's role should be. In recognition of the vital role the provision of child care plays in parents', especially women's, ability to join and remain in the labor force, most of the welfare reform proposals that were introduced in the 99th and 100th Congresses include a child care component. In 1987, both Republicans and Democrats were proposing that the federal government initiate new, and often, costly initiatives. Yet deep philosophical differences still separate the various proposals.

These differences in part reflect differing views about what child care should accomplish. Most child care advocates assert that the primary goal of child care is to encourage healthy child development and learning, especially for children from disadvantaged backgrounds. They believe that the opportunities afforded by good quality child care are as much a child's right as is public education. To this end, these advocates call for more public support for child care programs as well as government regulation to upgrade the quality of the services provided. This view has tended to favor public support of center-based care over other kinds of child care programs. These advocates also urge upgrading child care as a profession, by raising caregivers' very low wages and mandating increased training.

Others take a somewhat different position, and view child care as a necessary custodial service for parents seeking safe substitute care which does not need to be developmentally oriented, highly regulated care—always more expensive. They generally believe that government should help increase the supply of facilities and subsidize those families who cannot afford the care, preferably through business incentives and credits in the tax code. They also believe that regulation is unnecessary and costly in part because it discourages the supply of care, especially family day care, and should be kept at the minimum appropriate to deal with basic health and safety issues. Parents, not government, should determine issues of quality and be allowed to choose what type of care best suits their needs.

In recent years, there have been several relatively modest attempts to broaden or restore federal support of child care. Over the past 15 years, federal child care assistance has more than doubled and now totals around \$6.9 billion (U. S. Department of Labor, 1988). However, the main beneficiaries have not been low income families, but middle class families taking advantage of an expansion in the child care tax credit and tax-sheltered, employer provided benefits (Besharov & Tramontozzi, 1988). In the 100th Congress, numerous child care bills were proposed by Republicans and Democrats alike. The most ambitious of these was introduced in the House and the Senate in November 1987, known as the Act for Better Child Care Services (S. 1885 and H.R. 3660). It represented the first comprehensive child care legislation since 1971. These two bills

had an impressively long list of initial co-sponsors—nearly all Democrats. Some dubbed them Christmas Tree legislation since they provided funds for expanding and improving almost every aspect of child care. The price tag was also impressive—\$2.5 billion.

This legislation was the result of more than a year's work of meetings and consultation with about a hundred organizational members of a coalition, the Alliance for Better Child Care (ABC Coalition). Basically, the Act would provide formula grants to states which would be used to help low and middle income families pay for licensed and regulated child care according to a sliding fee scale. Twenty-five percent of the funds would be used by the states to improve the quality and availability of care through improving licensing and regulation requirements, providing education and training for child care providers, and improving their salary levels.

Family Impact Assessment of H.R. 1572

We choose here to examine with a family lens a much more modest bill, crafted and largely sponsored by moderate Republicans, known simply as the Child Care Act of 1986. Originally introduced in 1985 by Rep. Nancy Johnson (R-CT), this bill (H.R. 1572) would grant \$300 million to the states to fund a four year program of child care vouchers for families whose income was 200% of, or below, the poverty level. These low income families could use the vouchers to pay for center based care, registered but not necessarily licensed family day care, or care provided by relatives in their own homes. The bill is revenue neutral, funded by capping the present child care tax credit for those with incomes above \$75,000.

Seen through a family perspective, the bill has many positives. It targets those most in need of services, low-income families. For the first time, it provides federal support for families whose incomes are both too high to make them eligible for Title XX child care assistance and too low for the tax credit and those who do qualify for Title XX but do not live near a Title XX center. Further, it permits families to choose the kind of care they want for their children and thus helps subsidize the type of care, family day care, that most families use and that previously has received very little federal support and little attention from child advocacy organizations (with the exception of the Children's Foundation).

However, this bill has not generated the support of the child care advocates. Their opposition to the bill largely centers on its funding provision and the issue of licensing family day care centers. Many child care advocates want more federal resources overall, not necessarily more targeting of existing resources on low-income groups.

Furthermore, many disagree with the bill's treatment of family day care, especially its provision that permits voucher use in family day care homes that are registered but not licensed. Registration is a much simpler self-reporting procedure than licensing and does not involve government monitoring. In fact, it is estimated that 80% of family day care homes are unlicensed. Parents find these family day care services through an informal, almost underground network. Representative Johnson initially believed that her bill's provision would gradually bring family day care facilities into public view so that more formal supervision and support services would follow. After discussions with the child care advocates, she revised the bill and created a specific three-year grace period, after which licensing requirements would be imposed on those who had registered.

However, this change did not end opposition to the bill. Many children's advocates simply do not want federal dollars to be spent on unregulated services. Many also expressed the concern, in a letter the Coalition sent to Rep. Johnson, that "the bill even as amended, sends a signal that for at least three years family day care is not viewed as a profession, but as a casual endeavor which need not be taken seriously by the state, parents, or even the providers themselves" (Alliance for

Better Child Care, 1987). Supporters of the bill counter that the first objection smacks of a double standard, since child care purchased by middle class families through tax credits is not regulated at all. Furthermore, licensing by itself does not seem to guarantee quality or help increase the number of family day care homes that choose to be licensed. (There is one program that has brought many family day care homes into a sponsored network, the Department of Agriculture's Childcare Food Program which offers monetary incentives to providers to become licensed.)

The issue of regulation and licensing in child care is a difficult and sometimes emotionally charged issue. Advocates of regulation cite examples of unlicensed homes that jeopardize the safety of the children in their care. However, there are no formal studies on this issue, only anecdotal evidence that unregulated homes as a group are more harmful to children than licensed homes. Indeed, the National Family Daycare Homes Study found that, on average, unlicensed homes did not differ significantly from licensed or sponsored homes: all three provided children with a positive environment (Divine-Hawkins, 1981). While this study found that unlicensed providers spend somewhat less time in structured learning and play activities than licensed providers, no evidence was presented that unlicensed homes provided a less safe or healthy environment. And in general the unlicensed homes did not exceed the licensing requirements about numbers of children in their care (Divine-Hawkins, 1981). Another study found that regulation—especially local zoning ordinances—frequently acted to severely restrict the supply and raise the cost of child care and did not appear especially effective in ensuring health and safety (Lehrman & Pace, 1985).

The problem here seems to be that licensing only achieves its goals if considerable resources are assigned to monitoring the homes on a regular basis, which is seldom done as it is very expensive. And regulation is likely to discourage the supply of family day care homes unless incentives are also offered, such as considerably higher salaries to those who comply. Child care advocates argue for more government resources to be spent on monitoring. Others, such as those who support the Johnson bill, believe a more appropriate and effective strategy is to educate the parents about how to monitor the homes themselves.

In these debates about child care both sides appear to want to encourage upgrading of family day care homes by bringing them into networks of providers where they can get access to information, some training, toy supplies, and so forth. But the central tension between how to upgrade the profession of child care providers, and improve their salaries and yet keep the costs of child care within reach of employed parents, is rarely discussed directly.

Family Impact Questions Selected:

We summarize the child care discussion by listing the major family impact questions that should be raised about any child care proposal. We give our brief reply to each as applied to H.R. 1572.

Does the child care bill represent a significant public policy commitment to the value of family life?

No, not particularly. The legislation has many merits, but because it is revenue neutral it is not evidence of any major new commitment of public resources.

Does the policy strive to support and supplement parental responsibilities before substituting for them?

In one sense the answer is no. The policy simply assumes that mothers are going to be employed and that substitute child care is necessary. Subsidizing child care indeed provides incentives for maternal employment. In another sense, one could answer yes to this question. Subsidized child care can be very supportive, especially to low-income single parent families, since it can prevent the child neglect that may occur if the child is left alone and reduce the psychological stress to the parent of inadequate arrangements—which may lead to child abuse. (Many abused and ne-

glected children, in turn, end up in foster care.) It can also reduce parents' economic stress and sense of isolation resulting from being economically deprived but unable to go out to work because of child care problems.

Does the policy subsidize some types of families and discriminate against others? And if so, is this bias justifiable?

Yes, the child care subsidy in H.R. 1572 is specifically targeted on low-income families in which both parents—or the lone parent—is employed or in training. To pay for the program it withdraws subsidies previously available to higher income families by capping the child care credit. Thus mothers who choose to stay at home and better-off parents fail to benefit. Also it only targets the day care needs of families with child dependents (see below). This bias towards low-income families is justified, in our view, in light of other criteria (see below), and the present era of severe budgetary restraints which makes targeting more imperative.

Does the policy help parents with their responsibility to provide economic support for their children?

Yes, by providing subsidized child care the policy enables low-income parents to increase their income through employment. If the care was not subsidized, many parents could not afford to work since their wages would barely cover the costs of care. However, government subsidies such as refundable tax credits and family allowances could in theory be used to increase family income for those who wish to care for their children themselves and not go to work.

Does the policy help families care for those members who are chronically ill, disabled or frail of whatever age?

No, this program is not designed to provide support for day care for disabled adults or the frail elderly—as the dependent care tax credit now does (although originally it could only be used for child care). And although the vouchers could be used for child care for a disabled or seriously ill child, it makes no provision for the extra costs this kind of specialist care would require.

Does the policy give priority to those families in greatest economic need?

Yes, the program is carefully targeted to low income families, especially those who earn too little money to claim the tax credit and are not eligible for Title XX and those who are eligible for Title XX funds but who do not live near a Title XX day care center or licensed family day care home. It redistributes public child care dollars from middle class families—which have increased in recent years—to low income families whose subsidies have been cut.

Does the policy provide employed parents with a maximum degree of choice about the type of child care?

Yes, the program permits parents a great deal of choice and provides them with information about what their choices are. They may use the vouchers for many different types of child care or babysitting arrangements including care in a relative's home. However, there are some restrictions to parents' freedom of choice: the centers must meet state licensing requirements, and the family day care homes or baby sitters must be at least registered with the state. In addition, the bill requires states to provide information and education to all the parents who apply for vouchers about how to find, select and monitor child care.

Does the policy encourage parents to be involved personally in the care provided their child?

H.R. 1752 does not address the issue of parental involvement explicitly except that it only qualifies states for the program whose child care laws require parent involvement as one of the criteria

for licensing. However, in practice H.R. 1752 encourages the use of informal family day care which is the kind of care, next to relative care, that creates a greater potential for personal parental involvement than exists in formal group care centers. It is easier and more natural for parents to share information with, and ask questions about their children from, a family day care mother than from a number of child care workers in a larger, more formal and structured child care programs.

Does the policy make it easier for families to manage and coordinate their lives?

Yes, because H.R. 1752 expands their child care options, low income families are more likely to be able to find a child care setting that is easily accessible and meshes best with their work schedules than if they could only use the voucher for a Title XX approved center or licensed family day care home which might be further away and have more rigid hours. Many families find that family day care, or relative care, fits better with part-time, or shifting work schedules and can more readily accept their mildly sick child than formal group care.

Conclusion/Findings

The Child Care Act of 1987, H.R. 1572, is a well crafted, modest proposal that is designed to do two things. First, it redistributes existing public child care dollars from middle income families to lower income families. Second, it aims to encourage the supply, and increase the accessibility, of the type of care, family day care, that the majority of families seem to prefer, at least for their infants and young pre-schoolers and some for their school age children. It targets low income families more effectively than the ABC bill (Besharov & Tramontozzi, 1988). In the debate about the merits of "developmentally oriented" versus "custodial" child care, this legislation leans strongly toward custodial care. It allows low income parents to be the judges of what their children and families need, just as the child care tax credit allows middle income families. However, it does contain a few provisions that attempt to upgrade the quality of family day care according to professional standards.

It is not clear how effective this legislation would be in encouraging the supply of family day care. It offers few incentives to family day care providers other than increased demand through the voucher program and improved advertising through public channels. And although the bill removes some of the barriers that restrict the supply and visibility of family day care homes, it does not deal with one of the major barriers, namely, the fact that at present many unregulated family day care providers do not report their income which they presumably would have to do once they became registered and/or licensed. (Another Republican child care bill, the Child Care Services Improvement Act of 1988, also introduced by Rep. Johnson and Senator Hatch, does propose modifying the IRS rules for child care providers so as to diminish their tax liability.)

Unlike the much more ambitious ABC child care bill, this legislation does not attempt to set out a broad vision for federal child care policy. Nor does it propose increasing the amount of public support for child care which many, including the authors of this analysis, believe is sorely needed. However precisely because—unlike the ABC bill—the bill includes a proposal for raising revenues to pay for the program, and thus is revenue neutral, prospects for enactment would appear to be promising. Yet the bill is not supported by advocacy organizations and hence may not gain the legislative support it needs to become law.

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Application 3

SUBJECT: A FAMILY PERSPECTIVE ON LONG TERM CARE: H.R. 3436

FROM: Theodora Ooms, Director
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TO: Steven Preister, Chair
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As an application of the family criteria in this Report, I would provide this excerpt from the draft of a chapter in the monograph I co-author with A. Sidney Johnson, entitled, *Taking Families Seriously: A Challenge for Social Policy*. For your information, we use a slightly different set of family impact questions than appears in the Family Criteria Report.

Introduction

At the heart of much of the concern about exploding health care expenditures is the issue of long term care. Striking advances in nutrition, preventive health care and medical technology have greatly increased the numbers of chronically ill, disabled and frail persons of all ages who are dependent for daily care upon others. Many of these children and adults need intensive care and attention throughout the day, and sometimes at night. The kinds of care involved range very widely from highly specialized medical procedures, basic nursing care, personal care (bathing, dressing, feeding), chores and home management (shopping, cleaning, cooking, paying bills) and transportation. There is obviously a wide variation in the amount and degree of help needed. Some disabled dependents may need help just a couple of times a day for a brief period. Others, such as Alzheimer's disease patients or technology-dependent children will need to be monitored constantly 24 hours a day. These services, when needed over an extended period, are referred to in policy discussions as long term care. Long term care can be provided in either an institutional (nursing home, or hospital) or community, home setting.

Mothers, wives, daughters and daughters-in-law are overwhelmingly the care providers and care managers of the frail and disabled living in the community. However, demographic and social changes are on a collision course. While demands on families, principally women, for care giving will increase over the coming years—as more people live to be very old, and more seriously ill and disabled persons are kept alive—women are less likely to be able or willing to provide this care (Feldblum, 1985). The rise in women's employment means there are fewer women at home available to provide the care, or if they leave their jobs to do so it is at tremendous cost to the family budget. Rising rates of divorce sever the ties of obligation to spouses and in-laws. Increased geographical mobility separates family members from one another. Fewer children per family means that each family has fewer members who might be able to provide the care of their elderly parents. The aging of the population means that two-tiered dependencies in which both a mother and a grandmother need care will become increasingly common (Feldblum, 1985). Finally, it is not uncommon to find three generational families in which the parent(s) are caring for a chronically ill child and their own parent simultaneously.

The care that families provide these dependents is obviously of great value to them. Nearly all would much prefer to remain in the community. Family care usually provides a better quality of life and the dependents fare better medically and psychologically at home. Family care is also

tremendously beneficial to society. The institutional alternatives to family care are extremely costly and should presumably be reserved for those whose needs require institutional care.

Many of the frail, ill and disabled are cared for in hospitals or institutions for reasons that, for the most part, have little to do with the severity of their disability or the level of care they need. Three factors seem more important. First, is the absence, or burn-out, of family members to provide the care. Second is the exhaustion of spouses' or parents' financial resources together with the institutional bias of all the public and private insurance programs that are supposed to help individuals and families pay the costs of care. Lastly, there is a shortage of supply of community-based nursing and social services personnel skilled in providing home-based services that support family care (Caring Institute, 1987).

There are obviously some important differences for the families themselves in whether the dependent needing care is a child, adult or elderly person. From the point of view of public policy, the major difference is that parents are legally responsible for their disabled and ill children, and spouses for each other, but otherwise relatives providing care or financial support are doing so quite voluntarily. As a practical matter, however, the policy issues are very similar across the life cycle and for different types of disability.

Chronically Ill Children

The two million severely, chronically ill children may indeed be only a "frail minority" of the children in the nation. However, they presently account for 40% of all pediatric inpatient care. They are children with birth defects, and chronic and fatal illnesses including leukemia, cystic fibrosis, muscular dystrophy, hemophilia, and spina bifida. In addition, there are several million child accident victims per year, some of whom remain permanently and severely disabled. Ironically, advances in medical technology have kept these infants and children alive. But it is also new technology which makes it possible for almost all of them now to be cared for at home. This technology permits parents and other family members to learn to use highly sophisticated equipment such as apnea monitors, portable ventilators and suction machines, feeding tubes, blood transfusions and home dialysis (Hobbs & Perrin, 1985).

There is overwhelming evidence that when these children are cared for at home their physical and psychological condition improves, sometimes tremendously. And in spite of the enormous burden, costs and strain on the families, family members too almost always feel better when they can care for their children at home. There are of course some families who, for a variety of reasons, may be unable or unwilling to undertake home care.

The issue of the comparative costs of home-based versus institution-based long term care is a complex and controversial one. The evidence thus far is not clear on this question partly because it is so difficult to assess. Yet there is no doubt that home based care for many chronically ill and disabled children can often be highly cost effective. Studies have shown that home-based care can cost anywhere from one-eighteenth to one-half of the same care provided in a hospital or nursing home setting. And the average cost of home-based care is between one quarter to one fifth of the cost of institutional care (Caring Institute, 1987). The costs are astronomical: total costs for one child's care in hospital may exceed \$1 million a year. Costs of \$1000 a day are not uncommon. In contrast, costs at home can range from \$30 to \$300 a day.

A recent review of the comparative costs of home-based versus institution-based care for technology dependent children, conducted by the Office of Technology Assessment, cited several state studies that provide compelling evidence that for some technology-dependent children the home care charges are substantially less than those for intensive or intermediate hospital care (Office of Technology Assessment, 1987). However, the cost savings to the third party payer only occur if

the family is willing and able to carry out a large part of the needed nursing care and skilled services themselves.

Chronically Ill and Handicapped Adults and Frail Elderly

Although families have no legal responsibility to provide financial support for a dependent adult, families are much more involved in caring for adult and elderly members than is generally realized.

The research on this issue has focused almost exclusively on the elderly; however, we know that a large and growing number of seriously ill or disabled adults also depend upon relatives. A 1979 government sponsored national household survey (Feller, 1983) found that there were an estimated 3.4 million civilian, non-institutionalized adults who needed or received help from another person or special equipment in at least one of the basic daily activities of living: eating, bathing, dressing, getting in and out of bed and chairs etc. An estimated 4.1 million adults needed or received help from another person in home management activities: shopping, chores, cooking, handling money. There is some overlap in these two categories; overall, about 4.9 million adults *living in the community* needed the help of another person in carrying out their daily activities, of whom roughly two out of five were under 65 years of age (Feller, 1983). These figures include adults who are chronically ill or physically handicapped (such as the blind, paraplegic, and people with degenerative muscular disorders) and mentally and emotionally handicapped (such as victims of Alzheimer's Disease, serious retardation and schizophrenia). This group of dependent adults will continue to grow in number as chronically impaired and technology-dependent children become adults, and as medical technology increasingly preserves the life of serious accident victims.

This national survey did not include information on the respondents' living situation, or on who actually provided them with these services. Other studies have found that spouses, adult children and friends provide nearly 80% of the help for the frail elderly. Although it is now much less common for elderly parents to live with their adult children than it used to be, they continue to get substantial help, even on a daily basis, from their children (see Feldblum, 1985, p. 212-213). And parents or other family members frequently continue to care for disabled or mentally handicapped young adults past their childhood and even reaching into middle age.

In general, family members are willing to take on awesome caretaking responsibilities, at enormous cost to themselves. However, the extraordinary demands and stress such caretaking imposes can cause "burnout" and other negative effects such as pauperization, heavy financial debts, isolation, emotional strain, and illnesses. The stress of caretaking can exacerbate or even cause family tension and conflict and in some cases contributes to elder abuse.

Family care givers can obtain considerable help and relief from a variety of supportive and supplementary services such as day care for their dependent relative, homemaker aides, respite care (for part of the day, or days at a time), information and education, family counseling, and family support groups. However, all too often such services are unavailable or beyond the financial means of the families.

The Policy Response

The United States does not have a system of home and community based long term care. Instead, it has a patchwork of individual programs each with differing eligibility requirements and benefits that serve different populations and provide minimal support for family based care. Long term care across the age span is funded by more than eighty federal programs that provide cash assistance, in-kind transfers such as subsidized housing and transportation, or goods and

services (Shaughnessy, Price & Griffiths, 1987). Although many of the public programs are specific to certain age groups or types of disability, the major sources of support for long term care—Medicaid (Title XIX), Medicare (Title VIII), and Title XX (Social Services) of the Social Security Act—are available, with certain restrictions, for children, adults and the elderly. One major difference, however, is that many children and adults are not covered by any basic health insurance program, whereas all older people are covered by Medicare.

Many of these programs contain regulations and incentives that are biased towards institutional care and make it difficult, if not impossible, for families to care for their relatives or friends in their homes or community settings. For example, because Medicaid includes both the spouse and parent's income in determining eligibility for home based care but not for institutional care (if the patient is hospitalized for more than one month), many families are forced to keep their elderly spouse or young child in the hospital even if home care would be more beneficial to the patient and less costly. Medicaid also forces spouses, or parents, to spend down to a level of poverty to be eligible to receive benefits. This rule has caused some elderly couples to divorce in order to avoid pauperizing the non-institutionalized member. And it has led to many ill children remaining in hospital to avoid their family's having to lose all their assets if they were to be cared for at home (Caring Institute, 1987).

The gaps in coverage and regulations that severely limit Medicare funding of home-based care are multiple although they have been liberalized somewhat in recent years and are the fastest growing component of health care costs. A further major limitation of Medicare coverage of the non-elderly disabled is a two-year waiting period before they can become eligible. (This is a particularly poignant problem for AIDS patients.) And although other programs have much greater flexibility, their funding levels are very low—compared to Medicaid and Medicare—and they are simply unable to fund sufficient services to meet the needs.

Several states and the federal government have tried to encourage family-based care through favorable tax treatment for family members who care for dependent elderly persons. However, studies have suggested that families' motivations to care for their elderly are not very responsive to marginal tax incentives (Doty, 1986). Family members have consistently reported that their ability to care for their elderly is much more dependent on finding services—such as respite care—that can support and supplement their own efforts and relieve some of the stress and care giving burden.

More significantly, the federal government has introduced several new programs and authorized several experiments to provide funding for family based and community care in recent years. These include the 2176 Medicaid Waivers which allows the Secretary of HHS upon specific application by a state to waive requirements in order to allow Medicaid funds to pay for a broad range of home and community-based long term care services of both a medical and social service nature to individuals who would otherwise remain in a hospital or institutionalized setting. The total cost of services provided, however, must not exceed the cost of institutional care. One type of 2176 waiver, known as the Katie Beckett Waiver (named after its first recipient), has enabled many chronically ill, technology-dependent children from low and middle income families to be cared for at home.

Over the past decade the federal government has also invested in numerous research and demonstration activities that focus on facilitating and funding community-based care for the elderly. Their primary purpose was to find out whether provision of such care would reduce unnecessary institutionalization and hence the total costs of care. A second purpose was to learn whether a carefully managed system of community care would provide more efficient services and increase the wellbeing of the elderly.

The National Long Term Care Channelling Demonstration project was the largest and most important of these projects and ran for eight years. It was funded by three divisions of the Department of Health and Human Services and involved ten states with over 6,000 very frail elderly participants. The major finding of the study was that channelling did not reduce overall medical costs nor substantially reduce nursing home use. The study confirmed the enormous care giving burden that falls on families. However, it also found that expansion of community-based service availability in general did not diminish the amount of unpaid care provided by family and friends as some feared it would. And provision of such services did increase client and caretaker satisfaction with services and psychological wellbeing.

One of the major advances in family-based care has been the establishment and growth in hospice care services funded since 1982 under Medicare and increasingly reimbursed by private insurers. The Medicare program pays for a variety of services offered either in the hospice center or at home to those who are terminally ill. These include education, counseling and other supportive services to the families of those who are dying. Only a few states, however, have established hospice programs for terminally ill children. Although there are some caps on total expenditures, federal support for hospice care has increased. Hospice care is now being offered to AIDS victims and their families, and insurance companies are increasingly paying for hospice care because it has been found to be cost effective.

Public policy debates and discussions about long term care have mostly focused on issues of curtailing rising costs and deciding on the appropriate blend of public and private financing of services provided by hospitals and physicians and nursing homes. Much less attention has been paid to the need to finance and expand the kinds of services and supports needed to maintain long term care patients in their homes and communities. For example, the Reagan Administration's catastrophic health care proposal introduced in the 100th Congress and several similar bills introduced by legislators do not address the costs of community-based long term care at all. However, the House Select Committee on Aging has been studying this issue for several years, and in June 1987, Claude Pepper and Edmund Roybal introduced a bill, H. R. 2762 (later 3436), to amend the Medicare program to provide long term home care benefits for chronically ill adults and children.

Proposal to Provide Catastrophic Home Care Across the Life Span: H.R. 3436

Congressman Claude Pepper, Chairperson of the Sub-Committee on Health and Long Term Care, of the House Select Committee on Aging, introduced legislation in June 1987 which, if enacted, would be a giant step towards a public commitment to support family and community based long term care across the life cycle.

The bill (originally H.R. 2762, then changed to H.R. 3436) would amend Title XVIII of the Social Security Act and the Internal Revenue Code of 1986 to "provide long term care benefits under the Medicare program for chronically ill individuals and children, to provide quality assurance for home care services and for other purposes." In introducing the legislation Rep. Pepper criticized current catastrophic health care proposals for ducking the major issue affecting much larger numbers of people, namely the costs of long term care outside the hospital.

His bill establishes a new range of benefits under Part A of the Medicare program which would provide for the first time comprehensive health care assistance in the home for any person, of any age, who needs assistance with at least two activities of daily living as certified by a physician. Eligibility for benefits is not determined by income. The services the new benefits would pay for include case management, nursing care, homemaker/home health aide, medical social services, personal care services, rehabilitative services, medical supplies and equipment, and patient and family education, training, and family counseling.

The legislation includes a strong system of quality assurance for home care including mandatory training and regular review of paid care givers, a home care consumer's bill of rights, and community review boards and other mechanisms to ensure compliance. The cost of the services would be tightly controlled by limiting monthly payments to 75% of the monthly Medicaid rate for skilled nursing home services or similar services provided in a hospital.

Although requiring additional funds in the short run—between \$3.4 billion in the first couple of years—a Congressional Budget Office study reported that the new program would be self-financing within two years since the new benefits will be paid for by eliminating the cap on income which is exposed to the Medicare payroll tax of 1.45%. (This measure would only increase the premiums of those who earn more than \$45,000 individual income.)

Family Impact Assessment of H.R. 3436

In its first months of exposure Congressman Pepper's bill was received very favorably by a wide range of interest groups and had few opponents. With the proposed legislation he and his co-sponsors achieved three very significant steps forward. First, they asserted the commonalities of dependence and disability across the life cycle. Second, they redefined the term catastrophic to include the costs of home-based as well as institution-based services. And, most important, the legislation declared that home-based care needed major public support. From a family perspective the legislation has many welcome features. However, it does not realize its full potential to support family care givers.

For example, information issued by Pepper's office claimed that by including coverage for children, the bill "is really a family protection proposal...It recognizes that many young families face destitution as well as caring for their ill children." In thinking of families only as units of parents and young children Pepper is, in our view, underestimating the degree to which his proposal supports other family relationships such as between older parents, adult children and elderly spouses and siblings who care for disabled adults and the elderly. For example, this legislation, in providing funding through an entitlement program for home-based services, makes great strides in eliminating the spousal and family impoverishment that is so often the result of prolonged, chronic illness in such situations as these.

There are a number of ways this bill should be amended to provide more support for family care givers. The hearings record and other material demonstrates that the committee members involved in drafting the bill are very aware of the important role of family care givers, especially of course in the case of children. And yet, most of the services that are reimbursable are oriented to the medical needs of the chronically ill patient. The services that family care givers have repeatedly said that they need the most—respite care and day care—were not included in the legislation, apparently primarily for reasons of cost. However, some very important services for family care givers are reimbursable for the first time—patient and family information, education, training and counseling. Since health care professionals need to spend considerable time teaching and monitoring family members about how to care for their ill relative and, often, learn to operate high-technology equipment, it is essential that these services should be able to be charged. And it is very appropriate that family counseling should also be reimbursable, since the stress and strain of prolonged care giving can have such deleterious affects on the patient's and family members' physical and mental well being and sometimes may, if unabated, lead to institutionalization. These kinds of services both support family care giving and contribute to the patient's better health.

Another important feature of the Pepper bill is its emphasis on funding case management services performed by a health care professional, most often a social worker (who may be assisted by an interdisciplinary case management team) who locates, applies for and coordinates the array of

services that are needed by the ill or disabled individual. While this is a strong component of the bill, as currently drafted the case management provisions ignore the role and needs of family care givers in a potentially harmful way. It is true that a few chronically ill children, disabled adults and frail elderly have no relatives who are actively involved in their care. For these persons case managers are absolutely crucial to their ongoing care and treatment. But in the majority of cases, there are relatives involved, and they are attempting to manage and coordinate the services at least to some degree, however inefficiently and ineffectively. Even when a relative, for example an adult child, is not living near their frail parent, and cannot provide direct assistance, the one role he or she often does play is that of a "lay" case manager: finding and making arrangements for the services needed, processing the bills, handling crises or new developments, etc. And in many cases, especially with parents of chronically ill children, the family's role as case manager and coordinator of services is absolutely indispensable.

Most of these family members much appreciate the expert advice of professional case managers when it is offered in a respectful manner. Relatives will vary as to how much responsibility they can and are willing to assume. And some tasks are better performed by the family and others by the professionals. Thus it is very important that these professionals work cooperatively with the family, planning together how to share the case management function. Yet, there is no language in the bill at present to require or encourage professional case managers to work cooperatively with the family.

The legislation needs to underscore the partnership between case managers and families for another very important reason. Various trends in health care financing suggest there will be increasing pressure to discharge chronically ill patients from institutions in order to save costs. There will be many situations when it would be quite inappropriate and bad medicine to expect the family to provide the care and alternative intermediate placements will need to be found. Similarly, there are times when the family is currently providing the care when it should no longer be doing so. These difficult and often delicate decisions need to be made by health care professionals and case managers *based on full consultation with the family*, and a realistic assessment of the families' care giving capacity. These judgements are more likely to be valid if a relationship of trust and mutual respect has been established between the case managers and the patients' relatives (Jennings et al., 1988).

Another strong feature of H.R. 3436 is its provisions for quality control of home-based care and for establishing a system for assuring consumer's rights such as to be informed about available services and the patient's condition, given assurance of confidentiality, and established procedures for accountability. But once again, the role of the family care giver is overlooked. In the language of the bill the home care consumer's bill of rights "may be asserted by the home care consumer or his or her representative." The assumption here, presumably is that the representative may often be the parent in the case of a minor child, or the family care giver, but this is not made explicit and it should be.

In the implementation of this component of the bill, regulations or administrative memoranda should spell out the procedures for designating the patient's representative in the case of adult and elderly patients who are not considered able to exercise their rights themselves. This will sometimes be obvious, for example, in the case of a competent spouse. However, in many situations, it is not obvious and confusion and conflict can arise as to who that person or persons should be. For example, a neighbor or close friend may be the person in most frequent contact with the patient, but an adult child, who lives at some distance may really be the manager of care and the person who needs to be involved in crucial decisions about the patient. Sometimes there are conflicts between different family members and different generations and it is difficult for the professionals and home care agency staff to know to whom they should give information and need to consult with. Although this issue is normally resolved on a case by case basis, any legislation that spells out the consumer's rights should be careful to protect the rights of the

family care givers to information and to be involved in decision making as well. And in the case of children the rights of a divorced non-custodial parent may need to be considered also.

The rights of family care givers also need protection due to the intrusion of so many home care professionals and para-professionals into the privacy of their homes. Parents of technology-dependent children have provided eloquent testimony about occasions when their privacy and confidentiality were not respected, and the visiting professionals stepped beyond their assigned tasks to overrule the family's wishes and disrespect their values.

Family Impact Questions Selected:

We summarize our discussion by listing the relevant family impact questions and providing brief answers with respect to the Pepper long term care bill, H.R. 3436:

Does the proposal recognize families as society's most valuable social institution in providing long term care to the chronically ill and disabled?

Yes, implicitly the bill is very supportive of family care givers, but it could be more so. H.R. 3436 does not explicitly include language that acknowledges the family care givers' role with the chronically ill and disabled. While it does include family information, education and counseling as services that the Medicare home care benefits will pay for, there are other vital services family care givers need that are not reimbursable, for example, respite care—desperately needed to give family members a break from constant attendance—or adult day care—essential for families in which the care giver is employed.

Does the proposal aim to support and supplement the efforts of family care givers before inappropriately substituting for them?

Yes, the principal aim of the Pepper bill is to support home based care and thus provide a needed corrective to the main thrust of current policy which is to pay for out of home, institutional and highly professionalized care as a substitute for home care.

Does the proposal encourage and reinforce marital and family commitment and stability especially when children are involved?

Yes, although H.R. 3436 is not directly designed to target the marital relationship, it is likely indirectly to have a positive effect on marriages. Studies have shown that in many cases the burden of caring for a very ill child, disabled adult child or a frail spouse for long periods of time places enormous strains on a marital relationship and can cause it to deteriorate and even break up. Any program that relieves some of this stress can be expected to be helpful to the quality of marriage and family life.

Does the proposal encourage and support family caring for the chronically ill, disabled or the frail of all ages?

Yes, the Pepper proposal is the first major federal proposal that fully recognizes that family care giving in chronic illness and disability cuts across the entire life cycle.

Does the policy recognize families' complex tasks of coordinating and managing all the services needed to provide adequate care for their ill or disabled member?

No. The bill recognizes that someone needs to coordinate and manage the array of services and benefits needed by the ill or disabled individual. However, it assumes that this task is exclusively

a professional one. Yet, most often it is the family care giver who coordinates and manages all the services a chronically ill person needs, sometimes with great difficulty. The legislation needs to acknowledge the family's management role and include provisions that will require, or at least encourage, professional case managers to work in partnership with the relevant family members.

Does the proposal empower families to be more effective care givers by providing them with information, choice of services and opportunities for assuring quality of service?

Yes, but in a very limited fashion. Although patient and family information and education is a reimbursable service, there are no provisions that require that the family be given information or education, or opportunities to choose the type or level of service or the degree of their own involvement in providing care. This would best be achieved by recognizing the legitimacy of the family care giver's management role—as suggested above—and including family care givers' rights in the section establishing the patient/consumer's rights. For, in effect, the family care givers are also consumers of these Medicare benefits.

Does the proposal include provisions that assure that family care givers will be treated with trust and respect as partners when providing services to a dependent family member?

No. As discussed above, the concept of partnership with the family care giver is never directly addressed or encouraged in the legislation. One of the dangers that could result from a failure to formally require family involvement in the program is that family care givers are expected to assume an even greater burden of care than they presently assume. Even if family involvement was formally required, resources would need to be allocated for training and technical assistance to help case managers learn how to work with families.

Conclusion/Findings

Overall, H.R. 3436 is a very important constructive step forward in providing public funds to support family-based care across the life cycle. While it does not do anything to remedy the lack of basic medical insurance for many children and adults who are ineligible for Medicare, it has the potential for considerably lightening the financial burden of home-based care, improving the quality of such care, and enabling more chronically ill patients to be cared for at home. Its funding of information, education, and counseling services to family care givers is to be much commended. The bill has considerable merit, but from the family perspective it needs improvement. Its failure to fund two additional services family care givers most need—respite care and day care—is an unfortunate omission. Although costs may be a factor in excluding these services, it is also likely that the medical orientation of this legislation has led to a failure to appreciate how much they are needed.

Further, our analysis suggests that some additional language in the bill is required to acknowledge the role of family care givers explicitly, especially their management and coordination activities, and to provide the guidelines and allocate resources for training that will encourage health care providers to treat family care givers as partners in home based care. Finally, since the enormous responsibilities assumed by family care givers are becoming publicly acknowledged, it is surely appropriate that their rights should be legislatively protected, which this legislation does not do.

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Application 4

**SUBJECT: MANDATED MENTAL HEALTH BENEFITS AND FAMILY IMPACT:
A REVIEW**

FROM: Michael Bowers
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Introduction

The Family Criteria Task Force has developed principles and questions which provide the basis of a mechanism for conducting family impact analyses. The criteria discussed in the report of the Task Force are designed to apply to a variety of policy proposals and social programs. To test the applicability of these criteria, this application utilizes the impact questions in an analysis of the minimum mental health benefits mandate from the state of Maryland. This application has been prepared to illustrate the relative usefulness of the criteria, and should not be construed to be an in depth or definitive family impact analysis of mental health benefit mandates in Maryland or elsewhere.

Background

A majority of states have enacted some type of mandates concerning mental health benefits in health insurance policies, whether for mental and nervous disorders, drug and alcohol treatment, or both. Issues surrounding these mandates, or proposals for modifying those mandates, have centered on concerns of fiscal impact usually addressed in terms of utilization rates, cost offset, or cost shifting. Insurance companies point out that when mandates become effective in states, utilization rates and overall costs to the companies, and therefore to consumers (whether defined as individuals or corporations who purchase a health insurance policy), increase. They report that this increase is not adequately compensated for in cost offset (lower utilization of other medical services), but rather reflects new service utilization. This, of course, exacerbates the increase in costs. Proponents of mandated mental health benefits counter that without mandates for mental health benefits, the market will not function properly: those in need of mental health benefits will purchase policies which provide those benefits.

The tendency to purchase specific health insurance policies based on likelihood of utilization is known in the insurance industry as adverse selection. Adverse selection negates the basic principal of cost and risk sharing, common to all insurance underwriting, and makes the task of appropriately pricing a benefit package for mental health services most difficult.

Additionally, proponents note that without mandates, many of those who need mental health services, because of the stigma still attached to mental illness in the U.S., will not purchase coverage for those services. Therefore, when the services are needed, those uninsured individuals find themselves unable to purchase them. The result of this process is that local, state, and federal governments (with state governments shouldering the bulk of the burden) eventually pay a disproportionate share of costs for mental health care, both for the provision of ongoing care for those who are seriously mentally ill and for crises, when problems in uninsured families or

individuals which have gone untreated reach an acute stage. Mandates, then, are seen as shifting costs for mental health care from the public to the private sector. While costs to insurance companies (and consumers) do in fact increase somewhat, the overall costs and expenditures for mental health care within health care delivery systems are not significantly increased. The increase incurred by the insurance companies represents a shift in payment mechanisms rather than a significant overall increase in mental health service costs.

Significant arguments are marshalled on both sides of the fiscal and philosophical debate surrounding mandates for mental health benefits in health insurance policies. However, other than the conclusion that mandates lead to a relatively minor increase in premium rates (depending on the specific study, somewhere between \$10 and \$11 per year per insured individual), an analysis of the impact of those mandates' benefits upon families has not been undertaken. As mentioned above, this application addresses the topic of family impact and mandated mental health benefits, to illustrate the relative applicability of certain impact questions developed by the Family Criteria Task Force.

To provide a context for understanding the potential impact that the availability or non-availability of mental health coverage can have on families, three vignettes of enrollees who utilized mental health benefits in the Federal Employees Health Benefit Plans (FEHBP) are written below. When those benefits were drastically reduced in the early 1980s, these families suffered hardships because of the lack of coverage for their needs. Their cases were discussed in a federal court case in the District of Columbia, *Roe V. Devine*. Following the vignettes, the original provisions of the mandated mental health benefits law in Maryland, in effect from 1974-1986 (when the law was changed), will be used with the family impact questions developed by the Task Force.

1. **Roe v. Devine: impact of lack and/or loss of mental health benefits.**
Richard Roe (pseudonym), had a history of mental illness. Between 1961 and 1969, Roe was hospitalized several times for mental health care, for periods extending to a year at a time. Finally, he retired from federal employment, having been found mentally disabled and incapable of continuing his work. As a retired federal employee, Roe was covered by the high option Blue Cross/Blue Shield plan under the Federal Employee Health Benefit Act (FEHBA). For six years prior to the court action resulting in *Roe v. Devine*, Mr. Roe had not been hospitalized because of his mental illness. However, he had been receiving psychotherapy three times a week from a licensed psychologist. In the opinion of both the psychologist and Roe, long term outpatient psychotherapy was needed to continue Roe's improvement in mental health and to prevent possible reinstitutionalization from serious psychological disorders. When Blue Cross/Blue Shield drastically reduced the mental health benefits under FEHBA, which had made treatment financially possible for Roe, he was at risk of mental deterioration and rehospitalization.
2. **Ann Poe (pseudonym) was also a beneficiary of the high option Blue Cross/Blue Shield plan under FEHBA.** A federal employee since 1965, Poe had previously been hospitalized for emotional problems and stress, and at the time of the reduction of mental health benefit mentioned above, was receiving weekly outpatient treatment from a psychologist. She was seen more frequently during times of unusual stress or anxiety. Without the benefit which reimbursed for her treatment, Poe would be unable to continue treatment, and believed that without continued therapy she would be unable to continue in federal employment.
3. **A federal employee since 1972, Mary White (pseudonym) was insured by the low option Blues plan.** She had been in treatment, receiving twice

weekly psychotherapy, since April, 1980, for depression and anxiety. She was unable to afford treatment without the coverage provided previously under her health plan, and was at risk of being unable to continue employment without further mental health service. These vignettes set the stage for the court action of *Roe v. Devine*.

The personal impact of losing access to mental health services, as well as the impact from the loss of productive workers and the resultant hardships on family, and ultimately society, is seen in these personal accounts.

Minimum Mental Health Benefit Mandates in Maryland

The Maryland mandates for mental health benefits which were effective from 1974 -1986 provided for the following:

- Inpatient care: 30 days per year in any hospital.
- Partial hospitalization: 30 partial hospitalization treatment days per year. (The mandate requires only that this coverage be offered it can be purchased at the policy holders option.)
- Outpatient: after major medical deductible, copayment can be no less than 50% of the benefits provided for other types of illnesses.

Eligible providers for the services covered under the mandate are psychiatrists, psychologists, and social workers. Note: The mandated benefit package applies to both group and individual policies. The mandated availability of partial hospitalization applies only to group policies. Also, Maryland has mandates for benefits covering both mental and nervous disorders and drug and alcohol treatment. Only those related to mental and nervous disorders were included in this analysis.

Family Impact Analysis

Principle #1—Family Stability:

Policies and programs should encourage and reinforce family, parental, and marital commitment and stability, especially when children are involved. Thus, intervention in family membership and living arrangements is justified only to protect family members from serious harm or at the request of the family itself.

Family Impact Questions Selected:

How does the policy or program strengthen or weaken parental, marital and family commitment?

Given the stresses that a mental or emotional disorder will place upon a family, one can expect that, by providing protection against catastrophic costs associated with a mental or emotional problem, mandated mental health benefits will at least provide a cushion for, and potentially strengthen, the commitment present in any family relationship. The vignettes presented above illustrate the potentially devastating impact of a lack of adequate protection against these costs. Additionally, if the professional is trained to deliver services from a family systems perspective, or is at least sensitive to the family concerns and issues at work when a mental or emotional problem is present, one can assume the family dynamic and commitment in the relationships will be addressed.

How does the policy or program enhance parental competence?

By providing access to the mental health delivery systems, the provision for mandated mental health benefits promotes a sense of parental competence. Parents find themselves able to utilize, at their discretion, an array of mental health services.

To what extent does the policy or program ease or hinder the family's decision to change its membership (for example, through divorce/separation; the decision to have children through birth or adoption)? What incentives or disincentives are provided to marry, have or adopt children, separate or divorce?

On its face, mandated mental health benefits may seem neutral in this area. However the provision of mental health services can provide support for existing family structures, or lessen the trauma when there are changes in family structures or membership.

How does the policy or program recognize that major changes in family relationships such as divorce or adoption are processes that extend over time, and may require continuing support and attention?

Unfortunately, without a specific provision for family psychotherapy, the mandate provision in Maryland will not provide financial assistance for such transitional periods as divorce or adoption, unless a diagnosed mental or emotional condition is present. Support groups or services, which may be helpful in such periods, are not reimbursable under the mandate. However, for those situations where a diagnosed mental or nervous disorder is present, services are made available through the mandate.

Is involuntary intervention in the family through placement of a child or adult family member in alternative care settings done only as a last resort after sufficient efforts to help the family stay together? What resources are allocated to help keep the family together?

Under the mandate in Maryland, families have much control over the placement of a family member in alternative care settings. Their choices are usually based upon a family's sense of its own resources and ability to care for a mentally ill person and the advice of the professionals they have consulted. At any rate, the mandate requires the provision for 30 days minimum inpatient care, 30 days of partial hospitalization, and a more extended outpatient benefits. One can assume, given that availability, that institutionalized care will usually be a "last resort," and, because of costs, may only be utilized sparingly.

Principle #2— Family Support and Responsibilities:

The first presumption of policies and programs should be to support and supplement family functioning. Services that substitute for families should only be provided in situations where it is clear the family will not be able to function sufficiently even with support.

Further, policies and programs need to vigorously enforce and support parents' responsibility to provide economic support and adequate protection for their children; similarly, family members' responsibility to care for each other in crisis or in chronic sickness, disability, or frailty should be encouraged, facilitated, and supported.

Family Impact Questions Selected:

How does the policy or program help families perform their responsibilities and prevent government activities from inappropriately substituting for that responsibility?

The mandates provide a means of purchasing, with the copayment requirement, the delivery of mental health services. Unless identified by the court systems, families have the responsibility for the initial identification and support of those who have mental or emotional problems. Therefore, one can conclude that this program assists families in performing their responsibilities, rather than substituting for them. This is true unless one assumes creating a mandate for a benefit in a health insurance policy removes the freedom of choice of a family to determine its own insurance needs.

Does the policy or program provide incentives for other persons or institutions to take over family functions? How does the policy or program provide resources which help to supplement family roles and so strengthen families' own abilities to provide support for their own?

Mandated benefits do not provide incentives for other persons to take over family functions, unless one considers the temporary hospitalization of a family member usurping normal family functioning. The mandate act is designed to supplement and strengthen a family's ability to provide support for their own. One shortcoming of the mandate, from a family perspective, is that no provision is made for family psychotherapy, which would allow for treatment of the diagnosed mental or emotional disorder within the family context, thereby providing additional support for family members as they work with the identified patient in the family.

What effect does the policy or program have on families' ability to provide financial support for their dependents?

The analysis by the Center for Health Policy Studies of the fiscal impact of the mandated mental health benefit in Maryland concluded that the mandated benefit premiums in Blue Cross/Blue Shield policies for families in Maryland in 1984 cost \$5.35 per member month. (It should be noted that the mandated benefits in Maryland also include alcohol and drug treatment, which are not addressed in this analysis.) In testimony before the Maine legislature, Blue Cross/Blue Shield testified that mandated mental illness coverage in Maryland increased the average family contract premium approximately \$2 to \$3 per month. The total overall increase in costs to a family to have coverage under the mandate, therefore, would be somewhere between \$36 and \$212 per year. Obviously, the relative fiscal impact on a family of the mandated benefits act in Maryland is dependent upon that family's income. However, given the relatively small costs of the mandate, and in view of the potential catastrophic costs of a mental or emotional illness in a family, the mandate act provides a means for families to "pay" for their dependents' needed services. In fact, if one accepts the premise of adverse selection and market skew in relation to the purchase of mental health coverage, the mandate provides the most equitable way for all families in a state to avail themselves of this funding/purchasing mechanism for mental health services.

To what extent does the policy or program encourage adults to assume care giving for ill or disabled parents or relatives?

Again, this question is only tangentially applicable to mandated mental health benefits. If the ill/disabled parent or relative is considered a dependent and covered by the relevant health insurance policy, it will allow/encourage care giving. Otherwise, care giving is not addressed.

Does the policy or program build on or ignore informal support networks and mediating structures (such as community/ neighborhood organizations, churches,) that are so essential to families' daily lives?

The mandated mental health benefits act itself is neutral in terms of this question. However, if one can assume that mental health professionals who are consulted will encourage families to utilize all relevant supports available, there will be a positive impact in this regard. This assumption

tion, however, may be dependent upon a particular provider's training, predispositions, and assessment of each particular case.

Principle #3—Family Involvement and Interdependence:

Policies and programs should recognize the strength and persistence of family ties, even when they are problematic, and the influence family members have upon each other. In general, the most effective and efficient way to help a person in need is to involve the other members of the family so that the family reinforces rather than undermines the the goals of the program.

Family Impact Questions Selected:

How does the policy or program recognize the role family members play in contributing to or alleviating an individual's need for service?

The mandated mental health benefits act does not address this question directly. However, as mentioned above, a provision allowing for family psychotherapy would lead to a positive answer to this question, and provide a mechanism for greater family involvement in dealing with an individual's need.

How does the policy or program address and balance the individual's needs, the needs of the individual in relationship to his or her family, and the needs of the family system as a whole?

The policy does not directly deal with this issue. In fact, all the individuals in a family could theoretically be being treated concurrently as individuals for some mental or nervous disorder, without attention being given to the family as a system. Again, this deficit could be rectified by specifically listing family psychotherapy as a covered benefit in the program.

What are the policy's or program's assumptions about services maintaining confidentiality between family members (for example, between adolescent and parents; between wife and husband)?

While the policy does not address this issue directly, the nature of mental health services assumes confidentiality for those in treatment unless an explicit release has been signed by the recipient of that treatment. If conjoint therapy or family therapy is offered and covered under the policy, obviously those who are present will know all of the issues discussed in treatment. However, confidentiality is still maintained beyond the bounds of those in therapy.

How does the policy or program help individuals and families anticipate and deal with changes the service to the individual may have on the family as a whole?

The current policy does not address this issue, although individual practitioners who are consulted by a family and have family systems training may attend to this. The policy as it is written would not address this concern unless a specific provision for family therapy were added.

Principle #4—Family Partnership and Empowerment:

Policies and programs should treat all families with trust and respect as partners when providing services to a dependent member and should offer a range of levels of involvement depending on the family's wishes and situations. Families need to be empowered by providing them with information and a maximum degree of choice and decision-making.

Similarly, policies and programs should take into account the complex responsibilities of families, and enhance their ability to manage their dealings with multiple human service institutions.

Family Impact Questions Selected:

In examining the written materials about the policy or program, do they objectively state that families are equal partners in the service, or do they tend to marginalize or limit family involvement?

The policy, as it currently is formulated, does not address this concern. It is possible that family involvement can be marginalized or limited, depending upon the practitioner consulted, mode of treatment, and concerns of confidentiality as defined by that practitioner.

To what extent is family autonomy respected by the policy or program and the family left to make their own decisions and lead their lives the way they wish? On what principles is family autonomy breached and program staff intervene and make the decisions? How does the program protect the family from unwarranted intrusion and allow parents' choice?

Family autonomy is respected in this policy—families have freedom to use or not use mental health services. If they choose to use services, there is an array of possibilities within the mandate. There is little or no intrusion into a family's freedom to make its own choices; with the exception of the mandate itself, which does require the purchase of a mental health benefit within health insurance policies.

How does the policy or program concretely broaden the choices and options of the participating families?

Mandates broaden the choices of families by allowing them access, without debilitating costs, to an array of mental health services, when those services are needed.

What are the program professionals' concepts of their role with the family in providing the service, meeting the need? Do they see themselves as healer, expert, consultant, enabler, mediator, or resource provider?

Because the mandates provide access to an array of professionals, it is not possible to answer this question. One can assume that within the cadre of eligible providers under the mandate, some adopt various views of themselves as service providers.

How does the policy or program recognize that some families can and will be more involved in this partnership than others? How does the policy or program provide the opportunity to all families for at least some level of involvement?

Mandates require all families to participate, at least in purchasing coverage for mental health services. Families have complete freedom of choice when determining to utilize those services, and are given the opportunity to access services as they have need. This would support the concept of the principle addressed by this question. Insurance companies argue, however, that because there is a requirement to purchase coverage, it is more likely it will be used. The greater the utilization of the benefit, the greater the costs to the insurance company in question. Those who favor the concept of mandates counter that many who need mental health services either cannot afford them, are treated indirectly for other problems (gastro-intestinal disorders, headaches, etc.) while the emotional disorder remains unaddressed or untreated, or purchase coverage in a skewed marketplace, increasing the phenomena of adverse selection. It is the principle of easy access to services which are provided for under a mandate which makes this type of law controversial, from the point of view of insurance companies.

In what ways does the policy or program prevent participating families from being subject to humiliating circumstances and suggest that they have an inferior status, thus devaluing and stigmatizing them and causing them to suffer a loss of self-esteem?

Because of the private and confidential nature of service delivery, there is little possibility of being subjected to humiliating circumstances. However, because of the stigma still attached to mental and emotional disorders in this country, there will not doubt be a struggle within families before services are sought out by the family. This comes, though, not from the policy, but from the context and conceptualizations of mental illness in our society.

Principle #5—Family Diversity:

Policies and programs should not discriminate against or penalize families for reasons of structure, roles, heritage/values, or life stage which differ from the perceived or desired norm.

Family Impact Questions Selected:

Is there an explicit or implicit preferred family structure in the policy or program? Does the policy or program build in rewards or penalties for families of a particular structure (for example, one-earner versus two-earners; single versus married; married versus divorced/separated)? Are these preferences and incentives justified?

No family structure is preferred in the mandate act in Maryland.

Are there any explicit or implicit assumptions in the policy or program about what is considered "normal" or desired family functioning? How are these expressed?

There is no explicit or implicit assumption about family functioning in the policy.

Is the program or service equally accessible to families with different structures, life stage, or cultural expectations and values (for example, employed parents/homemaker parents)?

Yes, the policy is available, because of the array of service providers allowed for under the mandate. However, this availability may be limited by the constraints of the copayment required for outpatient services.

Does the policy or program take into account the differences in ethnic and religious backgrounds of participating families with respect to the need or problem which the program addresses?

The policy allows for freedom and non-discrimination in selecting mental health services. If a family is not comfortable with one provider, because of religious or value differences, gender, etc. they are free to find another with which they may be more comfortable.

How does the policy or program direct itself to the needs of individuals and families at specific stages of the family lifecycle?

This is unclear. The policy allows for access to services at any point in the lifecycle, as long as the individual is covered by the mandate under a health insurance policy in the state. It is not directed to any specific stage of the family lifecycle.

Principle #6—Targeting Vulnerable Families:

Families in greatest economic and social need, and those determined to be most vulnerable to breakdown, should have first priority in government policies and programs.

As a corollary, policies and programs should seek to prevent serious family crises rather than targeting all resources on remedial/band-aid services.

Family Impact Questions Selected:

What efforts are made to identify and target those families who are the most vulnerable and the least likely to have other sources of support?

No specific type of family is targeted. The mandate is designed to make services available to all persons in Maryland, and to prevent catastrophic expenses when mental health services are needed.

To what extent is the policy or program specifically directed toward low income families?

The program is not directed toward any income group.

Are there sliding fee scales so that families of different socio-economic groups can use the program according to their ability to pay?

No, not in terms of the policy. However, many practitioners who provide services have a sliding scale fee, so that those with lower incomes pay relatively less for service.

Are efforts and resources targeted on preventing family problems before they become crises or chronic situations? Are these sufficient?

Mandates are designed to prevent catastrophic expenses for necessary mental health services or the continuing harm, to individuals, families, and society of untreated mental or emotional problems. The prevention comes after an emotional problem has been identified, however, and the policy is not designed to prevent mental illness.

Conclusion/Findings

This review of the mandated mental health benefits in Maryland allows for several conclusions regarding the impact this policy has on families. These tentative conclusions are:

1. It can be broadly asserted that by providing a mechanism to avert catastrophic costs for necessary mental health services for all families in the state, the program neither stigmatizes one segment of the population nor disproportionately affects any one particular group. (It is recognized that lower income families will feel the impact of the mandate more strongly than higher income families. However, those same lower income families would be devastated by the uninsured mental illness of a family member.) All family configurations are recognized and affirmed as beneficiaries of the mandate, provided that they hold a health policy administered under the mandate.
2. Families are in control of this benefit. With only minor exceptions (court order, mainly), families choose when, and to what extent, to avail themselves of the benefits of the mandate.
3. Mandates support parental/familial responsibilities to provide necessary care for family members. Without mandates, more of this burden would undoubtedly fall to the state.

4. While the majority of families in the state undoubtedly benefit from the mandate, without specific provisions which include family psychotherapy as a covered service, or provisions allowing those specifically trained in family psychotherapy to provide service as qualified providers, it is possible, and even likely, that specific needs and problems of families and individual family members (as discussed in this memorandum) may go unaddressed and untreated. Additionally, there may be the inadvertent and unintended consequence of ignoring, or possibly reducing family supports for those needing mental health services. The mandate is silent on the issue of family involvement, and because there is not specific mandate for family psychotherapy, or the inclusion of qualified family therapists as providers, one can legitimately assume both the service and the provider group are excluded. This leaves open the possibility that the actual benefit to families from this mandate may be less than one would expect in reviewing the law itself. It seems self-evident from this analysis that both the service and the provider group inclusion would increase the positive family impact of mandates.
5. Because of the controversial fiscal impact of mandates, debate will continue regarding what constitutes a legitimate mental health service (e.g., divorce recovery groups conducted by mental health professionals, etc.). Insurers will fear burgeoning costs by including services not traditionally based on a "medical model," including diagnosis of illness or disorder. However, there is unquestioned data which indicates that when undergoing family trauma and stress, individuals are many times more likely to experience major illness (physical and mental) than at times of relative calm and stability. Therefore, one direction for future consideration may be a time limited benefit, which would allow for a wider range of covered services around nodal transition points in the family lifecycle. For example, a provision including coverage for divorce recovery workshops for adults and children, might be made available for a period of one year following legal separation or divorce. Other examples such as this could also be cited. One hypothesis of this suggestion, which could be examined through research, is that a family member's mental and emotional response and successful adjustment to such nodal events might lower overall medical costs (based on data mentioned above).

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Application 5

**SUBJECT: MILITARY SPOUSE EMPLOYMENT PROGRAMS:
A FAMILY CRITERIA ASSESSMENT**

FROM: William Coffin, Director
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TO: Steven Preister, Chair
Family Criteria Task Force

Introduction

Each of the military services has established a policy that programs should be set up to assist military spouses seeking employment.

We have reviewed military spouse employment policy/programs in light of the principles and family impact questions outlined in the Family Criteria Task Force Report. Approximately half of the questions were relevant to this significant military family issue. The breadth of the questions allowed us to examine our spouse employment initiatives from a number of valuable perspectives.

Principle #1: Family Stability

Policies and programs should encourage and reinforce family, parental and marital commitment and stability, especially when children are involved. Thus, intervention in family membership and living arrangements is justified only to protect family members from serious harm or at the request of the family itself.

Family Impact Questions Selected:

How does the policy/program strengthen or weaken parental and marital commitment, enhance parental competence?

Policies attempt to enable spouses who accompany their military sponsor on a permanent change of duty station (PCS) to find suitable employment, if so desired. By so doing, the Department of Defense (DoD) hopes to lessen the voluntary family separations that occur when spouses elect to remain at a previous station due to employment opportunities. Loss of employment for some spouses places severe financial stresses on the family when the costs of relocation are added.

Parental competence is probably enhanced when a spouse is capable of supplementing the military member's income; the financial posture of the whole family is improved.

In-quarters self-employment allows spouses to remain in their homes, a nice option for those with children.

To what extent does the policy/program ease or hinder the family's decision to change its membership (for example, through divorce/separation)?

Although spousal employment programs may have many beneficial effects on family income, lessening stress, and so forth, they may also make family break-up more likely. To the degree that financial self-sufficiency can enable a spouse to live on his or her own income, divorce is a more feasible option than it would be for one entirely dependent on another's income. But, that same self-sufficiency also lessens a willingness for an abused spouse to remain in an abusive situation.

Principle #2: Family Support and Responsibilities

The first presumption of policies and programs should be to support and supplement family functioning. Services that substitute for families should only be provided in situations where it is clear the family will not be able to function sufficiently even with support.

Further, policies and programs need to vigorously enforce and support parents' responsibility to provide economic support and adequate protection for their children; similarly, family members' responsibility to care for each other in crisis or in chronic sickness, disability, or frailty should be encouraged, facilitated, and supported.

Family Impact Questions Selected:

How does the policy/program help families perform their responsibilities and prevent government activities from inappropriately substituting for that responsibility? What effect does the policy/program have on families' ability to provide financial support for their dependents?

When spouses can supplement family income, they are less likely to need food stamps and other subsidies, including unemployment benefits. This program increases family income. Child care becomes necessary in many instances, which can consume much of the spouse's earnings.

Does the policy/program build on or ignore informal support networks and mediating structures?

Hopefully, family member employment assistance coordinators do network with community organizations for job and child care referrals.

Principle #3: Family Involvement and Interdependence

Policies and programs should recognize the strength and persistence of family ties, even when they are problematic, and the influence family members have upon each other. In general, the most effective and efficient way to help a person in need is to involve the other members of the family so that the family reinforces rather than undermines the goals of the program.

Family Impact Questions Selected:

How does the policy/program consider whether there are competing needs within the participating family?

The policy recognizes that the military member's mission availability comes first. Therefore, when relocation is required of the military member, DoD attempts to ease the spouse's loss of employment by aiding in the search in the new location.

How does the policy/program help individuals and families anticipate and deal with changes the service may have on the family as a whole?

There has not been any attempt to help individuals or families deal with the changes that come with two working spouses.

Principle #4: Family Partnership and Empowerment

Policies and programs should treat all families with trust and respect as partners when providing services to a dependent member and should offer a range of levels of involvement depending on the family's wishes and situations. Families need to be empowered by providing them with information and a maximum degree of choice and decision-making.

Similarly, policies and programs should take into account the complex responsibilities of families, and enhance their ability to manage their dealings with multiple human service institutions.

Family Impact Questions Selected:

To what extent is family autonomy respected by the policy/program and the family left to make their own decisions and lead their lives in the way they wish?

The recent Secretary of Defense memo and the DoD Directive on "spouses' right to work" issues emphasizes that the choice to work, to volunteer, and/or to continue their education belongs to them, not to the commanding officer of the military member.

How does the policy or program concretely broaden the choices and options of the participating families?

The policies and the spouse employment assistance programs increase the likelihood that spouses who want employment will find it, and will share the opportunity experienced by their civilian counterparts to achieve in their own right. Without the right to choose to be employed (vs. volunteering), and without the support of the preference in hiring and the assistance programs, spouses would perceive the institution as impeding their career progression. In the past, spouses have elected: 1) to remain behind at a former duty station in order to maintain their employment, thus separating the family unit; 2) to encourage their military sponsor to leave the Service in order to permit their career progression; or 3) to give up their own goals in order to lessen the frustration experienced with each relocation. Current research is being conducted on the long-term effects of underemployment on military wives.

What are the program professionals' concepts of their role with the family in providing the service?

Roles of DoD personnel include enabling (though spouse preference policies and self-employment in quarters) and resource provision (through family member employment assistance programs).

Principle #5: Family Diversity

Policies and programs should not discriminate against or penalize families for reasons of structure, roles, heritage/values, or life stage which differ from the perceived or desired norm.

Family Impact Questions Selected:

Is there an explicit or implicit preferred family structure in the policy/program?

There has been an implicit preference for the traditional family pattern in which the spouse of the military member is not employed. That has freed him/her to offer voluntary assistance in the community and has made the family more easily mobile—fewer ties to remove when the orders to PCS come. The employment assistance policies of the Services address the reality that many spouses must work for the financial well-being of their families.

Principle #6: Targeting Vulnerable Families

Families in greatest economic and social need, and those determined to be most vulnerable to breakdown, should have first priority in government policies and programs.

As a corollary, policies and programs should seek to prevent serious family crises rather than targeting all resources on remedial/band-aid services.

Family Impact Questions Selected:

What efforts are made to identify and target those families that are the most vulnerable?

The programs are not focused on any particular income/rank level. New legislation has opened positions in grades GS-2 through GS-4 to spouse preference in hiring, as well as GS-5 through GS-15. The preference for entry level will be especially helpful for young military spouses. Spouses of all age and income/rank levels use the assistance programs that do exist. Employment coordinators find different patterns of job placement (unskilled or highly skilled) depending on the employment climate in their community.

Are there sliding fee scales so that families of different socio-economic groups can use the program according to their ability to pay?

DoD spouse employment assistance programs are free of charge.

Are efforts and resources targeted on preventing family problems before they become crises or chronic situations?

The spouse employment initiatives are pro-active. They are designed to assist spouses' search for employment before financial crises arise.

All resources of the spouse employment initiatives are devoted to prevention—i.e., helping a spouse learn job search skills for a lifetime and helping him/her determine local contacts and/or job vacancies.

Conclusion

Looking at the policies and programs from the perspective of the Family Impact Criteria added a point of view sometimes missed when the major criteria for DoD tend to be the recruitment, readiness, and retention of military members.