

# **‘Children Needing Extensive Services’**

## **Work Group Report**

**July 2000**

## *Executive Summary*

The children and families that generated the need for this report are often invisible to the community at large, seen only through the lens of budgets, charts and graphs. The “call to arms” for these children is often lacking because there are relatively few compared to the total population. However, issues of safety, costs outpacing the ability of the locality to help these children, and the loss of human capital to the community are all compelling reasons to develop alternatives. These children often become the adults in our communities who end up in our jails, on the street, or as members of a second, third and fourth generation of families in the “systems.”

The CCF’s “Children Needing Extensive Services” Work Group defined these children as “children poised to harm themselves or others and likely to require costly out of home placements and innovative treatment programs currently served by one or more of the agencies on the CSA Committee **or** children currently unknown to these systems but either they or their families exhibit similar behavior patterns.”

The work group collected data from cases during the past year and reviewed the literature on children who experienced “protective factors,” even though they had risk factors such as poverty, neglect, abuse and parental mental illness, alcoholism and criminal behavior. They also reviewed short-term outcomes for children who experienced home visitation or residential treatment programs.

The surveys indicated common diagnoses (such as depression and mental retardation), behavioral problems (such as aggressive/assaultive behaviors and oppositional defiant disorders) and family histories (such as mental illness and substance abuse) in both localities. Twenty-four hour, highly structured supervision with medical monitoring, sexual abuse treatment and substance abuse treatment, as well as job mentoring and independent living skills, were the common needs for the child to remain in the community.

Research indicates that short-term positive outcomes can be gained from family therapy and cognitive-behavioral approaches. However, they have limited success with children who are dually diagnosed with mental illness/mental retardation, a common factor in the survey. Current research on eliciting long-term positive outcomes is not promising. The best chance for long-term help is to prevent the risk factors that are associated with these results and to establish protective factors.

Serving this population is a long-term and expensive community commitment. In order to communicate the complexity of the problems and create a desire to address them, the work group recommends four “next steps” for the Commission:

- Hosting a roundtable of local vendors and service providers;
- Initiating a public dialogue about these problems;
- Developing a guide for funding priorities and targeting resources where they can make the most difference;
- Establishing routine early screening programs for substance abuse and dependence.

## **Introduction**

In 1998 the Commission On Children and Families held an organizing retreat where key issues and benchmarks were established for 1999. Key Issues included the following: 1) Achieve Meaningful Community Involvement, 2) Raise Visibility, 3) Identify and Promote Top Issues, 4) Define a System for Managing Information and 5) Develop Operating Principles.

The Commission followed up on the retreat at their November 1998 meeting and established as one of its top two priorities (key issue # 3) the focus of children needing extensive services. A sub-committee of the Commission developed a brief synopsis of the issue and the full Commission voted to accept the report of the sub-committee in a later meeting ([Appendix A](#)). They charged the Comprehensive Services Act (CSA) Committee with the development of a work group that would look at the children and families that are the most difficult to deal with in the major community “systems.” The sub-committee defined these children as “Children poised to harm themselves or others and likely to require costly out of home placements and innovative treatment programs currently served by one or more of the agencies on the CSA Committee **or** children currently unknown to these systems but either they or their families exhibit similar behavior patterns.”

Those “systems” primarily include Social Services, Special Education, Mental Health and the Court Services Unit of the 16<sup>th</sup> District Juvenile and Domestic Relations Court. However, data was only collected on those children who received extensive services through the Comprehensive Services Act (CSA). This eliminated those children who were committed by the court to the Department of Juvenile Justice and placed in correctional centers. These children may, and frequently do, receive CSA services prior to their commitment or upon their return, but CSA does not pay for the residential services they receive while they are committed to the Department of Juvenile Justice.

## **Charge from the Commission**

The Commission specifically asked the CSA Committee to achieve four milestones:

- To contact vendors currently in use and ask them to propose service alternatives to our higher cost placements.
- Determine whether the current programming offered through our schools, recreation programs, libraries, etc., is sufficient for the community to care for these children.
- Contact local hospitals (UVAH, MJH and Charter) to determine use of bedspace at reduced rates with privileges from local providers to provide services.
- Finalize the Request for Proposals (RFP) developed by the CPMT and obtain bids.

The Commission was hopeful that the implementation of these milestones could help achieve success by having the ability to make ongoing cost comparisons, by the development of programs structured for this population, by lowering costs and by achieving the same or greater success with the children and families.

### **Scope and Methodology**

A work group of twelve people representing Departments of Social Services, Region Community Service Board, Community Attention, the Court Services Unit, Education, Parks and Recreation and the Commission met three times between July and November, 1999 to discuss the charge and identify ways in which to accomplish the tasks. There were several attempts to acquire a business representative without success.

The work group decided that little hard data existed with which to finalize an RFP, meet with area hospitals, or to meet with current vendors of service (three of the four milestones). There was consensus that current programming in the community is not sufficient for this population. There are no public recreation or library programs that could manage a child as defined by the Commission. There are extensive waiting lists for adult services for these children as they “age out” of the system and there are often few alternatives for educational day treatment programs that can be combined with adequate out of home placement for these children. Further complicating the task was whether to narrow the scope by age or sex of the child, types of delinquency behaviors or severity of psychiatric difficulties. In order to address the problem, the work group decided to gather data that would help the Commission make decisions regarding how to best manage this growing concern.

The work group developed two tracks to collect data. The first was to review the most recent CSA Supplemental Allotment Requests to determine patterns in the population that could help vendors, schools, recreation programs and others develop programs/services to meet the most pressing need. A review of the case summaries from the City and County Supplemental Requests for the past three years (FY 97, 98, 99) proved to be the most reliable data that was quickly available. ([Appendix B](#)). These summaries provided information about the most costly residential placements, which is indicative of services needed for the defined population.

The second track of data collection was a six month review of current cases and a survey of new cases having entered the “systems” via the Family Assessment and Planning Team (FAPT) process. A smaller work group developed the survey instrument ([Appendix C](#)). Although the survey allowed for more descriptive information to be obtained, the two basic questions asked were 1) what services are (were) necessary to avoid residential placements outside of the community and 2) what services are (were) necessary to bring children from residential placements back to the community. The survey instrument was used for fifteen facilities ([Appendix D](#)) that were identified based on the trend data from the CSA Supplemental Case Review.

A third analysis was done by a graduate student assigned to the small work group. She looked at factors that made the difference for children with similar circumstances but who were able to overcome the odds. Again, the work group only reviewed those youth receiving community-funded services. Youth who were committed to the Department of Juvenile Justice were not included in this survey. These youth, however, return to the Charlottesville-Albemarle community after serving their time in state correctional facilities, and they often fit the profile defined by the work group as “poised to harm themselves or others.”

### **Who are the “children needing extensive services?”**

The children and families that generated the need for this report are often invisible to the community at large, seen only through the lens of budgets, charts and graphs. The “call to arms” for these children is often lacking because there are relatively few compared to the total population. However, issues of safety, costs outpacing the ability of the locality to help these children, and the loss of human capital to the community are all compelling reasons to develop alternatives. These children often become the adults in our communities who end up in our jails, on the street or as members of a second, third and fourth generation of families in the “systems.” The combined City/County CSA Supplemental Requests Charts are too large to include in this report. Imagine the challenge the following children present to a community:

*“Travis” is a 15 year-old white male who returned to the custody of the Department of Social Services after placement with relatives broke down due to Travis’s threatening behaviors, including fire-setting, cruelty to animals, and sexually inappropriate actions. He was hospitalized at Charter Behavioral Healthcare in Charlottesville and remained in their psychiatric residential program for several months, when he was moved to another residential treatment facility. After an extensive search, a therapeutic foster family was identified for him in the Chesapeake area, but after several months this placement, too, disrupted because of Travis’s oppositional and aggressive behavior. He was placed in Detention on destruction of property charges, and later was transferred to another residential treatment program.*

*Travis first entered foster care when he was almost nine years old after experiencing chronic abuse and neglect as a young child. He has a history of multiple placements. Travis has been diagnosed with Attention Deficit/Hyperactivity Disorder, Depressive Disorder, Post-Traumatic Stress Disorder, and learning disabilities. Although Travis’s IQ falls in the mid-70’s, he is a very concrete thinker with limited insight. He is identified as emotionally disturbed. Efforts are being made to transition Travis to a less restrictive setting, possibly to a structured group home or another therapeutic foster home.*

*“Jamal” is an 11 year-old African-American male who has been in a residential treatment program for the past two years. According to records, Jamal has a long history of aggressive, self-destructive, and out of control behaviors. He had previous placements in foster homes, with his paternal grandmother, and acute psychiatric hospitalization for impulsive, aggressive, assaultive, and suicidal behavior. He was*

*removed from foster care placements due to aggressive and threatening behaviors, killing animals, and stealing. He is also alleged to have exhibited sexualized behaviors towards his brother, who is mentally retarded. Jamal continues to need intensive supervision, therapeutic services, medication, and behavior management 24-hours a day/7 days a week.*

*Jamal's current diagnoses include Major Depression, Oppositional Defiant Disorder, Attention Deficit/Hyperactivity Disorder, Pervasive Developmental Disorder, and borderline intellectual functioning. His maternal birth family has an extensive multi-generational history of mental illness, and child abuse and neglect. His mother was a substance abuser. His father had a history of violence and was murdered when his mother was two months pregnant with Jamal. Jamal apparently was severely beaten and burned by his mother's boyfriend before he was removed from the home at age 7.*

*"James" is almost 17 years old, and is about to be discharged from the Hanover Correctional Center after completing the mandatory sex offender program there. He has been in Social Services custody since 1996, and was placed in a residential program for almost a year. James was committed to the Department of Juvenile Justice on two felony charges of rape and sodomy. Prior charges dating back to 1996 include grand larceny, probation violation, and grand and petit larceny.*

*James's mother is hard-working and would like her family to be re-united. However, she works long hours and has two daughters living with her at home. One of them is over 18 years old and has completed the Job Corps. The other daughter remains in the custody of the Department of Social Services and is attending the Lafayette School day treatment program. Recently she has begun violating the rules of Supervised Probation. Social Services staff are concerned about returning James directly to the family. They believe he needs a post-correctional placement that will help him transition back to the community by providing vocational and independent living skills while offering a high level of structure, limits, security, and supervision.*

*"Robert" has been in a residential treatment facility for the past four years. In spite of receiving support services at home and as a special education student in public school, Robert began showing dangerously inappropriate sexual and aggressive behaviors. When it was decided that he could no longer be served by the public educational system, residential placement was made. Robert is mentally retarded, at the lower end of the mild-moderate range, and has been diagnosed with Impulse Control Disorder. His current education has a functional/vocational emphasis. He receives counseling weekly with the focus on reviewing his behavior problems and helping him to develop an understanding of cause and effect regarding consequences for his actions. Robert also receives community-based vocational instruction, with a one-on-one job coach to help him learn appropriate behavior in the work place and develop competence as an employee.*

*Staff at Robert's placement have concluded that he has reached the highest level of academic achievement which can be expected of him, and they are recommending discharge for him shortly after his eighteenth birthday. Robert has gotten into trouble several times during home visits for committing delinquent acts in the community. School staff refused to provide transportation home for him after he bit a staff member. Robert's mother is mentally retarded and cannot control his behaviors. She has legal custody of him until he is eighteen. Robert's case manager is exploring options for him after he leaves his placement and returns to Charlottesville.*

Innovative treatment programs and costly out of home placements are sometimes hard to understand if one does not work with these children/families on a regular basis. Social workers, Probation officers, education specialists, and mental health workers understand that what used to be the norm in out of home placements has changed. Placement in foster family homes and psychiatric hospitalization for acute or chronic behavior/mental illness was not unusual. It was the unusual child (or the child who was involved in more criminal behavior) who required a highly structured locked setting with treatment for substance abuse, sexually offensive behavior, medical monitoring, crisis intervention and intensive supervision (often twenty four hours/seven days a week). Today, Charlottesville and Albemarle find that what used to be unusual has become much more common. As a result, foster families or traditional in-home services are not a viable choice for these children. A definition of traditional and more innovative treatment choices is attached to this report to bring a broader perspective to the reader's understanding. ([Appendix E](#))

### **Survey Findings – CSA Supplemental Request Report ([Appendix B](#))**

The past three years of reports identified trends for both localities that were not surprising, although there were slight differences for the two localities.

- The County population was much older (majority were 16+) while the City reported much younger children (majority were 11-15) who needed these extensive services.
- Psychiatric behaviors, suicidal/assaultive behaviors, serious Child Protective Services involvement, and Serious Emotionally Disturbed behaviors were the most common characteristics noted for both localities.
- Special Education services were common among this population for both localities.
- Most County placements for this three-year period of time were in residential facilities, while in the City most placements were in therapeutic foster homes, a likely indicator of the age differentials for the two localities. Therapeutic foster care is not necessarily a lower cost alternative. It can often cost the same, or slightly lower or higher than residential care.

### **Survey Findings – Six Month Review ([Appendix F](#))**

The data from these surveys provided information that confirmed a continued trend of a difference in age groupings for the localities.

The most common diagnoses for children in both localities were:

- Major depression; depressive disorders
- Mental retardation, mentally borderline, mentally handicapped
- Oppositional Defiant Disorders
- Attention Deficit/Hyperactivity Disorder.

The listed diagnoses are notable for the low incidence of substance abuse diagnosis. This is contradicted by the experience of social workers, teachers and others who identify drug and alcohol use and abuse as a major presence in the lives of most of these children. It can be speculated that drug and alcohol abuse and dependence are under identified and under reported.

The top three behavioral problems for both localities were:

- Seriously Emotionally Disturbed (SED)
- Aggressive/assaultive
- Dysfunctional/chaotic family

Although a large variety of residential programs were utilized, the two most commonly used facilities during the six month test period were Grafton School and Charter Westbrook Behavioral Health Center, which is now no longer in business.

Three services were provided most often:

- SED/LD (Learning Disabled) school services
- Child Protective Services
- In-Home services

The most common family history characteristics were mental illness in the parent and substance abuse by the parent. Of the thirty-six children in the test period, **20 do not** have a family willing/able to cooperate with services and willing/able to provide the high degree of structure required.

Eighty-nine percent of the City children and seventy-six percent of the County children studied were currently in foster care. The high number of children in foster care has a significant community impact, on the Departments of Social Services, the Juvenile and Domestic Court and attorneys, local implementation of the Safe Families Act, as well as stretching Charlottesville and Albemarle's funding capabilities to meet the extensive needs of this population.

In Charlottesville, seventy-four percent of the children in the six-month study were African-American. A comparison of total population figures in the City shows that thirty-five percent of children ages 0-19 are African-American. In Albemarle, eighteen percent of the children in the six-month study were African-American, while twelve percent of children ages 0-19 in the County are African-American.

The services identified in both localities to return the child to the community from a residential treatment center, or to keep the child in the community were:

- Highly structured settings with clear behavioral expectations and external controls for enforcing expectations.
- High level of supervision, 24 hours/day, seven days/week, to prevent runaway and delinquent behaviors, and control aggression.
- 24-hour crisis intervention
- Medical monitoring including appropriate use of psychiatric medications could also include other medical conditions like diabetes.
- Substance abuse treatment
- Treatment for sexually offensive behavior

The County identified two additional services as necessary, which likely reflect the population age difference:

- Job mentoring
- Independent Living Skills

### **Comparative Data**

Bright Stars is an early intervention program designed for preschool students in Albemarle County. Children selected for the program are considered to be at risk of failure in school because of known risk factors – including poverty, illiteracy and abuse – in their homes. The program aims to intervene and provide the skills needed for these children to be successful in kindergarten. During the 1998-1999 school year, a study of the program conducted through the Curry School of Education concluded that thirty-four of the forty-two children enrolled had experienced statistically significant developmental growth. Children who showed growth in the Child Observation Record sub-category of “Beginning Reading” were considered likely to pass the Phonological Awareness and Literacy Screening (PALS test) in the fall of their kindergarten year.

The study also found a statistically significant relationship between the risk factor of domestic abuse and the child’s developmental growth. Of the ten children who entered the program with the risk factor of domestic abuse, seven did not show statistically significant growth in any of the developmental areas. It appears that domestic abuse has a negative impact on children’s continuing academic and social achievement.

### **Outcomes From Current Services**

Research indicates two approaches have been found to result in at least short-term positive outcomes – family therapy and cognitive-behavioral approaches. However, these approaches have limited success with children who are dually diagnosed with mental illness/mental retardation. The best chance of success with these children is a highly structured setting. The greatest predictor of post-discharge functioning was the quality of the discharge setting.

Diana Emblar-Vose, a graduate student from VCU assigned to the Charlottesville Department of Social Services for one year, reported: “Studies show that adolescents

whose mothers have home visitation and fewer founded reports of child abuse were significantly less likely to display problematic and delinquent behaviors than those who had greater child abuse and no home visitation. Other studies show relationships between family dysfunctional characteristics and child emotional and behavioral dysfunction, between family criminal behavior and subsequent child delinquency behavior, between adjustment disorders in children and depression in mothers, and between parental drug use and childhood antisocial behavior.

“The current state of research on the ability of residential programs to elicit long term positive outcomes in participants is not promising. However, “...residential programs are not any worse off than nonresidential alternatives in this respect. Summaries of existing studies done on residential programs demonstrate that these programs have not been able to establish methodologically sound evidence supporting the effectiveness of their treatment approaches on a long term basis. However, a number of programs have demonstrated positive changes in short-term outcomes for children and youth.”

Currently the community does not have a way to gather information in the aggregate that could tell us the outcomes from the current services that are provided to our children. We have no information, other than anecdotal, that tells us what has happened to “yesterday’s” children who received extensive services.

### **Prevention Strategies**

Diana Emblar-Vose provided information from a review of the literature on children who need extensive services. According to her, “A better way of understanding youth who are placed in residential treatment programs is through research on resiliency and protective factors.”

Protective factors are those conditions that have been correlated with positive outcomes despite the presence of multiple risk factors such as poverty, neglect, abuse, and parental mental illness, alcoholism and criminal behavior.<sup>1</sup> The risk factors that have been most strongly correlated with residential placement are a history of childhood abuse and family dysfunctional factors, including parental criminal behavior, drug use, and maternal mental illness.<sup>2</sup> Protective factors can be divided into four areas: individual, school, community, and family factors. Individual protective factors for the youth have been identified as social competence, problem-solving skills, autonomy, and a sense of purpose and future. School, community, and family protective factors include individuals in the youth’s life who are caring and supportive, who have high expectations of the youth, and who provide opportunities for the participation and involvement.<sup>3</sup>

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<sup>1</sup> Benard, B (1992). *Fostering Resiliency in Kids*. Portland, OR: Western Center for Drug Free Schools.

<sup>2</sup> Frick, P. et al., (1992). Familial risk factors to oppositional defiant disorder and conduct disorder. *Journal of Counseling and Clinical Psychology*, 60, 49-55. and Stage, S. (1997) Predicting adolescents’ discharge status following residential treatment. *Residential Treatment of Children and Youth*, 16, 37-55.

<sup>3</sup> Benard, B (1992). *Fostering Resiliency in Kids*. Portland, OR: Western Center for Drug Free Schools.

A summary of longitudinal studies on children growing up under extreme conditions of poverty, neglect, abuse, and parental mental illness, alcoholism and criminal behavior have established that although a higher percentage of these children developed [more] problems than the normal population, a greater percentage of these children became healthy, competent adults.<sup>4</sup>

The children needing extensive services as defined in this report would not have experienced protective factors to a large enough extent to offset the influences of the risk factors.

### **Summary and Next Steps**

The opening words to the definition of this priority issue are “Children poised to harm themselves or others...” Data tells us that these children are as young six and as old as eighteen. They have multiple mental illness/mental retardation diagnoses, they live in chaotic families who abuse substances and who are themselves mentally ill, and they require intensive services that may or may not result in their being productive members of our communities. They will re-enter the community regardless of their treatment outcomes.

Local efforts to serve this population result in a collective sigh of relief as we know that these children and the community are safe while they are living in highly structured and supervised residential settings. Broader public policy questions loom as we ponder the escalating costs associated with this population after they come to the attention of the “systems” and the costs associated with preventing them from ever reaching that point.

- Do we as a community want to continue to reach out to this small but vulnerable group of our citizens, to ensure their safety and that of their neighbors, and to continue providing the services that will enhance their quality of life and hopefully provide them with the skills to transition successfully to adulthood?
- What are the ways to break the multi-generational, ingrained patterns of substance abuse, mental illness, child abuse and neglect, and poverty, and their effects on new generations of families?
- How do we as a community want to use our limited resources to fund services for these youth?
- Can we develop local services that will strengthen family ties, make more efficient use of agency personnel, and better prepare these youth for transition back to our community?

Serving this population is a long-term and expensive community commitment. With extensive mental health, substance abuse, educational, day treatment and supervision needs, these children present a daunting challenge to any community. Instead of sending these youngsters to expensive out-of-town placements, we are interested in exploring how we could provide some of these services in the Charlottesville/Albemarle area.

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<sup>4</sup> Ibid

Local service provision will not likely result in cost-savings, but it would have the advantage of keeping families closely tied to their children, saving agency personnel travel time, and making it easier to re-integrate these young people back into the community.

To that end the following are put forth for the Commission's consideration:

- 1) CCF should host a local roundtable discussion of vendors and service providers (inclusive of area hospitals, public recreation, police, juvenile justice, schools) to brainstorm about, or even design, services in the community to meet the needs of these families.
- 2) CCF should initiate a "wake-up" call to area leaders and the community at large in the form of presentations, roundtable discussions, etc. CCF should take the lead on initiating a public dialogue about the problem.
- 3) CCF should develop a *guide* for recommended funding priorities for the two local governments as well as a *guide* for private funding sources.
- 4) Social Workers, counselors, teachers, and others who work with children and youth should receive training in early screening and identification of drug and alcohol use or dependence, depression, and hyperactivity and attention deficit disorders. Routine early screening programs should be instituted.

## APPENDIX A

### CCF Issue for 1999 - Children In Need of Services (CHINS) Workgroup

**Definition:** Children poised to harm themselves or others and likely to require costly out of home placements and innovative treatment programs currently served by one or more of the agencies on the CSA Committee **or** children currently unknown to these same systems but either they or their families exhibit similar behavior patterns.

#### Achievable milestones:

1. The following components of the plan can be achieved within a short time frame:
  - Contact vendors currently in use and ask them to propose service alternatives to our higher cost placements. Innovative cost containment utilizing the creative ideas of everyone can at the very least provide cost comparisons from which to choose.
  - Determine whether the current programming offered through our schools, recreation programs, libraries, etc., is sufficient for the community to care for these children.
  - Contact local hospitals (UVAH, MJH and Charter) to determine use of bedspace at reduced rates with privileges from local providers to provide services.
  - Finalize the Request for Proposals (RFP) developed by the CPMT and obtain bids. This RFP provided an opportunity for vendors to design services for these children and their families that would be delivered locally.
2. Success would be measured by our ability to make ongoing cost comparisons, by development of programs structured for this population, by lower cost and by achieving the same or greater success with the children and families we serve.
3. The workgroup believes that the timing is right for this initiative because of the large expenditures required in CSA as one of the fastest growing items in the City and County budgets. Additionally, juvenile crime has risen sharply in the past few years adding to the “neighborhood fear” felt by many parents and their children.

#### CCF Members are willing to dedicate time and resources to this issue:

Members are willing to devote time and resources because to ignore it will not make it go away.

#### Compelling Local Need

- The workgroup did not determine whether residents needed or wanted this initiative. Frequently these families and children are not visible to the community in a way that requires a “call to arms.” Rather, they are moved through systems, i.e. courts, social services, mental health to secure settings away from the community. They are rarely visible except to their victims and frequently only seen by the community at large through the lens of budgets, charts and graphs.
- The community may not demonstrate concern for these families because they are relatively few compared to the population. However, issues of safety, costs outpacing the ability of the locality to help these children and the loss of human capital to the community are all compelling when you think of them in relation to the fact that what we are talking about is our community’s children.
- Trends that indicate this as a compelling local need include large increases in foster care & juvenile crime, the JLARC study of 1997-98 and the recently mandated Utilization Review system.

#### History/Existing Resources

- The CCF can add value to the current spectrum and organization of services by issuing a “wake up call” to the community along with strategies for communities to identify these children earlier and enhance the community response.
- Every children and family serving institution in the community has a piece of the solution for this population. These are multiple problem families requiring a diverse response from the community.

#### Additional Challenge for the CCF:

If the community is compelled to embrace these children, then it will mean a long-term commitment and the ability to withstand the pressures of the NIMBY syndrome. The children either grew up or came to the community with years of dysfunctional and deviant behaviors. The community will need to focus on transitional services as these children age into adulthood. Services such as halfway houses, job mentoring/coaching, therapy, etc., must be part of an overall plan if we are to have any hope of containing some of these behaviors and providing an opportunity for these children to be self-supporting, productive and good citizens. It must be viewed as an investment in our human infrastructure.

**APPENDIX B**

**Albemarle County FY 1997**

<b>AGE</b>	<7	7-10	11-13 6	14-15 5	16-+ 12
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<b>FACILITY</b>	Westend 8	Grafton 1	Charter 2	Shalom 1	Georgia House 2
	New Dom. 2	Elk Hill 1	Va. Home for Boys 1	Region Ten 1	Little Keswick 1

<b>COST</b>	<1000	1-2000 1	2001-3000 8	3001-4000	4001-5000 4	5001-6000 1
	6001-7000	7001-8000 1	8001-9000 3	9001-10000 2	10001-11000 2	1001-12000

<b>SPECIAL NEEDS</b>	<b>SED</b> 14	<b>Men. Handicapped</b> 9	<b>Sexually Molested</b> 3	<b>CPS</b> 9	<b>SUICIDE</b> 7	<b>volatile rages</b> 3	<b>assaultive</b> 13
	sex w/younger 3	sp.ed. 13	eating disorder	beh.problems 3	substance abuse 6	jail	property destruction 3
	LD 1	fire setter	animal cruelty	chins	Autism 2	psychosis 2	meds
	teen parent 1	Delinquency 8	psych. Hospitalization 9	homicidal	Truancy 3	ADHD 3	sexaul promiscuity 1
	depression 7	probation 5	runaway behavior 8	psycho-social dwarfism	failure to thrive 1		

**Albemarle County FY  
1998**

<b>AGE</b>	<b>&lt;7</b>	<b>7-10</b>	<b>11-13</b>	<b>14-15</b>	<b>16+</b>
	1	5		9	25

<b>FACILITY</b>	<b>Westend</b>	<b>Three Springs</b>	<b>Grafton</b>	<b>C-Attention</b>	<b>Presby. Home</b>	<b>Georgia House</b>
	11	1	4	3	5	5
	<b>Bridges</b>	<b>YES</b>	<b>New Dom.</b>	<b>Graydon Manor</b>	<b>Elk Hill</b>	<b>UMFS</b>
	2	1	6	2	1	1
	<b>Shalom</b>	<b>Piedmont Behavioral</b>	<b>Charter</b>	<b>Deep Run</b>	<b>VTC</b>	
	2	1	6	3	2	

<b>COST</b>	<b>&lt;1000</b>	<b>1-2000</b>	<b>2001-3000</b>	<b>3001-4000</b>	<b>4001-5000</b>	<b>5001-6000</b>
	2	7	12	13	8	2
	<b>6001-7000</b>	<b>7001-8000</b>	<b>8001-9000</b>	<b>9001-10000</b>	<b>10001-11000</b>	<b>11001-12000</b>
	2	3	2	4	6	2

<b>SPECIAL NEEDS</b>	<b>SED</b>	<b>Men. Handicapped</b>	<b>Sexually Molested</b>	<b>CPS</b>	<b>SUICIDE</b>	<b>volatile rages</b>	<b>assaultive</b>	<b>delinquency</b>
	21	7	10	22	16	3	25	11
	<b>meds</b>	<b>LD</b>	<b>sex w/younger</b>	<b>sp.ed.</b>	<b>eating disorder</b>	<b>beh.problems</b>	<b>substance abuse</b>	<b>jail</b>
	1	5	6	14	1	9	10	1
	<b>failure to thrive</b>	<b>depression</b>	<b>probation</b>	<b>psycho-social dwarfism</b>	<b>teen parent</b>	<b>fire setter</b>	<b>animal cruelty</b>	<b>chins</b>
	1	5	6	1	1	2	1	3
	<b>psych. Hospitalization</b>	<b>homicidal</b>	<b>Truancy</b>	<b>ADHD</b>	<b>property destruction</b>	<b>runaway behavior</b>	<b>sexaul promiscuity</b>	
	18	6	7	4	3	12	3	

## Albemarle County FY 1999

<b>AGE</b>	<b>&lt;7</b>	<b>7-10</b>	<b>11-13</b>	<b>14-15</b>	<b>16-+</b>
	1	6	3	6	12

<b>FACILITY</b>	<b>Westend</b>	<b>Three Springs</b>	<b>Grafton</b>	<b>C-Attention</b>	<b>Presby. Home</b>	<b>Georgia House</b>	<b>Deep Run</b>	<b>Piedmont Behavioral</b>
	3			5	4	1		1
	<b>Bridges</b>	<b>YES</b>	<b>New Dom.</b>	<b>Graydon Manor</b>	<b>Elk Hill</b>	<b>Timber Ridge</b>	<b>St. Joseph's</b>	<b>Child Help</b>
	1		5		1	1	4	1
	<b>UMFS</b>	<b>VTC</b>	<b>Charter</b>	<b>Jackson-Fields</b>	<b>Shalom</b>			
		3		1				

<b>COST</b>	<b>&lt;1000</b>	<b>1-2000</b>	<b>2001-3000</b>	<b>3001-4000</b>	<b>4001-5000</b>	<b>5001-6000</b>
			10	1	11	1
	<b>6001-7000</b>	<b>7001-8000</b>	<b>8001-9000</b>	<b>9001-10000</b>	<b>10001-11000</b>	
		3	3		1	

<b>SPECIAL NEEDS</b>	<b>SED</b>	<b>Men. Handicapped</b>	<b>Sexually Molested</b>	<b>CPS</b>	<b>SUICIDE</b>	<b>volatile rages</b>	<b>assaultive</b>
	11	3	1	13	6	2	14
	<b>meds</b>	<b>LD</b>	<b>sex w/younger</b>	<b>sp.ed.</b>	<b>eating disorder</b>	<b>beh.problems</b>	<b>substance abuse</b>
		2	4	3		6	9
	<b>sexaul promiscuity</b>	<b>failure to thrive</b>	<b>depression</b>	<b>probation</b>	<b>psycho-social dwarfism</b>	<b>teen parent</b>	<b>fire setter</b>
				5			1
	<b>psych. Hospitalization</b>	<b>homicidal</b>	<b>Truancy</b>	<b>property destruction</b>	<b>runaway behavior</b>	<b>ADHD</b>	<b>chins</b>
	9	3	3	1	6	5	
	<b>delinquency</b>	<b>jail</b>	<b>animal cruelty</b>				
	7	1					

### Charlottesville FY 1997

<b>AGE</b>	<7	7-10	11-13 8	14-15 5	16-+ 4
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<b>FACILITY</b>	Westend 2	Grafton 2	Charter 1	Graydon 1	Hughes 1	C-Attention 2	Vanguard 1
	New Dom. 1	Institute 1	Pres. Home 1	UMFS 2	Intercept House 2	The Pines 2	

<b>COST</b>	<1000 2	1-2000 1	2001-3000 3	3001-4000 3	4001-5000 1	5001-6000 1
	6001-7000 1	7001-8000 1	8001-9000 2	9001-10000 2	10001-11000	1001-12000 1

<b>SPECIAL NEEDS</b>	SED	Men. Handicapped	Sexually Molested 2	CPS	SUICIDE 3	Explosive 6	assaultive 6
	sex w/younger 1	sp.ed. 5	eating disorder	beh.problems 8	substance abuse 5	jail 1	property destruction 1
	LD 4	fire setter 1	animal cruelty 2	chins	Autism	psychosis	meds 3
	teen parent	Delinquency 3	psych. Hospitalization 7	homicidal	Truancy 1	ADHD 4	sexaul promiscuity
	depression 2	probation 1	runaway behavior 5	psycho-social dwarfism	failure to thrive	MR 1	Child Parent 1

Charlottesville Fy 1998

<b>AGE</b>	<b>&lt;7</b>	<b>7-10</b>	<b>11-13</b>	<b>14-15</b>	<b>16+</b>
	<b>3</b>	<b>8</b>	<b>13</b>	<b>10</b>	<b>14</b>

<b>FACILITY</b>	<b>Eleventh House</b>	<b>DeJarnette</b>	<b>Grafton</b>	<b>C-Attention</b>	<b>F&amp;C Services</b>	<b>Georgia House</b>	<b>Barry Robinson</b>
	<b>1</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>1</b>	<b>1</b>	<b>1</b>
	<b>Hughes</b>	<b>FOGH</b>	<b>New Dom.</b>	<b>Pines</b>	<b>Elk Hill</b>	<b>UMFS</b>	<b>Anne C. Tyler</b>
	<b>1</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>4</b>	<b>1</b>
	<b>Boys Home Inc</b>	<b>Oasis</b>	<b>Charter</b>	<b>DePauls</b>	<b>VTC</b>	<b>People Places</b>	
	<b>1</b>	<b>1</b>	<b>3</b>	<b>1</b>	<b>1</b>	<b>18</b>	

<b>COST</b>	<b>&lt;1000</b>	<b>1-2000</b>	<b>2001-3000</b>	<b>3001-4000</b>	<b>4001-5000</b>	<b>5001-6000</b>
	<b>6001-7000</b>	<b>7001-8000</b>	<b>8001-9000</b>	<b>9001-10000</b>	<b>10001-11000</b>	<b>11001-12000</b>

<b>SPECIAL NEEDS</b>	<b>SED</b>	<b>Men. Handicapped</b>	<b>Sexually Molested</b>	<b>CPS</b>	<b>SUICIDE</b>	<b>volatile rages</b>	<b>assaultive</b>	<b>delinquency</b>
	<b>2</b>		<b>2</b>	<b>6</b>	<b>6</b>	<b>1</b>	<b>17</b>	<b>9</b>
	<b>meds</b>	<b>LD</b>	<b>sex w/younger</b>	<b>sp.ed.</b>	<b>eating disorder</b>	<b>beh.problems</b>	<b>substance abuse</b>	<b>low IQ</b>
				<b>3</b>		<b>12</b>	<b>8</b>	<b>1</b>
	<b>Psychotic</b>	<b>depression</b>	<b>Sex. Acting Out</b>	<b>MR</b>	<b>teen parent</b>	<b>fire setter</b>	<b>animal cruelty</b>	<b>IL</b>
	<b>2</b>	<b>4</b>	<b>3</b>	<b>3</b>	<b>1</b>	<b>1</b>	<b>2</b>	<b>2</b>
	<b>psych. Hospitalization</b>	<b>homicidal</b>	<b>Truancy</b>	<b>ADHD</b>	<b>property destruction</b>	<b>runaway behavior</b>	<b>sexaul promiscuity</b>	
	<b>6</b>	<b>3</b>	<b>3</b>	<b>5</b>	<b>3</b>	<b>8</b>	<b>2</b>	

Charlottesville FY  
1999

<b>AGE</b>	<7	7-10 3	11-13 2	14-15 7	16-+ 4
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<b>FACILITY</b>	Westend 2	Genesis TX 2	Grafton 2	The Pines 1	Piedmont Behavioral 1
	Charter 4	Jackson-Fields 2	Anne C. Tyler 1	Child Help East 1	

<b>COST</b>	<1000	1-2000	2001-3000	3001-4000	4001-5000	5001-6000
	6001-7000	7001-8000	8001-9000	9001-10000	10001-11000	

<b>SPECIAL NEEDS</b>	SED	Men. Handicapped	Sexually Molested 2	CPS 2	SUICIDE 4	volatile rages	assaultive 10
	meds 1	LD	sex w/younger 1	sp.ed. 2	sexual acting out 1	beh.problems 2	substance abuse 2
	sexaul promiscuity	failure to thrive	psychotic 1	probation	psycho-social dwarfism	teen parent	fire setter 1
	psych. Hospitalization 3	homicidal 4	Truancy	property destruction	runaway behavior 4	ADHD 2	chins
	delinquency	jail	animal cruelty 1	sexual offenses 3	MR 4	ED 3	MI 1

*Appendix C*  
**CSA NEEDS/SERVICE ASSESSMENT**

Child's full name \_\_\_\_\_ • Charlottesville • Albemarle

Child's date of birth \_\_\_\_\_ Race \_\_\_\_\_ Sex \_\_\_\_\_ Current placement \_\_\_\_\_

Monthly cost of services \$ \_\_\_\_\_ Mandated ( *circle* Foster care, Special education, FC Prevention) or Non-mandated

**I. Service History** • *In-home counseling* • *Out-patient (Individual/family)* • *Detention* • *Psych hospital* • *SED/LD svcs* • *Day treatment* • *Residential facility* • *Therapeutic FC* • *Child aide/Mentor* • *Child Health Partnership* • *CPS involvement* **DISPOSITION**

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**II. Presenting problems/history**(Check all that apply) **DIAGNOSIS**

- Dysfunctional/chaotic family • Neglected • Psychiatric hospitalization • Seriously Emotionally Disturbed • Learning Disabled
- Attention Deficit/Hyperactivity Disorder • Poor academic performance • Autism • Mentally handicapped • Physically handicapped • Self-harm/mutilation
- Chronic health problem ( \_\_\_\_\_ ) • Substance abuse • Physically/Emotionally/ Sexually abused • Sexually inappropriate behavior
- Pregnant/teen parent • Runaway • Truant • Suicidal/homicidal • Delinquency/court involvement • Aggressive/assaultive behaviors • Fire-setting behaviors • Other \_\_\_\_\_

**III. What would it take for this child to remain in(return to) the community?** (Check all that apply)

- After-school care • Respite care • Mentor • Parent aide • Personal assistance/Nursing care • One-on-one aide in public school • Day treatment
- Case management • Out-patient treatment • Family treatment • Emergency or crisis shelter • Behavior management program (intensive/non-intensive)
- In-home services ( \_\_\_\_\_ hours/week) • Hospital setting • Psychiatric medication • Treatment foster care • Therapeutic pre-school
- Sexual offender treatment • Substance abuse treatment • Job training • Independent living skills • 24-hour supervision • Locked unit
- Other (specify) \_\_\_\_\_

**IV. Which service(s) were NOT available locally?** (List all)

**WHY were they unavailable locally?** (Specify for each service: Child's behavior inappropriate; Waiting list or space not available; Service doesn't exist locally; Other)

## Appendix D

### *Residential Treatment Programs*

1. Valuemark/West End Behavioral Healthcare, Richmond
2. Piedmont Behavioral Healthcare, Leesburg
3. Charter Behavioral Health, Charlottesville
4. Hughes Memorial Home/Presbyterian Homes, Lynchburg/Danville
5. Charter Westbrook Hospital, Richmond
6. Timber Ridge School, Winchester
7. Grafton School, Berryville
8. Menninger Clinic, Kansas
9. The Pines Residential Treatment Center, Norfolk
10. Woodside Hospital, Newport News
11. The Barry Robinson Center, Norfolk
12. Bridges, Virginia Baptist Hospital
13. Graydon Manor, Leesburg
14. Virginia Treatment Center for Children, Richmond
15. Genesis Treatment Center, Richmond

## APPENDIX E

### *Glossary of Treatment/Therapeutic Options*

#### ***Home-based Services:***

*An alternative form of treatment involving a creative engagement with the families of children who are at risk of removal from the home, to foster an independent and empowered family unit that can nurture children. A specially trained therapist works with the parents and children to teach necessary skills, provide family therapy and support, and coordinate community services. The focus is on the entire family system, with the goal of concrete behavioral changes. In-home therapists intervene with families on a short-term (usually six months) and intensive basis (about 5 hours per week).*

**(Source: Region Ten Community Service Board)**

#### **Therapeutic Foster Care:**

Therapeutic foster care, also known as “treatment foster care,” offers the guidance and nurturance of family living that many children need who have been abused, neglected, or raised in dysfunctional homes. Typically the child has special needs exceeding “regular” foster care. Treatment foster care is often used as a “step down” program for children who are transitioning from residential or psychiatric care. A treatment-oriented placement provides them an opportunity to be stabilized living in a family setting. Each approved foster family is specially trained in meeting the needs of children in therapeutic family living and is closely supervised by the child’s case manager. Therapeutic foster families receive stipends that are higher than those paid to regular foster families, to reflect the extra time, education and training that are involved in this kind of care.

*(Source: Charlottesville Social Services; Braley & Thompson, Inc.)*

#### **Group Home:**

Group homes provide supervision, education and treatment for children and adolescents who are experiencing difficulties at home, in school, or in the community. Treatment programs usually combine individual, group, and family counseling to identify issues and to develop interventions that promote improved individual functioning and possible family reunification. There is a high level of supervision of recreational, vocational, educational, daily living skills, and other activities. Education is provided on-site or in the public school setting, depending on the child’s needs. Family involvement in family therapy during and after placement is considered an essential part of the treatment continuum.

*(Source: TEKOA, Inc.)*

#### **Emergency Shelter:**

An emergency shelter that provides short-term crisis care, usually for up to sixty days, with the focus on stabilization of the crisis situation and prevention of abuse and neglect for children and adolescents.

**Residential Treatment Program:**

These programs provide psycho-social-educational interventions directed by consulting psychiatrists and psychologists. Intensive behavior management is designed to meet the challenges of children and adolescents with severe disruptive behavior disorders, mood disorders, and anxiety disorders. On-site regular and special education services are provided to meet the child's needs. Some residential treatment programs will not accept children with low cognitive levels; others do provide educational services for those who are significantly below average or mentally impaired. Depending on the level of the child's placement in the residential treatment program, he/she may be in a locked setting. Supervision can be as intensive as one-on-one. "Step-down" levels of residential care provide an opportunity for the child or adolescent to continue in treatment with less intensive behavior management while pursuing additional inter-personal and intra-personal skill building.

*(Source: Presbyterian Homes & Family Services Inc.)*

**Psychiatric Hospital:**

Psychiatric hospitalizations provide acute, usually short-term, care for children and adolescents who are suicidal, homicidal, or having other psychiatric crises. Care is provided in secure, locked settings. Medication is often prescribed by the attending psychiatrist to stabilize the child's behavior. Some psychiatric hospitals also have residential programs which provide longer-term care and education for children needing intensive services.

*APPENDIX F*  
*Six-Month Survey Findings*

**Charlottesville**

Total # of children -	19	White	4
Boys	11	African-American	14
Girls	8	Bi-racial	1
 Foster Care placements:	 17	Special Education placements:	 2

Ages of children:

18 y.o. this year	(3)
17 y.o.	(2)
16 y.o.	(2)
15 y.o.	(3)
14 y.o.	(3)
13 y.o.	(1)
12 y.o.	(2)
11 y.o.	(2)
8 y.o.	(1)

Diagnoses *(some children have more than one diagnosis):*

Major Depression; Depressive Disorders	(11)
Mental retardation, mentally handicapped	(9)
Oppositional Defiant Disorder	(8)
Attention Deficit/Hyperactivity Disorder	(6)
Adjustment Disorder	(3)
Conduct Disorder	(2)
Psychotic disorder NOS; early onset	
Schizophrenia; Schizoaffective disorder	(2)
Post-traumatic Stress Disorder	(1)
Mood Disorder	(1)
Impulse Control Disorder	(1)
Dysthymia	(1)

Presenting Behaviors/History *(some children have more than one of the following)*

Aggressive/assaultive	(15)
Dysfunctional/chaotic family	(15)
Seriously emotionally disturbed	(13)
Sexually inappropriate behaviors/ sexual offender	(9)
Physically/emotionally abused	(9)
Delinquency/Court involvement	(8)
Substance abuse	(5)

Sexually abused	(4)
Enuresis	(4)
Suicidal	(3)
Diabetes	(2)
Fire-setting	(1)
Cruelty to animals	(1)

Placements (*Costs listed are direct CSA costs, with room/board already deducted for the 10 children found eligible for Title IV-E funding*)

Grafton School	(4)
Monthly cost: \$6900 - \$13,000	
Woodside Hospital	(4)
Monthly cost: \$8835	
The Pines	(3)
Monthly cost: \$5300 - \$5800	
West End Behavioral Healthcare	(1)
Monthly cost: \$4250	
Charter Residential	(1)
Monthly cost: \$9610	
Charter Westbrook	(1)
Monthly cost: \$9362	
Va Treatment Center for Children	(2)
Monthly cost: \$8750	
The Barry Robinson Center	(1)
Monthly cost: \$7161	
Genesis Treatment Center	(1)
Monthly cost: \$5454	
Piedmont Behavioral Healthcare	(1)
Monthly cost: \$8500	
Poplar Springs Hospital	(1)
Monthly cost \$11,250	

Service History

SED/LD school services	(14)
CPS involvement	(13)
In-home services	(9)
Out-patient counseling	(9)
Detention	(2)

Family history

Substance-abusing parent	(11)
Mental illness in parent	(8)

## Disposition

Of the 2 Special Education placements:

- Returned home to mother, attending public school (1)
- Remain in placement (1)

Of the 17 Foster Care placements:

- Remain in placement (8)
- Transitioned to therapeutic f.c. (2)
- Returned to family, with support services (2)
- Adoption planned upon discharge in June (1)
- Returned to Grandmother's home; on house arrest pending court hearings (1)
- Transitioned to A-Home (1)
- Moved to another residential treatment center (1)
- Committed to DJJ (1)

***Ten of these 19 children do not have a family willing/able to cooperate with services and willing/ able to provide the high degree of structure required. Fifteen of the 19 are aggressive/assaultive.***

*To return to or remain in the community, some or most of the children would need:*

- Highly structured setting with external controls, little opportunity for runaway
- High level of supervision with consistent expectations/consequences
- 24-hour crisis intervention
- Medical monitoring/medications
- Substance abuse treatment
- Treatment for sexually-offensive behavior

Charlottesville/Albemarle Commission on Children and Families

**Children Needing Extensive Services Work Group**

Kathy Ralston, *Chair*, Albemarle Department of Social Services

Carl Brown, Court Service Unit

Rory Carpenter, CCF Juvenile Justice Coordinator

Johnny Ellen, Charlottesville Department of Parks and Leisure Services

Diana Embler-Vose, intern, Charlottesville Department of Social Services

Cheryl Lewis, Albemarle Department of Social Services

Bill Lieb, Community Attention

Pat Mullaney, Albemarle County Parks and Recreation Department

John Pezzoli, Region Ten Community Services Board

Kris Santa Maria, Charlottesville Department of Social Services

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Debbie Stone, CCF Comprehensive Services Act Coordinator