At-Risk Youth: The Need for New Directions

The system isn't working. That's the first message. In report after report, study after study, the conclusion is the same — a new approach to at-risk youth is needed. Deficiencies exist in every system — health, mental health, schools, corrections, and social services.

For example, the 1991 report from the U.S. Advisory Board on Child Abuse and Neglect summarizes the concern. "The scale of the problem of child maltreatment is enormous, its nature is complex, and its significance is profound, both for individual children and families and for the nation. Not only is the scale of the problem enormous, but the scale of the failure of the current system is comparable. The system needs a new child protection strategy that is carefully crafted to respond to the nature and magnitude of the problem." (p. 147)

"Americans have struggled for an effective approach to protect children and safeguard families for more than 200 years" (National Commission on Child Welfare and Family Preservation, 1991, p. 3). In earlier times, it was believed that deprived, abused, or neglected children should be removed from their homes and from their "adult" patrons. More recently, another philosophy has challenged that view. Based on the idea that a family is a child's most important resource, this approach stresses family preservation and states that a child should not be separated from his or her family without a compelling reason.

The development of the foster care system, orphanages, and other residential and group care all sanctioned removal and placement as a way to protect children at risk of abuse or neglect, rehabilitate delinquent youth, and treat those with emotional disturbance. By the 1970s, growing public and political concern about the large numbers of children who had become permanent residents of state foster and other out-of-home care systems led to enactment of P.L. 96-272 (the Adoption Assistance and Child Welfare Act of 1980). This legislation endorsed children's rights to permanence, either through a return to the biological family or through adoption or other permanent placement in a family-like setting.

A fundamental problem in the family-focused approach is that a wide gulf exists between what is needed to create successful, caring parents and what services are available. All families need basic support in order to function in a positive way that will produce healthy children.

Basic family needs are well documented. They include:
- Employment/economic means to support a family
- Access to health and mental health care
- Decent, affordable housing
- Safe communities
- Educational opportunities
- Recreation
- Social services in times of trouble

Current service systems, however, respond most consistently to families and children in acute crisis. Those with problems of drug abuse, serious abuse or sexual abuse, serious physical or mental health problems, or teenage pregnancy capture the bulk of the attention. Prevention services are limited. When budget cuts are needed prevention services are the first to go. The results are predictable. The United States has a higher child poverty rate than virtually any other Western industrialized country (U.S. National Commission on Children, 1991). Studies suggest that between one quarter and one half of behaviorally or emotionally disordered students live in poverty. A disproportionate number also live in single parent families (Knitze, et al., 1990). The growing number of troubled families and family living patterns that provide open-ended entitlement for out-of-home care but a fixed amount for preventative and family support services has resulted in a child welfare system that is inefficient (Buttrick, 1992). Of the estimated $300 billion spent on child welfare programs annually, it is estimated that 60 percent supports foster care facilities and child placement (Pierce, 1985 in Buttrick, 1992).


continued on page 3
Focus on Virginia’s Children

According to statistics, Virginia is slightly below the 11.8% prevalence estimate for children requiring mental health services. The estimated distribution into subcategories is presented below:

- Anxiety, Afflux Disorders: 4.5%
- Conduct Disorders: 3.5%
- At-Risk: 2.4%
- Multiple Handicapped: .8%
- Psychosis: .3%

In 1984, the Virginia Department of Rehabilitative Services provided mental health services to 4,287 clients at an average cost of $1,645 per client. Of these hospitalized clients, 775 were younger than 21 years old. As of October 1984, 122 children, 5 to 17 years old, were in state mental health facilities. In 1984-85, 90% of all children were placed in residential facilities such as group homes, treatment centers, and boarding schools.

Children who have been abused or neglected make up a large population of the youth in residential care. In 1983-84, as a result of legal actions taken in the most severe abuse and neglect cases, 920 children were placed in some type of residential care, with 73% of these children going to residential institutions.

In fiscal year 1988, 4,993 children were in residential care. Of these, 83 percent were in the 14 to 19-year-old age range and 96 percent were 10 to 19 years. Males represented 76 percent of the total and minorities were nearly 40 percent.

Children in care showed serious problems. About 128 were reported to have substance abuse problems. About 68 percent were adjudicated as delinquent and 29 percent were adjudicated as CHINS (children in need of services). About 77 percent were described as having serious problems in school. Suicidal behavior was documented for 29 percent and 58 percent had shown assaultive behavior.

A total of $93.6 million of federal, state, local and other funds were expended in fiscal year 1988 for the 4,993 children in residential care. Costs per child to the Common-wealth ranged from no cost (paid by parents, social service agencies, third-party payers, or State contributions) to $17,000. Expenditures per child averaged $19,000, even though a significant number of children were in care for only part of the year.

The annual rate of increase in the state share of expenditures for purchased services was 22 percent from fiscal year 1988 to Fiscal Year 1989. The increase was due to increased availability and use of more expensive treatment programs, limits placed by insurance companies on coverage and a shift from local only facilities to shared state and local expenses. The largest percentage (38 percent) of the total expenditures were for restrictive or out-of-home residential programs.

*All figures were obtained from Virginia’s Children: A Statistical Summary, published by the Virginia Division for Children and from Study of Children’s Residences, Services, March, 1990, prepared by Virginia Department of Planning and Budget.
At-Risk Youth

continued from page 1

Approximately 30 percent of children placed outside of their home are in group homes or institutions. The Select Committee projects that by 1995, if no major changes in government policy occur, the number of children in care will increase to 850,000.

It is estimated that 81,000 children under age 18 were admitted to inpatient psychiatric services in 1989. Troubled adolescents in many states were placed in mental institutions not because they were mentally ill but because "there was nowhere else for them to go" (Turkington, 1983, p. 10). Additionally, four percent of the 400,000 children identified by school as having behavioral or emotional disorders are placed in residential settings, while two percent are in correctional facilities and an additional two percent are in inpatient hospitals or home-based care (Knitzer, et al., 1990). Current fiscal practices, according to Knitzer, et al., often act as incentives for placing children in higher cost, more restrictive care than is necessary.

Knitzer and her colleagues (1990) identified some of the reasons for overuse of expensive out-of-home and residential care. Often, locations are not required to help fund the residential placement, thus, local professionals have no fiscal reason to search for other alternatives. Indeed a local system might be financially "better off" if a child/teen child was placed in a state hospital, juvenile center, or group home.

An alternative problem is apparent: what is needed for the child mental health services to availability of help. It is estimated that between 17 and 22 percent of children, some 11 to 14 million, require intervention due to a diagnosable mental disorder (NIMH, 1990 as cited in Lecroy and Ashford in Buttrick, 1992). Yet, in many communities, child mental health services are unavailable or underdeveloped. Thus, children do not receive attention early and develop more serious problems.

In places where alternatives are available, clients has shown that the expressed place- ments can be avoided. The findings of Heying (1989) are typical. Intensive, in- home services to 61 San Diego families over a three-year period resulted in an 83 percent success rate in six months follow-up where 52 families avoided placement of their children. A study in Minneapolis (Mracek Protection Report. Vol. XII, No. 13) with similar findings documented that home- based services were less expensive for minorities as for whites. (For a more comprehensive description of intensive home-based services, see VCFSN, volume 24).

Other types of alternatives have started to appear. In Illinois, the Phoenix program provided intensive day treatment at an alternative to residential care (Ham, 1989). Beech Brook, in Ohio, piloted a weekend only residential model as an alternative (Atrashan and Harris, 1989). Although this program is no longer available, Beech Brook has created a wide range of treatment options.

You need for more systematic study between agencies dealing with children with complex needs has also been well documented. Without effective collaborative efforts, children with multiple needs and serious emotional disturbance will go unserved (Richardson, et al., 1989).

It was against this backdrop of national data that Virginia agency heads began to examine the condition of the Commonwealth. It was apparent that Virginia was not different than the rest of the nation.

An Existing Initiative for Virginia

In May 1987, First Lady Janice Baliles sponsored a forum to address the service needs of Virginia's "at-risk" and "in need" abused, neglected, and abandoned children and adolescents. This forum brought together key Virginia legislators, cabinet secretaries, department heads, advocacy and civic groups, parents, providers, and state department representatives for a one-day discussion of perspectives and action recommendations.

The Forum discussions were the first step towards an interagency initiative to meet the complex service needs of Virginia's "at-risk" and "in need" seriously disturbed children and adolescents. The secretaries and department heads involved in a discussion after the Forum developed a memorandum of agreement and an interagency budget initiative for the 1989-90 biennium. The agreement created an Incarcere Funds pool to help localities meet the needs of twenty emotionally disturbed children and victima for eligibility for funding. The Consortium administering the Incarcere Funds pool comprised of representatives from each of the five child serving agencies (Departments of Corrections, Education, Mental Health, and Substance Abuse Services; DMHHRAS); and Social Services).

A year after the Forum, in May, 1988, an interagency conference, "Investing in Virginia's Future: A Continuum of Care for Our Adolescents at Risk?" was held. This jointly sponsored conference was a unique opportunity for agency representatives and service providers to come together to learn state-of-the-art models of care for children and adolescents, and to consider strategies for system change.

In late 1988, the governor, secretaries, agency heads, general assembly members, legislative staff and the Department of Planning and Budget agreed that a study of children's residential services would provide an opportunity to set direction for improved short-term, and long-term care for children.

Tony's Story

I could recount an array of statistics from national and Virginia data, but I believe more important to consider is the impact of our policies on people. I would like to take a few minutes to share with you a story of a fifteen-year-old boy, Tony.

Tony's father abused him as a young child. To protect him, the child waited. When Tony reached 12, the boy's system began to show signs of the father's presence. Tony violently turned his father four years ago and has been living with his boyfriend, for the boy's parents, Tony has been rebellion and aggression. As a result, the mother has lost many jobs on several times requesting help.

Not too long ago, Tony joined a school administration and would have been school, Tony spent the next year in and out of several juvenile correctional programs and facilities before returning home.

Tony, back at school, Tony is now major with a B+ in English and B in History. Tony is a good student, but an emotional disturbance. Tony is a good student, but has a special education teacher. Tony has a special education teacher. Tony's major with a B+ in English and B in History. Tony is a good student, but an emotional disturbance.

The House of L. Douglass White戈verner April 29, 1991
Advantages of the New Model

- The service program is tailored to the child's needs rather than firing the child into a prestructured program.
- System of care is built on the strengths of the child and family rather than on problems and deficits.
- Services are organized in a functional rather than agency-based manner, encouraging genuine interdisciplinary planning.
- The model takes into account the diversity of local communities and allows communities to choose from proven interventions and strategies that are best suited for them.
- The family is the initial and primary point of intervention and the child is served within the context of the family.
- The locus of responsibility for services, case management and decision making rests at the community level.

Subprogram codes. Seven of the 14 funding streams also purchase services other than residential care, making it difficult to isolate the effects of programs. The study concluded that agency data was maintained in a way that enabled the study to obtain accurate information about the number of children in residential care and the costs.

The study recommended that localities share the cost of residential placements. They recommended higher levels of state support for therapeutic foster care and other alternatives to residential care. Finally, the recommendation was that state funding for residential and alternative services be based on a locality's ability to pay. The study documented the need for alternative community-based services. Children at risk for residential placement should be considered as a priority for mental health services through the community service board. Individual children whose service needs overlap among the four agencies (Social Services, Youth Services, Education, MIMRSAS) should receive interagency screening, planning and evaluation.

The study further called for stimulating the development of respite services, day treatment programs, home-based services, drop-in prevention, therapeutic foster care and intensive probation or court supervision. Diagnostic and treatment services should be offered to children who have been abused or neglected. Out-of-home care, including residential care, should be reduced.

The report called for a task force composed of representatives from social services, MIMRSAS, Education and Youth Services (Caroline). The task force was to identify existing services and service gaps, to develop objective criteria for the use of residential care, to prioritize and coordinate the development and location of alternative services, and to estimate funding needed to develop new services that will result in cost saving over time. The 1990 study by the Department of Planning and Budget was an important step.

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The Council’s charge was to develop a plan to control the escalating costs of residential care for state and local governments and to provide services for youth with emotional and/or behavioral problems. This interagency, cross-sectional Council was a high priority for Governor Wilder’s Administration. The Council was composed of 145 people from family, private, and public sectors. The Council proposed its final version of the “Comprehensive Community Service Model for Troubled Children and Their Families” in November, 1991. The goal of the Council’s major initiative was to create and implement a shared vision for community support and services across the state before the year 2000. The purpose of the proposed plan was to create a new direction in service delivery that is child centered, community based, and family focused. The Council intended its model to serve as a guide to local officials, parents, service providers, and others interested in developing service systems for children who are at risk of becoming, or are already diagnosed as behaviorally disordered and/ or emotionally disturbed due to environmental, physical, or psychological stress. Rather than attempting to fit a child into a prestructured program, this model endorses adopting each service plan to the child’s unique needs. The model system must concentrate on the strengths of the child and family more so than on their problems. This model is also of a preventive nature, placing emphasis on promoting wellness and increasing individual and family resistance to stress. The many service components aim to build competence and self-esteem, enhance self-esteem, and provide social support for the child and family. The service model is best described as a “cyndical” continuum which is designed so that children and their families can be appropriately assessed and then referred to services which will be most effective. The process begins with the child and family and their involvement with various organizations within the community. These local organizations, such as schools, child care, recreation, health, and the court system provide services to children and offer the ideal setting for recognition and identification of problems. A recent parent or family self-referral is also available.
Spotlight on Richmond: Youth Service Assessment Team Network

"It's a great program," exclaims Beth Rafferty, clinician with the Richmond Community Services Board. She is describing the Youth Day Treatment Program, one of six components in Richmond's demonstration grant. Richmond's comprehensive approach was built on "bits and pieces" of prior programs and offers a full range of options to severely emotionally disturbed youth.

In January, 1991, the Richmond Youth Service Assessment Team Network (R.Y.S.A.T.N.) received one of the five state demonstration grants. The grant has been administered by a three level inter-agency organizational structure. The top level, the Director's Team, is comprised of administrators of social services, community service board, parks and recreation, public schools, youth and family services, a probation representative and a peers. Under the Director's Team is a Coordinator's Team, comprised of chairpersons of each of the five youth assessment teams, plus a representative from the interagency team coordinator. Under the Coordinator's Team is five Youth Assessment Teams that are comprised of representatives from area child serving agencies and a peer. In addition to representatives of the lead agencies, a number of other agencies serve on the teams. The assessment teams, formerly known as prescription teams, are the entry point for youth receiving demonstration grant services. The five grant services available are

- Intensive individual behavioral intervention, intensive in-home services, youth day treatment, therapeutic foster care, and residential treatment.

The team restrictive option, intensive behavioral intervention, is not traditional outpatient treatment. Instead, the approach focuses on building skills needed to parent, teaching behavioral management and in-home or in-school services.

Intensive in-home services is the next level. This intervention includes providing individual and family support during the intervention, behavioral management, parenting techniques and case management. All services are provided within the home. Each family receives 10 to 20 hours of on-site per a two to six month duration.

The first three options are methods that have been proven effective in many communities. The fourth option, Youth Day Treatment, is an unusual option. The children receiving this service attend their regular school each day. They are picked up after school by program staff, an aide and a driver, and are transported to a park and recreation site. There the students receive a snack, help with homework, group therapy and structured activities. Youth arrive home about 6:30 with homework finished. In the summer, the program runs five days a week.

"These children," states Rafferty, "are not able to be placed in regular after-school programs. They are children coming back into the community after a time in residential care." The program serves nine children in the winter and 12 children in the summer. All children in the day treatment program also receive other treatment services.

"We have learned a lot," notes Rafferty. "And we are learning more about what is most important to these children. We have focused on developing the best possible intervention that can be offered to these children. We have learned that the youth are much more capable of doing things than we thought. We have been able to develop a program that is more family-oriented and that has a lot of community involvement.

The program has been successful in helping children return to their homes. The children are doing well in school and are more involved with their families. They are also more involved with the community, participating in community activities and programs.

The program is funded by a combination of state and federal funds. It is a collaborative effort involving several agencies, including the Richmond Community Services Board, the Richmond Public Schools, and the Richmond Area Mental Health Board.

The program has also received support from the Richmond community. Local businesses and organizations have provided funding and support for the program. The program has also received positive feedback from families and community members.

The Richmond Youth Service Assessment Team Network is an example of how communities can come together to address the needs of emotionally disturbed youth. The program has been successful in helping children return to their homes, improving their academic performance, and improving their relationships with their families and communities.

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At-Risk Youth
continued from page 5

Communities have the option to select among specific service modalities, all within a common framework. This particular model includes ten service modality headings, each with a list of possible offered services. Each locality can choose particular interventions that best accommodate the structure and needs of their environment.

The proposal was sent to the General Assembly with a recommendation to phase in the changes over a 15-year period. The 1992 General Assembly approved the bill — a very exciting initiative for Virginia. The historic legislation is entitled the Comprehensive Services Act for At-Risk Youth and Families. However, although the General Assembly approved the bill, funding is contingent upon a funding formula team studying the proposal for a year and reporting back to the Assembly in 1993 with a specific funding plan. Advocates and staff working closely with the implementation plans are excited about the potential impact of the proposal. "We are moving from the concept of 'save the child from the family' to a concept of 'save the child in the content of the family.' We are acknowledging that we can't merely separate child from family," states Demos Stewart, State Department of Social Services representative to the State Management Team. "This act streamlines communities and empowers families. The community and the family join in a partnership to parent the child," emphasizes Stewart.

In order to implement the changes called for in the Comprehensive Services Act, a State Management Team has been meeting every two weeks since July, 1992. Meetings are open to the public. Note work groups are currently active:

- Certification and Technical Assistance
- Communications
- Early Intervention
- Evaluation
- Fiscal
- Funding Pool/Service Delivery
- Planning
- Training
- Trust Fund

If the legislation is fully implemented, new funding streams will be consolidated into one

There are DSS state-local foster care payments, DSS foster care purchase of service funds, DSS foster care supplemental funds, DMHAS/SAH beds purchase for adolescents, DOE private tuition assistance, DOE interagency assistance, DVS upon placement funds (286 and 270) and the Interagency Consortium's funds pool. Starting in July 1993 in order to be eligible to use funds, communities must meet certain standards. These standards are delineated in a certification package.

The act requires coordination among a community's five major child-serving systems: schools, social services, health, mental health and juvenile justice. Each community must form at least one interagency team that will provide family assessment and planning as well as a community policy and management team that will determine which children and families will receive funds for treatment and will coordinate long-range community-wide planning of child services.

Beginning January 1, 1993, there is $4.8 million available in a trust fund. The trust fund offer grants awards of up to $300,000 for communities to create options to residential care. There is no local match required for the trust fund grants. On a statewide basis, 25 percent of grant awards must be spent on early intervention while 75 percent is devoted to development of community services to prevent placement.

The funding pool money must be used for services and cannot be spent on administrative costs. No community will be cut in its allocation because of "funding hiccups" in the legislation. A funding formula will distribute sums in excess of what communities currently receive. Match for these additional funds is expected to range from 17 to 45 percent.

Pilots Programs

The state pool is contingent upon action by the 1993 General Assembly to fund it. Whether or not this occurs, the pilot initiative of the General Assembly will have available funding from the state program currently underway. The pilot programs, or demonstration grants, are located in Norfolk, Lynchburg, Roanoke City, and Rappahannock.

Roanoke City

Roanoke City was one of the first pilot projects. They received the grant award in February, 1991 and went "up and running" by July, according to April Kiser, Child Social Work Supervisor for Roanoke City Department of Social Services. At the start of the grant, Roanoke had 320 children in foster care and 50 in residential care. They succeeded to adopt a dual focus. One emphasis is the provision of intensive in-home services in cases where placement is imminent. The second emphasis is the development of special foster care needs. Roanoke's effort is directed by an Interagency Consortium of agency boards that set policy. The Manager's Group, under the direction of the Interagency Consortium, is responsible for implementation and planning. The Manager's Group oversees the Supervisor's Group. This group supervises the staff of the four city case management teams.

In the case of Roanoke, the teams handle eight cases at a time. Those accepted for services are offered a long-term service of six to nine months. The case management teams are multidisciplinary. Thus far, three homes have completed the 30 hour training necessary for therapeutic foster care. Short-term, crisis/respite homes are also being developed.

"The children served have been ones who would have been placed," explains Kiser. "Our success will be the number of children diverted from residential care." The project has returned 11 children in care to the community.

Contact Dr. Kiser, M.S.W., at Roanoke City DSS, 215 W. Church Avenue, Room 307, Roanoke, VA 24011, (703) 901-2427, FAX (703) 901-2047.

Lynchburg

Six or seven years ago, Lynchburg started examining the problems of providing services to seriously disturbed, at-risk youth. Paula Ryan, current coordinator of the Community Coordination Network (CCN) describes the early efforts. "We held interagency meetings with 35 or more professionals. The focus was always a few families who were known by all the agencies. The services were a hodge-podge."

Community coordination was formalized in 1980. The earlier initiatives had revealed gaps in services: the group had applied for, and in 1986 received, a mental health grant to begin intensive home-based services and therapeutic foster care. Lynchburg also applied for and was awarded a grant for a coordinator to oversee the interagency services. This was Ryan's position, which started in October, 1988.

When the demonstration grants for the Comprehensive Services Act were announced, Lynchburg was in an excellent position to apply. They already had the required interagency structure and community planning was an established fact. The interagency team had been utilizing state interagency coordination funds to support individualized planning and had been successful in obtaining assistance for over a dozen youth.

The largest remaining need for Lynchburg was a child care program. Child care provides immediate one-on-one support when they differ from the intensive home-based workers who are profession-based. Child aids are para-professionals.

A pool of approximately 35 child aids is available to be matched with children. The program's flexibility allows a child to be assigned more than one aide, if needed. Aides are role models for the children and assist in a variety of practical tasks. Lynchburg has budgeted $111,000 for the child aide pool. Offering $7 per hour, the continued on page 10
Who Are Vulnerable Children?

Abused and Neglected Children
There were 2.4 million children reported abused or neglected in 1989. This is a 10 percent increase over the 1988 figure and a 147 percent increase since 1979. In Virginia, there were 12,072 substantiated cases of child abuse and neglect in 1989. 12,129 in 1990, and 13,694 in 1991. The 1991 figures are a 14.5 percent increase over 1990.

Children Born Drug-Exposed
It is estimated that as many as 375,000 infants are born drug-exposed each year. The rate of perinatally acquired AIDS increased nearly 40 percent between 1988 and 1989. VCPF, Volume 33 is devoted to substance-exposed babies.

Children With Emotional Problems
The U.S. Public Health Service says 12 percent of all children under 18 suffered mental disorders in 1989. Between 7.5 million and 9.5 million children have severe emotional disturbances. In Virginia in 1983, the schools identified a total of 46,665 children ages 3-21 with handicaps. Of these, 8,708 children had serious emotional problems. It is estimated that in 1984 in Virginia 17,250 children were in need of mental health services.

Runaways and "Throwaways"
The 1990 data from studies sponsored by the U.S. Department of Justice show that in 1988 there were an estimated 450,750 children described as runaways (those leaving home or residential center without permission and are gone at least one night). An additional 127,100 "throwaways" (those told to leave home, refused permission to return or were not looked after they ran away) were identified nationally.

In Virginia, in 1985, there were 472 unresolved missing children reports. Over 98 percent involved runaways.

See VCPF, Volume 15 for more information.

Children Who Are Homeless
Today, families with children make up one-third of the homeless population. Nationwide, one in every five homeless people is a child. Falling family incomes and a strictly inadequate supply of low-cost housing are two factors contributing to homelessness.

Children Living in Poverty
The U.S. child poverty rate rose slightly in 1989, increasing to 11.6 percent from 19.5 percent in 1988. A total of 12.6 million children now live below the poverty line, an increase of more than 2.5 million from a decade ago. Every 25 seconds, an infant in the United States is born into poverty. In Virginia in 1989, there were 13,305 children under 18 living in female-headed households with no husband present who were below the poverty level. There were 53,144 families in poverty with children under 18.

Low Birthweight Children
One of the surest predictors of infant death or long-term disability is low birth weight. Though largely preventable through comprehensive prenatal care, low birth weight continues to be the single most serious infant health problem. Every two minutes a U.S. infant is born low birthweight. In 1980, 8.8 percent of the U.S. births and 7.2 percent of Virginia births were below 5 pounds. In 1989, Virginia's figure is the same.

Children Who Drop Out of School
Nationally, 79 percent of children gradu- ate from high school. However, among those 18 to 24 years old in state operated, long-term facilities for delinquents, only 10 percent had graduated. Every 10 seconds of the school day a student drops out of school. Every 15 seconds an infant is born to a mother who is not a high school graduate.

Children With an Incarcerated Family Member
More than half of juveniles and young adults in long-term state-operated juvenile institutions have a family member who had been incarcerated. In Virginia, in 1984, there were 914 youths committed to the Virginia Department of Corrections. The cost for maintaining a youth in a training center in 1983-84 was $24,283.

Children of Alcohols
VCPF, Volume 18, detailed the risks to children who live with an alcoholic parent. In 1984, 2,672 juvenile arrests were made on alcohol-related charges.

Children Exposed to Marital Violence
In Virginia there were 23,411 battered women and their children reported during 1989. Also, 120 homicide victims were known to be committed by family members.

Children of Teenage Mothers
There are at-risk for poor parenting (see VCPF, Volume 13). Every 64 seconds in the United States an infant is born to a teenage mother. Every five minutes an infant is born to a teenage mother who already has another child. In Virginia, 55 teenagers become pregnant every day. In 1987, the common- wealth spent $198,332,000 to support families that resulted from adolescent pregnancies. The average annual cost per baby was $15,500.

Some information obtained from
Historically, residential treatment facilities for youth have undergone much change. Stone (cited in Zimmerman, 1990) traces the development of modern treatment centers. Following the scientific revolution when adults switched from basic survival to materialism, institutions were created to isolate disruptive youth. Early facilities stressed punitive control and management. The development of institutions paralleled the rise of large urban centers and an increasing number of homeless, abandoned youth.

Charitable and religious organizations founded orphanages, poor houses, group homes and work farms. While most of these programs provided residential care for dependent children, the public sector was largely responsible for emotionally disturbed, handicapped or delinquent youth, as well as some of the dependent population. Nevertheless, prior to the 19th century, most deviant youth in the U.S. were "placed out" to relatives, farm families, or informal community placement.

The latter part of the 18th century and the early years of the 19th century were a second stage in development of residential treatment. The concept of more humane care for persons in institutions began to take precedence over the earlier punitive, restrictive ideas.

During the mid-19th century, residential care entered its third phase of active, but "trial and error" efforts to develop specific milieu programs, grouping youth into categories of "criminal," "delinquent" and "innocent." Specialized institutions were opened for deaf and blind. Pediatrics and child psychiatry emerged as medical specialties.

It wasn't until the 1920's that children's institutes and child psychiatric units first appeared. The first units were in response to the widespread infectious epidemic of 1919 which caused nervous behavioral disorders. The first medically supervised unit for adolescents in a psychiatric hospital was opened at Bellevue Hospital in New York City in 1937. The majority of the 40-50 males served were referred by juvenile courts judges. Referred youth had been labeled delinquent with crimes of truancy, stealing, fire setting, sexual offenses and murder. After a 30 day observation and diagnostic period, most adolescents were returned home, some referred to institutions for "mental defects," to correctional institutions or to state hospitals. Prior to the 1950's, most adolescents admitted to inpatient psychiatric treatment were housed in the adult-patient units. The first reported all-adolescent unit at a private hospital was established at the Hillside Hospital in New York in 1955. By the 1960's, specialized adolescent treatment programs and all-adolescent wards proliferated (Zimmerman, 1990).

The strong influence of psychoanalytic theories was evident in the founding of many innovative residential treatment programs. Most of these programs stressed the importance of a therapeutic milieu, differentiating it from the earlier "clinical model" which emphasized hierarchy distancing professional staff from child care workers.

**Trends From 1960's to 1980's**

Provision of residential group care for children and youth changed markedly during the two decades of the 1960's and 1970's (Young, et al. in Barkczak, 1989). Two national research efforts, both carried out at the University of Illinois, document the changes from 1966 to 1981.

During the 15 years between surveys, the total number of residential group care facilities for children nationwide increased, while the number of children served declined. In 1966, 2,318 facilities reported a total of 155,905 children in care. In 1981, 3,914 facilities reported a total of 245,321 children.

The type of children served also changed between the surveys. In 1981 there were fewer facilities for children labeled dependent or neglected and fewer facilities for pregnant adolescents. In contrast, all types of facilities for juvenile justice (those for delinquent children, for juvenile offenders, units for detention) had increased. Mental health facilities for children, considered emotionally disturbed and for children requiring psychiatric inpatient care had also increased.

Facilities operated by the Catholic or Protestant churches and those operated by state governments decreased. These decreases were offset by a substantial increase in the numbers of children living in facilities operated by private non-for-profit groups or by private, for profit groups.

Facilities in 1981 were smaller than those in 1966, declining from an average of 67 children to 32 children. Two-thirds of the 1981 facilities served 25 or fewer residents, compared to 36 percent in 1966. However, large numbers of children in residential group care continued to live in big facilities. In 1981, three-fourths of the children in public facilities were living in groups of 50 or more. Most of the public facilities were detention or long-term facilities for delinquents.

In addition to shifts in type of children served, sources of support and size of facilities, another major change was a reduction in length of stay. In every category of care for which a comparison could be made, 1981 showed shorter length of stay. It is possible that emphasis on family preservation, permanency planning, and community-based facilities had a desirable impact on length of stay.

In general, the degree of disturbance in children, the number of problems exhibited by children, and the numbers of children with abuse in their backgrounds was higher in 1981. In particular, the numbers of children who were violent to themselves or others was higher in 1981 as were the numbers of children with learning and/or perceptual problems. The increased availability of illegal drugs in 1981 may have been a factor but one in nearly 40 percent of facilities reported developing substance abuse treatment programs. Thus, providing residential care in 1981 appeared to be far more complex and difficult task than in 1966.

Facilities in 1981 were caring for more seriously disturbed children for shorter periods of time.

In recent times, treatment approaches other than the psychodynamic model have developed, including behavioral therapy, positive peer culture, and the psychoeducational model. The treatment process for adolescents in residential programs has become increasingly sophisticated, usually consisting of a combination of individual psychotherapy, special school programs, group therapy, family therapy, and medication. Programs have also shown a recent shift to emphasis on post-placement adjustment, creativity of community-based settings, and development of a network of community supports.

*Center of Virginia, Department of Social Services*

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Evaluation of Residential Treatment
The low priority given to institutional care is reflected in the scarcity of research on the topic. Experimental and descriptive data are needed on all aspects of institutional care. The research that does exist suffers from serious methodological flaws (Harving, et al., in Buttrick, 1992).

Wilson and Lyman (1983, reported in Zimmerman, 1990) surveyed evaluation research on residential treatment. They reported that most studies of residential programs found some improvements at time of discharge or shortly thereafter. Few studies offered control or comparison groups.

Carr (1986, reported in Zimmerman, 1990) summarizing results of three major studies, concluded that 60 to 80 percent of youth will improve and be functioning adequately at follow-up when compared to status at admission. According to Zimmerman, specialized programs for adolescents yield better long-term treatment results, especially for those diagnosed as character disordered or acute schizophrenic.

Factors that appear to predict post-treatment outcome, according to Leeory and Ashton (in Buttrick, 1992), include the involvement of family members in the treatment, availability of social support, and the amount of environmental and family stress. Thus, the effectiveness of residential treatment cannot be considered in isolation, but rather must be evaluated in conjunction with the client's own post-treatment living arrangement and follow-up care (Sat, et. al., 1988, cited in Buttrick, 1992).

Leeory and Ashton conclude that most children appear to improve as a result of residential care. Likewise, psychiatric hospitalization is often beneficial and is especially useful when specialized treatment programs and aftercare are available. Still, little knowledge is available to guide teams or practitioners in deciding who is appropriate for residential or inpatient care, when children are ready for a particular type of program is best suited for which childhood disorder (in Buttrick, 1992).

The Future of Residential Care
In many places, residential centers were established to fill gaps in outpatient services for children. In fact, most of the services done in residential settings can be done on an outpatient basis or day treatment unit (Barker, in Schaefer & Swanson, 1988).

Many children are admitted to residential centers because those caring for them or their school or their home community have had enough of them or (at least have had enough of their disturbed behavior). The community may feel that a change in environment or the family may need a break (Barker, in Schaefer & Swanson, 1988).

Barker makes some suggestions for improving effectiveness of residential care. First, admissions should be for as short a time as possible. He defines this as days, if possible. Secondly, a provisional discharge date should be set at time of admission. Third, the goals of treatment should be defined, preferably in writing, prior to admission. Parental involvement is included in treatment decisions. While in residential treatment, youth should spend as much time as possible in the physical care of their parents and guardians. The primary aim of residential care should be to produce change in the family system. Admission to a residential center should be considered only when less drastic, less intrusive and less costly treatments have been given a fair trial and failed. Finally, residential centers and communities should establish close liaison, ideally with cross-staffing so children do not feel they are being switched or from one adult to another upon admission and discharge.

There will continue to be a need for quality out-of-home care. Embracing concepts such as "least restrictive alternative" does not mean that out-of-home placement is to be avoided at all costs (Fitzharris, in Balzer, 1989). It is recognized that a considerable number of families may not be "treatable" or "restorable" by current methods. As family intervention programs are more successful, the diathesis of children needing placement are likely to be those with severe and multiple problems. It may be that these seriously disturbed children will require longer, not shorter stays. Many children in residential care will not go to their biological homes and despite best efforts, no adoptive home may be available.

Available statistics support the idea that many seriously disturbed children have dysfunctional families. A Washington State study found 70 percent of children with behavioral and emotional problems had been victims of abuse or neglect, 66 percent were from a family with substance abuse problems and 79 percent were from families with a history of mental illness.

Thus, while much more remains to be done to assure that only children placed in out-of-home care are those without alterna- tives with a serious mental health problem. Children in out-of-home placements, the role of residential care in the spectrum of intervention choices is established and is crucial (Fitzharris, in Balzer, 1989).

Virginia's Picture
Sixteen residential centers (group homes and schools for emotionally disturbed youth) in Virginia were interviewed by telephone about their services and their reactions to the Comprehensive Services Act for At-Risk Youth and Families (see main article). Centers surveyed did not include correctional centers, psychiatric inpatient facilities, emergency care facilities or therapeutic foster care agencies.

Most facilities served 30 to 40 children, with three serving 20 or less and seven serving over 40. No facility served over 80 children. All but two facilities served boys. Eleven served girls. Only five facilities served children 10 and under, and only ten served children over 16. Most served those in the range of 11 to 16.

The average length of stay varied considerably. One facility reported a six month average stay, four reported 9 to 12 months, three reported 15 months, five reported an 18 month average stay, two reported two years as average, and one reported three years.

Staff to child ratios also varied widely. They ranged from 3:1 staff/resident ratio to 3:1. Half the facilities (8) reported less than a 1:1 ratio of staff to residents.

The problems of the youngsters in care were similar. These included delinquency, behavioral problems, school achievement difficulty, learning disabilities, and family dysfunction. Some facilities served teens who were depressed and/or suicidal; others did not. Some facilities served children needing drug rehabilitation; others did not. Some facilities also excluded those diagnosed as mentally retarded, children who set fires, or sexual offenders.

Nine of the 16 facilities had their own school. The other seven used public schools for their residents. One center had some school- associated services for a private local school.

Counseling was available at nine of the facilities from one to three counselors. Of the nine facilities utilized Ph.D. level psychologists or psychiatrists as treatment providers. Five utilized M.A. level counselors or social workers. Two facilities had only B.A. level counselors. One had seven programs that did not provide counseling at the facility utilized community service boards or community clinics as a therapy resource. Only three facilities required family therapy. Other facilities except two had family therapy available but accepted referrals that had no family involvement.

continued on page 18
At-Risk Youth
continued from page 6
program has had no trouble attracting applicants. "We are especially pleased to be able to match minority youth with minority males who can act as positive role models. With such a large pool of aides, we can match on specific needs," notes Ryan. The aides pool has served 47 youth as of Sep- tember, 1992.
The grant has also allowed Lynchburg to increase intensive home-based services, with 90 families receiving services. Therapeutic foster care has helped four youth, 48 youth have received school-based interagency case management and eight youth have been placed in out-of-community residential care.
The team has brought seven children back into the community in a planned fashion from the residential centers where they lived. Ryan recalls, "We have been even able to bring home and maintain one child who was at DejaVu for a total of seven years. Lynchburg has designated approximately $8,000 as flexible funds for purchase of child-specific family needs. They have also spon- sored training for parents in drug education. Fourteen parents have been trained to facili- tate drug prevention workshops and two workshops per year are provided.
Lynchburg's Community Coordination Network is organized in a similar fashion as the other demonstration projects. The Intergency Consortium is comprised of the directors of the child serving agencies. The Intergency Advisory Committee contains supervisors from the key agencies. The third component are the six Community Assess- ment Teams of direct service providers who meet weekly and are responsible for assess- ment and treatment planning.
For more information, contact Paula Ryan at Central Virginia Community Services, 2255 Landis Place, P.O. Box 2497, Lynchburg, VA 24501, (804) 847-8000, FAX (804) 846-8008.
Rappahannock
The Rappahannock Area demonstration grant is a truly multidisciplinary undertaking. The Child-Serving Intergency Board over- sees grants activities in the City of Fredericks- burg and the four surrounding counties, King George, Spotsylvania, Stafford, and Caroline. In addition to serving a wide area, grant coordinator Ronald N. Branscome notes that the area has a high incidence of high risk factors, according to a survey of Youth and Family Services study.
At the beginning of the grant, the group listed every child in service, every child in residential care, and every child at risk. This data allowed the team to develop a wide- range of services. "You can't say that all emotionally disturbed children need this service or this one," explains Branscome. "Rather, you need to design a program specific to the child."
Rappahannock Area has developed an impressive array of services, seven in all. Parent Aides assist with transportation, teach child discipline, arrange social or recreational outings, and teach problem-solving. This year, 29 children have received services and the waiting list is at 25.
The Homebuilder Program is similar to other intensive in-home programs. Twenty- one families have been assisted this year and 8 are waiting. The Care Management Pro- gram provides assessment, treatment plan- ning and crisis services. Up to September, 61 children had been served.
One service that has been instrumental in bringing children out of residential care has been the Student Aide Program. In this service, trained student aides assist teachers by providing one-on-one or small group assistance. This year 11 children are served with 10 children awaiting service.
A local provider, Employment Resources, Inc. can serve up to three youth who are unable to be served in the school. Both education and vocational services are available, including job training and place- ment. An Intensive Probation Program works with up to 12 youth at a time. Finally, therapeutic foster care enables some youth to assist in one-on-one family placements.
Has it worked? The initial data are im- pressive. In FY 1992, Rappahannock reduced bed day utilization of state psychi- atric placements by 24.35 percent (2,805 bed days in 1991 to 2,122 bed days in 1992). From July to September, 1993, only 184 bed days were used.
Contact: Ronald Branscome at Rappa- hannock Area Community Services Board, 800 Jackson Street, Fredericksburg, VA 22401, (703) 737-3223, FAX (703) 737-3753.
(Note: Two other demonstration projects, Norfolk and Richmond, are described in Spotlights, this issue.)
Looking Forward
Communities will face challenges in reor- ganizing children's services. Our experience with the demonstration grants has shown that the undertaking is considerable. Branscome, coordinator of the Rappahannock Area team comments, "You have to have a mind set from the outset that the alternatives to placement are mandatory. Alternatives take work, time, effort and creativity."
Kinsey of Roanoke notes a type of several coordinators who noted the difficulty in forming an interagency approach. "The hardest part," notes Kinsey, "is to pull together agency heads and agree upon a direction. We had a field of lilies at first." Lynn Moore, of Norfolk Youth Network agreed, "The biggest obstacle to an inter-
agency effort in the initial 'buy-in' from each agency and the governmental bodies." It is perhaps natural that agencies fear a new way of working. There are many worries, includ- ing fear of sharing funds, of losing control, of greater scrutiny by others and of more formal accountability for services. Branscome notes that the assessment teams require a great deal of time. "The team approach is very positive, but our infrastructures weren't set up to give this kind of time," he states.
Is it worth it? Every project responded with a resounding "YES!!" Ryan, coordinator of Lynchburg's project, answers succinctly, "The whole concept works."
Moores talks about how sharing with other agencies has resulted in an expanded knowledge base. Beth Rafferty, of Richmond, radiates enthusiasm. Kinsey counts successes in the numbers of youngsters that would have been placed outside the community. Branscome agrees, "The easiest way to go is to simply place a troublesome child in residential care. But it's not always the best way to go." References available upon request.

Resources
Training for Residential Child Care Workers Available from National Resource Center for Youth Services, The University of Oklahoma, 202 E. Eigle, Tulsa, OK 74121, (918) 697-5621.

AWARE Special Issue
The July/August 1992 issue of AWARE was a special issue on child advocacy organizations. A copy is available from Children's Resource Center, c/o (MARMERAS, P.O. Box 1757, Richmond, VA 23214, (804) 785-5507.

Commonwealth Alliance for Children and Families
A Voice for Virginia's Children
Richmond, VA 23207-2595
The mission of the Commonwealth Alliance for Children and Families is to formulate and promote a comprehensive, cross-disciplinary public policy agenda for the Commonwealth. Current subcom- mittees include Healthy Children, Housing Families, Improving Educational Success, Effective Juvenile Justice System, Prevention of Abuse and Maltreat- ment and Quality Child Care.

Virginia has, indeed, embarked upon a bold, new initiative. Larry Jackson, Com- missioner of the Virginia Department of Social Services and Chair of the State Execu- tive Council, summarized, "Implementation of Comprehensive Services for Youth and Families is the product of the work of thousands of dedicated families and children. Those visionaries have worked and struggled for over three years and have dared to dream of revolutionary ways to change for the better the delivery of services for children and families. Each state has tried something new. We are breaking ground that others will want to walk. We are planning and preparing for the future."

10
Innovations...

While interviewing residential centers and treatment programs for this time, VCNP un- covered some innovative approaches and ideas that deserve mention. Space precludes spotlighting each program. Excerpts from programs are described and readers can contact the programs for more detailed information.

Boys’ Home, Inc., in Covington continues to experience success with its volunteer monitoring program. Monitors assist with keeping the youth’s home community contacts in place and builds youth in the transition back into their home community.

For more information, contact Dannie Wheatly, Boys’ Home, Inc., Covington, VA 24426, (703) 962-1118.

Book Review

Available from: Brak Street College of Education 610 West 132nd Street New York, New York 10025 (212) 663-7200.

This volume addresses today’s education system documenting the gaps in service to children with emotional and behavioral problems. The authors challenge those who work directly with children and the children’s families as well as those who advocate for or make policies on their behalf to recognize that children with these disabilities are appropriately served within educational settings.

This report emphasizes that the school system alone cannot adequately meet the challenge. The authors provide an agenda for reform that must involve appropriate, public child-serving agencies as well as several community agencies.

The authors highlight exemplary programs that are seeking to do a better job of addressing the complex needs of children and adolescents with emotional and behavioral problems. These efforts include early intervention activities, open-end programs, services designed to improve social skills, and services requiring family involvement.

This volume is a must for those interested in opening the window of opportunity for children with behavioral handicaps. The hope is to make exemplary programs like those featured available in school districts across the nation.

Wilderness Experiences

The Adolescent Health Center in Midlothian, Virginia offers a therapeutic outdoor program, Wilderse Rends Experiences, Inc. to “at risk” youth and their families. The program is conducted by Blackwater Outdoor Center in Davis, West Virginia. It includes a wide selection of one week and two week trips. Activities include white-water rafting, canoeing, rock-climbing and repelling, canoeing, backpacking, cross-country skiing and mountain biking as well as campfires, outdoor skills training and art initiatives. These offerings we combined with individual treatment plans which enable participants to develop a pattern of successful experiences. Confronting fears, sharing feelings, developing relationships and having fun comprise a total therapeutic package.

Wilderse Rends is a non-profit foundation and provides scholarships for youth in need. In 1991, $25,000 of scholarships were awarded. For more information, contact Wilderse Rends, Suite B, 13821 Village Mill Drive, Malcolinith, VA 23113, (804) 794-4900, FAX 904 378-1022.

Timber Ridge School in Winchester offers vocational training. Included are skills programs in basic carpentry, plumbing, electrical wiring, basic and advanced electronics. Instruction in problem-solving strategies for the work setting and career orientation is included.

More information is available from Phillip E. Arntz, A.C.S.W., Director of Admission and Records, Timber Ridge School, P.O. Box 1369, Winchester, VA 22604-2390, (703) 838-3456.

Programs spotlighted and described used in this issue or other issue of VCNP are not "endorsements." VCNP describes programs and approaches in order to offer models and ideas to communities. Information about the program is supplied by the program.

New Dominion School, Inc., also operates a wilderness program. Their program, founded in 1979, is a year round residential center located in Dilwyn, 45 miles south of Charlottesville. Using a group-process problem-solving model in which small groups of students and staff work together, each group designs, builds and maintains their own living quarters. Backpacking, canoeing and bicycling wilderness trips are available as well as a full complement of academic and therapeutic services.

One unusual component is the availability of evaluation research. The program has just completed its third five year evaluation study. Thus, 15 years of follow-up data are available on a total sample of 272 students. While lacking control groups, the research still provides an impressive array of data, including pre- and post-treatment, examination of court referrals, interviews with student and family, agency contacts, and demographic data.

Those interested in more information about New Dominion’s program or evaluation methods can contact Don Williams, New Dominion School, Inc., P.O. Box 546, Dilwyn, VA 22936, (804) 983-2651, FAX (804) 983-2698.

CHILDREN’S MINISTRIES
Presbyterian Home & Family Services, Inc.

Presbyterian Home, Inc., in Lynchburg reports that they are currently serving 14 former students who are pursuing college or higher education. Any student who is a prior resident of the Presbyterian Home can apply to the Advanced Education Program. It is a cooperative program that assists students in applications to higher education and assistance in obtaining student loans. If the student successfully completes the program, then the Presbyterian Home pays the student’s loans, allowing the individual to be debt-free. Currently, 14 prior students are in college or higher education, including two in graduate school. Director John Alexander relates that the Presbyterian Home has a long tradition of sending students to college.

For more information about the Advanced Education Program or the other programs at Presbyterian Home, contact Alexander at 110 Linden Avenue, Lynchburg, VA 24503, (804) 384-3311.

The National Commission on Children was created in 1988 by Congress and the President through P.L. 100-203 to serve as a forum on behalf of the children of the nation. The commission is a bipartisan body of 34 members appointed by the President, the Speaker of the House and the President pro tempore of the Senate. The mission of the Commission is to develop a national agenda for public and private sector policies to improve the opportunities for every young person and to address the social, economic and cultural circumstances that have deprived children of a healthy, secure, educated, economically self-sufficient and productive adult.

The Commission has produced the final report of the National Commission on Children: Beyond Rhetoric—a New American Agenda for Children and Families, which includes recommendations on: ensuring income security, improving health, increasing educational achievement, protecting employees for adulthood, protecting vulnerable children and their families, making policies and programs work, creating a moral climate for children and investing in America’s future.


This revised edition of standards, a guide for quality care, was created to be used by policymakers, legislators, social workers, directors of group homes and other people who care for and work with children and families and carry no explicit regulations or controls. In all, the guide and manual are designed to assist in providing quality care services.

This new volume of standards is different from previous DCAI residential care standards. Rather than merely detailing details of facilities, it emphasizes and emphasizes the care and treatment by which children’s needs are assessed, the selection of appropriate services to meet children’s needs, and the matching of the child in the most appropriate setting, and an understanding of the unique features of various kinds of residential settings.

This volume of standards encompasses the array of residential group care settings, the process and elements of service delivery and treatment, programs of service, the administration of residential facilities, and community support for children in residential treatment.


This report discusses policies in the child protection system and offers a bold new alternative. The report advocates the replacement of the current child protection system with a new, national, child-centered, neighborhood-based child protection strategy.


Thousands of children in America's cities are growing up amidst a worsening problem of community violence. Most violence occurs in poor, inner-city neighborhoods and public housing projects. Young children witness violence and are victims of child abuse. Their chance is to be a victim or a witness, as the cycle of force and perpetual fear. The authors write the book for those who are inner-city workers and those who wish to understand the "urban war zone."


This guidebook contains all the "basics." An explanation of what an emotional or behavioral disorder is. How to tell if your child has one. What to do. Where to go for help. What sorts of treatment programs are available. Treatment options are also how they deliver. An explanation of special education services. Several Appendices for state parent organizations, parent training institutes, organizations concerned with child mental health and educational reading.


The National Commission proposes a three-part, inter-linking service approach to address family and children’s needs. The first part broadly supports all families, the second assists families in need; the third protects children from sexual abuse and neglect. Model programs that are examples of innovative service delivery are highlighted. This report can serve as a comprehensive framework to accomplish change. The National Commission challenges all of us to work with them to make the report a reality.


This volume is comprised of essays and discussions that address the place of group care in today’s society as well as the challenges and efforts of individuals and organizations as we proceed to the year 2000. This book is divided into four separate sections: child in group care, policy issues affecting group care, organization and program approaches that are based on child’s needs, and improving group care through research. Current issues and trends today are discussed along with their implications for group care. As well as presenting new information and knowledge, each of the author’s other goals is to acquaint people with each other through a common contributor’s list with addresses that continues this volume.

This type, benefit all who are deeply concerned about children and providing the highest quality of services in mind and the families. It is noted in a philosophy of flexibility and transition, rather than rigidity that values years of unthinking adherence to one idea.
Research on Children, edited by Shirley Buttsick, 1992, 60 pages. Available from: AASW Press. National Association of Social Workers. 750 First Street, NE, Suite 700 Washington, DC 20002-4214. In selecting articles for this special issue, the editorial board sought manuscripts that provide research findings of interest to practitioners. The six articles chosen cover current findings in child mental health and evaluation of services, research on family preservation projects, child welfare research, and projects examining AFDC and foster care.

CHILD ADVOCACY

Childhood Advocacy for Early Child Educators by Beatrice S. Fertigov, 1989, 250 pages, $7.95 (paper), $36.95 (cloth). Available from: Teachers College Press. 1234 Amsterdam Ave. New York, NY 10027

Fertigov's premise is that there needs to be a fundamental national reconsideration of roles and responsibilities of teachers, including early childhood educators. There is a need for teachers who are knowledgeable about children, their cognitive, social and emotional development and the factors that influence development. There is a need for teachers who account for cultural and individual differences in their teaching, teachers who believe in the critical role of families and community organizations in educating young people. Finally, there is a need for teachers who can connect with individuals and organizations outside the school building to develop the full potential of every student.

Fertigov makes an appeal for teachers to act on behalf of children, not only in the classroom but in every keeps of children's lives that affects their development and, hence, their ability to learn. Good early childhood educators must be strong, comprehensive, people wishing to support their professional and moral convictions. Equity must be a way of life for teachers.

This book presents current perspectives on advocacy. It also addresses problems early childhood educators face, advocacy, and professionalism in the classroom and in society, and the role of child advocates in policy. Fertigov's commitment to child advocacy is apparent throughout the book. She makes an inspired appeal for all teachers, particularly early childhood educators, to act on behalf of children in every setting of their lives.

The book is a collection of essays written by and for child care practitioners. These professionals have addressed what they perceive as the most significant issues in the field today, including the nature of child and youth care, current issues in education and training, research and policy issues, key support functions in child care, the changing work environment, and developing professionalism in the field of child and youth care.

In an effort to steer away from mere theory, the writers make a strong effort to address the practicality of caring for children. Their writings are reminiscent of empirical research and clear conceptual thinking, as well as the recognition of the relevance of personal transformation in sustaining quality care. A main assumption is that holistic and collaborative approaches to child care and social action as well as personal change.

The book was written for use in academic courses in child development and family relations in individual child and youth care, and in professional and postgraduate programs from related disciplines.


Human care and treatment, stability, and a commitment to take the time needed to heal are emphasized in this volume. Badly damaged children present special clinical issues and problems, making the Heart approach for the multiply damaged child who hungers for understanding rather than behavior management.


This report is the result of two years of work done by the Committee on Child Welfare and Family Preservation, formed in 1988 by the American Public Welfare Association (APWA). The report is the culmination of a cabinet level state human service commissioner, local administrators, public child welfare directors and APWA heard members from around the country. Their mission was to study the status of the family in contemporary society and to establish a strong family policy. They listened to experts from across the nation and examined the shortcomings of child welfare systems. They heard suggestions to improve programs to support troubled families and their children. The result is this report.

The commission proposed a new framework for children and family services which would include the following three components: 1. a commitment to support families for healthy child development; 2. strong community investments—human and financial—to address the needs of vulnerable families before crisis emerge; and 3. a service perspective based on family strengths and not deficits and dysfunctional.

This report outlines the recommendations for reorganization of services to address these three components, it is thorough and complete in its analysis of these issues and strategies for addressing them. The concluding statement of the executive summary states: 'The three components of our report offer a new way to build on strengths. Through an unswerving commitment to family and an open minded emphasis on cooperation, this proposal can move us closer to a family-focused system of services that should exist for our children and ourselves. It applies the use of these strategies could indeed move child care along a path that will best serve the interests of families and children.'
Governor’s Advisory Board on Child Abuse and Neglect Recognizes the 1992 Outstanding Child Advocates

The Reverend John Douglas Sterrett, Jr. Lebanon
As minister of the Lebanon Presbyterian Church, the Reverend Sterrett has led the church in a progressive approach to meet the community’s need for quality day care, preschool programs and parent support groups. From 1946 to 1952, the church developed a preschool program, a day nursery day care program and supported a Parents Anonymous group. The Reverend Sterrett has also served on the board of directors for both Russell County Head Start and for the Presbyterian Children’s Home of the Highlands.

Kathryn M. Jarrell Christiansburg
From 1985 to 1992, Mrs. Jarrell served as executive director of the Child Abuse Prevention Council of the Blue Ridge Valley. She was primarily responsible for establishing the Parent’s Place, a resource center for families the offers parent education, support groups and enrichment activities. The Parent’s Place has served over 800 families.

Thomas J. Minkie, Jr., Charlottesville
Mr. Minkie has spent a legislative lifetime committed to improving the quality of life for families and children. Throughout his 20 years in the Virginia General Assembly, he has sponsored and supported numerous bills. He drafted the first comprehensive child abuse statute for Virginia, enacted in 1973. He has introduced legislation to promote education quality to establish services for children with mental and physical disabilities, and to study an experimental family court. He assisted in the passage of the Spousal and Child Support Enforcement Acts and the Virginia Parentage Act. Irreplaceable children have benefited from the thoughtfully written legislation and the legislature will continue to exert a lasting positive effect on Virginia’s children and families.

J. Martin Bass
Fredericksburg
While he seeks to promote family preservation, Mr. Bass vigorously protects the rights of children in his role as legal counsel for Sperosavias County Department of Social Services. Mr. Bass has served as training coordinator for juvenile and domestic relations court judges. He consults to the Rappahannock Area CASA program and is an officer for Rappahannock Big Brothers/Big Sisters. He was commended for his rapport with children and his availability both during and after working hours.

Linda Woods
Norfolk
For the past five years, Ms. Woods has directed the Norfolk CASA program, developing it into a model program. She has assisted numerous communities in planning, developing, and improving CASA programs throughout Virginia. Ms. Woods has done more than any other single person to expand CASA programs throughout the Commonwealth and thus assure a safer, more hopeful life for countless vulnerable children.

Mary E. McGhee
Fredericksburg
Described as “exceptional, compassionate, understanding, invaluable,” Ms. McGhee is a therapist who has counseled child victims of sexual abuse and assisted them in recovery. She also trains CASA volunteers, consults to CPS, prosecutors and law enforcement and serves on protocol teams in several jurisdictions. She trains foster parents to deal with abused children and has organized support services for hyperactive children.

For the outstanding work provided by the Virginia Department of Social Services, Office of Juvenile Services, Office with a Grand Title to the National Center for Child Abuse and Neglect, Administration for Children, Youth and Families, Department of Health and Human Services.

For the outstanding work provided by the Virginia Department of Social Services, Office of Juvenile Services, Office with a Grand Title to the National Center for Child Abuse and Neglect, Administration for Children, Youth and Families, Department of Health and Human Services.
Spotlight: Norfolk Youth Network

The "founding fathers" of Norfolk's interagency network were the juvenile court judges, according to Lynne Moore, Network Coordinator. Frustrated by the lack of coordination, they requested that the community develop a unified approach for multi-need children and families. In 1989, the Norfolk Youth Network was formed.

Convinced that the interagency concept was sound, the Norfolk City Council appropriated $200,000 to the network to establish a home-based service program. When the demonstration grant was offered, "We were in an excellent position to apply," comments Moore. "First, we had the interagency structure in place. Secondly, our risk indicators were very high." Moore explains that the Division of Youth Services performed a study and issued a report in February, 1989. Norfolk was second in the state for percentage of youth living in poverty, second for percentage of adolescent pregnancies, first for percentage of reading failures, and fourth for both high school dropout rate and founded child abuse complaints. Norfolk also was third highest in delinquency and child-in-need-of-services court petitions.

Norfolk Youth Network combines the resources of six agencies. These are the Community Services Board, schools, public health, social services, juvenile court services and the Juvenile Services Bureau. Administrators from these six agencies comprise the Interagency Consortium. Under the policy body are the teen Community Assessment Teams which accept referrals, perform assessments and generate treatment plans.

From the demonstration grant monies, the Network has developed five key services. Similar to other states, Norfolk has intensive home-based services. Of the 25 families served, all but 1 were prevented from out-of-home placement.

A Preschool Prevention Program offers an intensive eight week program that nurtures parent-child attachment. The program costs three hours per day, three times per week in different sites and throughout the city. To date, 61 parents and 73 children have been served.

Therapeutic Respite Care is provided both in-home and out-of-home. It can be requested on either a planned or a crisis basis. Thus far, 42 families with 86 children have benefited from this service.

Therapeutic foster homes will serve 30 youth over the 18 month grant period. Intensive probation has served 50 youth with a 64 percent success rate. All these youth were committed to youth centers and diverted into the program.

Norfolk is enthusiastic about their program. They have created a booklet titled "Norfolk Youth Network" which describes their program, including forms used by the assessment teams. To obtain the booklet or further information, contact Lynne Moore, Norfolk Youth Network, 1600 East Little Creek Road, Suite 315, Norfolk, VA 23518, (804) 441-1657, FAX (804) 460-1245.

Spotlight on Richmond:

St. Joseph's Villa, originally established in 1836, offers an extremely diverse range of programs on its 75 acre campus. Of special interest are two programs, Project Divert and the Extended Day Program.

Project Divert is a 90 day program designed to provide an alternative to detention for adolescents. Project Divert, started in July, 1991, serves 12 youth ages 11-16 at a time. Henrico County Courts has purchased nine of the spaces and departments of social services statewide have access to the remaining three spaces. All youth have had some court involvement.

The approach of Project Divert is extremely structured and very group oriented, according to Linda Santosanti, Admissions Coordinator. The program works intensively with families and begins the transition back into the family unit or other living arrangement immediately.

A second innovative program is the Extended Day Program, one of the first of its kind in Virginia. Designed to help keep emotionally disturbed or behaviorally disordered children with their families, the program offers therapeutic after-school care Mondays through Fridays until 7:00 a.m. daily days of programming from 8 a.m.-4:00 on Saturdays, and a full day 8 a.m.-9:00 every other week on Sundays. Up to 24 children ages 9 to 18 can be served in this program.

Children must attend at least three days a week. Parents are expected to attend a parent support group and parent education on Thursdays from 5:30 to 7:00.

The program offers recreation with a purpose, meals, tutoring, and field trips. A close relationship is fostered with the schools and other agencies serving the child. Children operate on a point system. Special topics such as building self-esteem, anger control, how to make friends and how to communicate with parents are covered.

The Extended Day Program has been in operation since August 1, 1991. Referrals were slow at first, but currently the program is serving 20. Thus far, the program has been able to keep 66 percent of the families intact and 91 percent of children served continue satisfactory progress in school.

St. Joseph's Villa also operates a long-term residential program for 12 children ages 11 to 18. The average length of stay is 12 to 18 months. Family counseling is available, but youth in this program usually have family involvement. Most are victims of serious abuse or neglect and the families have not responded to rehabilitative efforts.

All these programs (known as the Dooley Programs) are supported by the Dooley School which serves elementary through secondary students. Each student receives a customized educational plan. Vocational training, independent living skills and computer training are available for the secondary students.

Four other divisions of St. Joseph's Villa offer innovative programs for various populations. Flower Home is a transitional living center that provides housing and supports for 23 women and their children for up to 24 months. The facility opened in 1989 and has served over 50 families. Hollybrook Apartments which opened in 1984 is a 60 unit independent living complex built for adults with disabilities. The Child Development Center has been in operation for almost 10 years. It provides professional day care services to more than 180 children 6 weeks to 12 years. Finally, the Respite Care Center provides respite to families with children who have developmental disabilities. Respite can be weekend, after school or summer camp. Up to 75 families can be served on a rotating basis.

For more than 150 years, St. Joseph's Villa has been a place of healing for children and their families. Today, the Villa continues its tradition through the development of innovative approaches for at-risk youth. More information is available from Linda Santosanti, Admissions Coordinator, St. Joseph's Villa, 9000 Brook Road, Richmond, VA 23227-1336, (804) 266-2474, FAX (804) 262-9166.
Facilities offered a wide range of programming and special services. Offerings included peer counseling, group therapy, wilderness experience, speech therapy, occupational therapy, testing and career assessments, family planning and pregnancy prevention, summer jobs, substance abuse treatment, art therapy, groups for survivors of sexual abuse, recreational programming, and independent living skills training. Reactions to the legislation varied. Thirteen of the 16 facilities were aware of the existence of the Comprehensive Services Act for At-Risk Children and Families. Most of those interviewed felt uncertain about the potential impact of the legislation. Some respondents thought the impact would be positive. Steve Anstel of Jackson-Field Homes, Inc. in Jarret said, "The act will force families to be more involved in the placement process." Ronald K. Spears of Dr. Hill Farm, Inc. in Gosnoldtown noted, "There will be a positive impact on child services in general because problem families will be identified earlier." John Mitch of Tricewater Regional Group Home Commission felt that the legislation would give rise to innovative programs. Dan Williams of New Dominion School in Claymont hopes for quicker placement of youth in need. Other respondents, while remaining positive about potential benefits, tied some concerns. Several thought the legislation might result in fewer referrals for placement. Some disagreed, feeling that more youth might be placed with the same mechanism. Don Whaley of Boys' Home, Inc. in Covington offered an interesting observation. "The act may result in a dip in requests for out-of-home placement in the public sector, but it is likely that this will be offset by an increase in private placements," he suggests. "Wheatley." Tom Williamson of Broadfield, Inc. in Glen Allen was one of several people who speculated that youth might be referred at a later point in time and thus be more damaged, more difficult to work with and less amenable to reconciliation. Others were worried that some youth might fail to receive needed services because of an emphasis on cost containment.

John Alexander of the Presbyterian Home in Lynchburg, had a different concern. "I feel that the wording of the law implies that the child is the problem," he stated. "In reality, it is usually the dysfunctional family that has precipitated placement." Many of those interviewed expressed concern about the need to conceptualize residential care as part of the continuum, rather than as a "last resort" that is outside the continuum of care. Paula Ryan, coordinator of Lynchburg's demonstration program, spoke of differences in types of residential care. "We should not be 'dumping together' all residential programs. Residential placement in our community is different from placement out-of-community. A child who is in a local residential placement can maintain contact with his family and may even be able to continue to attend the same school," she said. Ryan. Thus, communities with residential facilities may have increased options compared to communities who do not.

Summary Virginia has established a system of quality residential care. It is a service that has changed and adapted to changing needs. Virginia is restructuring the way that care is delivered to seriously emotionally disturbed youth. While it is clear that use of residential care will change, residential institutions have a place in the continuum of care. Those working on the Comprehensive Services Act and community service providers express the hope and the vision that the new approach will result in beneficial changes both within the community care network and for residential programs. References available upon request.