Every child deserves a childhood-a safe time and place in which to grow, to develop skills, to love and trust other people, and to be loved and trusted in return. But when children and adolescents come into group and residential care, they have already been robbed of a significant part of their childhood . . . Our challenge is to create an environment where children can learn to take the risk to love and trust again, where they can develop an inner sense of control and regain a place for themselves in the world. ***Our gift is to return to them whatever part of childhood is left.***

On the Safe Side. Timothy FitzHarris

LOST CHILDHOODS

A SURVEY OF CHILDREN IN RESIDENTIAL CARE

BY JULIE TURNER

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SURVEY RESULTS - A SUMMARY

The New Jersey Association of Children's Residential Facilities (NJACRF) represents private providers of residential services for children and adolescents placed by New Jersey's Department of Human Services. In 1993, the Association conducted a survey which reviewed the characteristics of 812 children and families served by member agencies. The results depict a stark picture of the children's lives.

The majority of children in residential care are adolescent, males and minorities. Most have been victims of familial abuse and neglect. On average, these "system" children have been in the state's out-of-home placement system two and a half years prior to entering residential care. Four/fifths had been in out-of-home placements for at least a year prior to their current placement. Almost all have experienced multiple placements: more than three/quarters of the children, three or more placements; more than a third of the children, six or more placements.

Most children are known to at least one other "system" typically either juvenile justice or mental health. Forty percent of the adolescent boys had records of delinquency. Half the children have had at least one psychiatric hospitalization. The majority are educationally classified by a child study team. Considering their histories of serious abuse/neglect and of multiple placements, it is not surprising that the children have multiple serious behavioral problems. Most of the children have serious difficulties functioning in at least two critical life areas: social/inter-personal and school. They are explosive and assaultive, destructive and angry, suicidal and depressed. Many are at risk of delinquent and criminal careers. Without treatment, they are, according to David Fanshel, at "high risk of moving into adulthood as social failures, unable to become economically independent, unable to house themselves adequately, emotionally unstable, and antisocial in behavior."[1]

Many of the children were orphans -orphans in fact or orphans of the living. Only a quarter of the children had at least one parent who visited regularly. While the plan for most of the preadolescent children was discharge to a family setting, only a third had a plan of reunification with a natural parent. Discharge to a family setting was the plan for less than half the older children. A third of the adolescents' discharge plan was independent living. As is typical of many children in residential care, as Weisman noted, these "kids have had it with parents--biological, adoptive, or foster--and the feeling is usually mutual. These kids do not trust adults, especially parents."[2] They are children who have lost their childhoods, denied a safe, healthy and nurturing environment in which they can love, trust and grow.

In three years--1990-1993, the picture has become bleaker. More of the children had suffered abuse and neglect. The increase in the number of children, particularly preadolescents, who experienced failure in multiple placements before receiving treatment is striking. Fewer have families who visit regularly; more have no families at all. Many "orphans of the living" have been abused and neglected by both their families and the system.

The survey results cry out for action **to return to these children whatever remains of their lost childhoods.**

HISTORY/BACKGROUND

Between 1990 and 1993, a significant shift in New Jersey's children's systems occurred as the state placed greater emphasis on preventing placement in some- -but not all--out-of-home settings. Reliance on short term, often more restrictive and costly, placements increased; certain costs were shifted from the state budget to the counties and to Medicaid and private insurance. *Least restrictive, community-based, placement prevention, and family empowerment/preservation* became themes underlying several initiatives/plans developed by the Department of Human Services (DHS). Additional parallel residential and treatment "systems" were created. Although some of the initiatives were conceived and begun in the late 1980's, their full implementation and impact occurred in the early 1990's.

Mental Health: The 1987 children's mental health plan was developed by DHS in response to an adolescent's death at the Trenton Psychiatric Hospital Adolescent Unit, the resulting media attention, and a Public Advocate suit. The plan lessened the state's responsibility for the provision of intermediate and long term children's psychiatric hospital care by eliminating 70% (100 out of 140) of the state psychiatric beds and by prohibiting the placement of children under the age of eleven in the one remaining state psychiatric hospital. The plan relied on the development and greater utilization of short term placements in community hospitals funded through Medicaid and private insurance. By 1994, the number of short term Children's Crisis Intervention Services (CCIS) hospital beds increased from 80 to 155. The Division of Mental Health and Hospitals (DMHH)-- since renamed the Division of Mental Health Services (DMHS)-- created and funded eighty new beds in community residences to provide care for up to six months for children discharged from CCIS's. Although the plan recognized that many children were in the state psychiatric hospital as a result of the lack of appropriate beds in the Division of Youth and Family Services' (DYFS) system and stated that "it was imperative that DYFS proceed with planning for the expansion of resources to serve these children[3]," the state did not implement this recommendation. By the early 1990's, the shift toward a parallel DMHS children's residential system with relatively short-term and comparatively expensive placements had occurred. DHS developed additional non-residential services and encouraged family involvement/empowerment.

Out-of-State Placement: In 1987, NJACRF issued a position paper, *Out of State, Out of Mind*, later reprintedas a newsletter by the Association for Children of New Jersey (ACNJ). It called for reform in the state's practice of placing children out-of-state and recommended a unified children's system in a Department of Children and a coordinated cross-system needs assessment and planning. It raised a number of issues concerning juvenile justice. The relatively short-lived Children's Budget Collaboration, spurred in part by the NJACRF paper, made the out-of-state placement of children its central issue. In response to this advocacy and the resulting community, legislative and media pressure, by the fall of 1991, DHS began a serious effort to address the out-of-state issue.

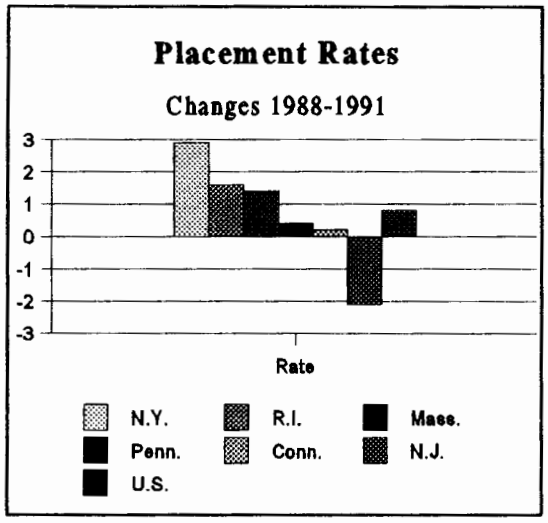
Youth Incentive Program: Both as a means of addressing the out-of-state issue and as an outgrowth of the aforementioned children's mental health plan, the Department created the Youth Incentive Program (YIP). Lacking significant additional funding, YIP was predicated on downsizing Brisbane, cutting the number of children DYFS placed out-of-state, and limiting the placement of children in **DYFS** funded residential treatment centers. Although the Department's children's mental health plan had called for **increasing** DYFS residential beds, the Department's YIP plan called for **decreasing** the number of children placed in DYFS residential care. A CART review was required for children for whom a **DYFS** residential placement was a consideration, but not for children for whom DYFS, DDD, DOH, DOE, DOC, or DJS placement was a possibility. YIP established twenty-one county-based child welfare "systems" which, in certain areas paralleled the functions of the Child Placement Review Boards and of DYFS district offices. YIP also established state, regional and county planning bodies. In the fall of 1992, the *Bring Home Our Children Home Act* codified the Youth Incentive Program, but provided no additional funding to carry out its mandates.

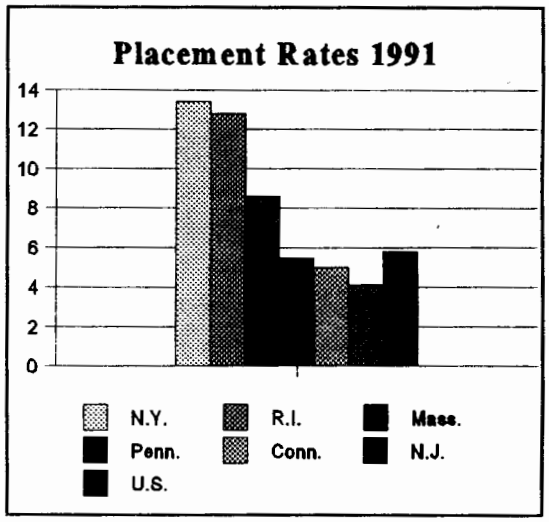
Fiscal: Between FY'92 and FY'95, state funding for DYFS-funded **private** residential treatment was cut by more than $10 million. This included more than $6 million transferred from DYFS to the Division of Developmental Disabilities (DDD). By 1994, more than 20% of the DYFS budget line for private residential/group home treatment was eliminated.

Family Preservation: New Jersey Supreme Court decisions, state legislation, state and federal policies, and fiscal considerations resulted in greater emphasis being placed on family preservation, parental rights and placement prevention, while lesser emphasis was placed on children's rights or best interests.

DYFS Foster Placements: In response to the drug epidemic and escalating reported child abuse/neglect, the national rate of foster placements increased significantly. In contrast, New Jersey's foster placement rate declined; its placement rate fell well below the national average and those of adjoining states.[4]

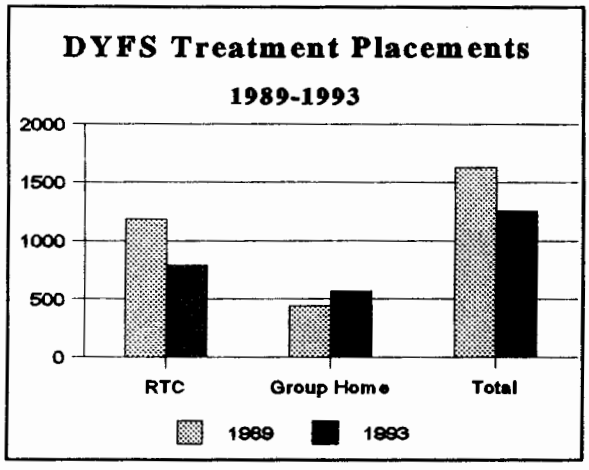
	N.Y.	R.I.	Mass.	Penn.	Conn.	N.J.	U.S.
1991	13.4	12.8	8.6	5.5	5.0	4.1	5.8
1988	10.5	11.2	7.2	5.1	4.8	6.2	5.0
Change	+2.9	+1.6	+1.4	+0.4	+0.2	-2.1	+0.8



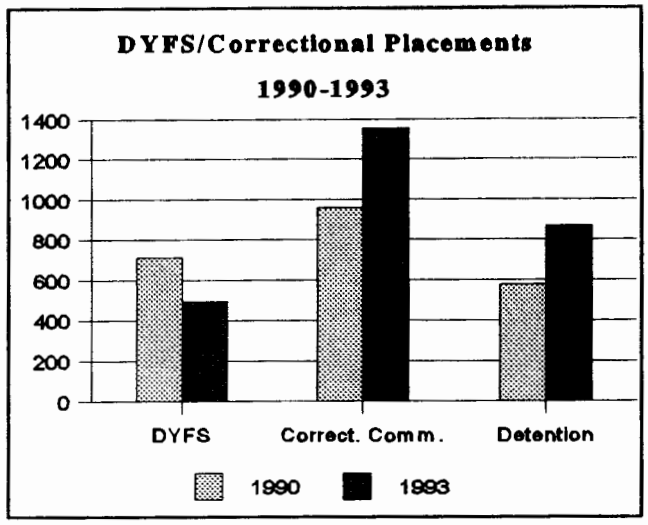


DYFS PLACEMENTS 1989-93				
Substitute Care	1989	1993	Change	% Change
Foster Care	6,491	5,804	-687	-11%
Shelter/Public Institutions	462	383	-79	-17%
Independent Living	176	129	-47	-27%
Residential Treatment	**1,186**	**790**	**-396**	**-33%**
Group/Treatment Home	**444**	**567**	**+123**	**+28%**
Total DYFS Treatment	**1,630**	**1,257**	**-373**	**-23%**
Total DYFS Placements	8,759	7,673	-1,086	-12%

Residential Placements Decline: Between 1989 and 1993, as DYFS foster placements declined by 11%, DYFS treatment placements declined by 23%. While placements in treatment homes increased, placements in residential treatment centers were cut 33% -- almost 400 children- as DHS placed increasing emphasis on least restrictive and "pushing down" on the system.



Correctional Placements: During the same time period, the number of youth in correctional (Department of Corrections [DOC]; Division of Juvenile Services [DJS]; detention) settings soared, with much of the increase occurring in already overcrowded county detention centers. Costs were thus shifted to the counties. As placements in DYFS residential treatment centers **declined** 36% between 1990 and 1994, commitments to Corrections/Division of Juvenile Services placements **increased** 41%. The average detention center census increased 50%'



DYFS/CORRECTIONAL PLACEMENTS 1990-1993						
	1990		1993		Changes	
	number	% total	number	% total	number	% change
DYFS RTC male	714	32%	494	18%	-220	-31%
Corrections total	1540	68%	2270	82%	+687	+45%
Corr. Commitment	961	32%	1357	50%	+396	+41%
Detention	579	43%	870	32%	+291	+50%
Total	2254	100%	2721	100%	+467	+21%

In the summer of 1993, the New Jersey Council of Juvenile and Family Court Judges issued a resolution citing the crisis resulting from an absence of dispositional and placement alternatives provided by DYFS and DJS. Many judges were openly critical of YIP/CART which they viewed as yet another bureaucratic barrier delaying or denying necessary treatment for youth. In July 1993, the Division of Juvenile Services was severed from the Department of Corrections; however, responsibility for Jamesberg and Bordentown remained with DOC. Juvenile Services became a new Division of DHS. By 1994, following the closing of Skillman and the reduction of placements in DYFS residential treatment placements, Jamesberg was operating 25% above capacity. New Jersey was ranked fourth highest nationally in the rate of juvenile arrests for violent crimes.

National Perspective: Articles in national publications raised concerns about the impact of permanency planning and family preservation policies which "do not specifically address children's intermediate and/or long-term health, adaptive functioning, or mental health needs . . . [Research indicated that children entering out-off-home care have] problems in several areas, including developmental delays, anti-social behavior, learning disabilities, sexual behavior disturbances, and risks of behavior disturbances."[5] Richard Small, director of The Walker Home and School, expressed the concerns shared by many of his colleagues. "We in the field have been reporting a worsening struggle to work with a much more damaged group of children and families, and a scramble to adjust our practice methods to meet both client needs and policy directives that may or may not have anything to do with client needs . . . Those of us immersed in everyday residential treatment practice see these same guidelines as less and less applicable to the real families with whom we work."[6] Retired Columbia Professor, David Fanshel, for decades one of the leading proponents of permanency planning, modified his views, recognizing that permanent placement with a family is not an appropriate goal for about a quarter of the older more seriously damaged and criminally inclined children in the system. "Such youngsters are older, have suffered many disrupted placements, and are beyond the tolerance of their own parents or potential adoptive parents."[7]

Between 1988 and 1993, the national rate of reported child abuse/neglect increased 50% rising to 45 per 1,000 in 1993. A majority of states cited substance abuse as a major problem of families on the child welfare caseloads. Between 1986 and 1991, the number of children in foster care soared more than 50% from 280,000 to 430,000. A 1991 United State General Accounting Office (GAO) Report provided some of the reasons cited by state officials for the "dramatic" national increase in children placed in foster care. These reasons included increased abuse/neglect reports and increased numbers of children entering care as a result of parental substance abuse, particularly crack cocaine. Officials reported longer stays in foster care as a result of the length of time required to treat substance abuse and other family problems, and the increasing numbers of children with special needs requiring longer treatment.[8]

New Jersey: Recent articles raised serious concerns about the impact of the changes in state policies and practices on New Jersey children. *New Jersey Reporter* asked: "Can New Jersey's child-welfare system, already crippled by budget cuts, manpower shortages, and a steady decline in the number of qualified foster homes respond to this crisis [AIDS; crack; child abuse]? It is a system grown obsolete, failing to meet the needs of fostering children already in its care, wholly unsuited and unprepared for those of a new and more deeply troubled generation headed its way . . . More children remain in less stable and [less] nurturing environments much longer before a crisis erupts. Experts say this accounts greatly for the deeply entrenched emotional problems seen in older children now entering foster care for the first time."[9] Former Governor Kean, in an Op Ed Article, *Take Kids from Unfit Parents*, was critical of "state and national policies . . . aimed at keeping families together **at all costs**."[10] (Emphasis added.)

Stolen Futures,[11] issued by the Association for Children of New Jersey in 1994, described the results of their study of children entering foster care and of focus groups conducted with DYFS staff. ACNJ found that not only were there almost no unnecessary placements, in some cases "placement should have occurred earlier to better protect the children." Older children had a significant prior history of parental abuse or neglect; half had six or more prior case openings. By the time placement was considered, many of the children needed treatment for severe emotional problems. "No one could read about what happened to these children and not be enraged by their stories or mourn for their lost potential. Some are already on their way to involvement in the juvenile justice system . . . Some have already suffered abuse or neglect or the consequences of parental substance abuse that may change them for life." DYFS workers saw the YIP/CART process, in many cases, as delaying needed placement until it became even more difficult to treat the child. This study was limited to children placed in traditional foster care, and did not review children placed in residential treatment programs.

NJACRF SURVEY

The New Jersey Association of Children's Residential Facilities (NJACRF) represents private residential providers serving children and adolescents placed by New Jersey's Department of Human Services. NJACRF is a nonprofit organization with a thirty-five-year history of advocacy for children requiring residential treatment and for the agencies serving these children. "Residential treatment" includes the full range of out-of-home treatment programs, including residential treatment centers, group homes, treatment homes and independent living programs.

In 1993, The Association conducted a survey which reviewed the characteristics of children and families served by member agencies. Members were asked to fill out the survey on all the children in the program on one day (rather than all the children in the program throughout 1993). Responses were received on 812 children from 53 programs: 10 Residential Treatment Centers*; 33 Group Homes; 4 Shelters; 3 Independent Living Programs; 3 Specialized Treatment Home Programs. Member agencies provided vignettes on children under their care as well as poems written by the children. They help make real the children behind the numbers.

NJACRF had conducted a similar survey in 1990; however, some questions were reworded and additional questions were added, making certain comparisons difficult. Wherever possibly, we will point out changes between 1990 and 1993.

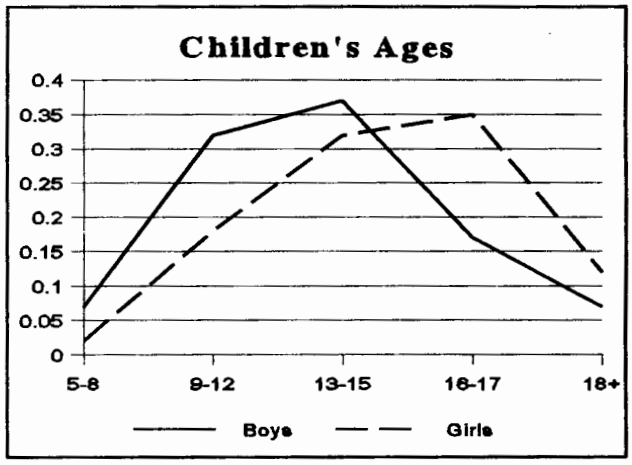
* Unfortunately, the largest residential treatment center serving approximately sixty girls did not participate in the survey. Thus we do not have information on about a fifth of the girls in residential care and on over half the girls in treatment centers. The survey also did not include children placed in state-operated programs nor in programs which were not members of the Association.

THE CHILDREN

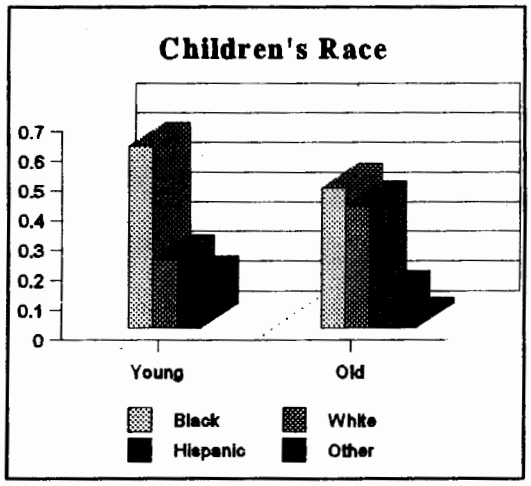
The survey looked at a number of characteristics of the 812 children in residential care: age; race; abuse/neglect; number of placements; educational classification; psychiatric hospitalizations; juvenile justice history; and behaviors; problems.

Age/Sex: The majority (69%) of the 812 children were boys. Not only are more boys in residential care, they enter at younger ages. While 40% of the boys enter residential care as preadolescents; this is true for only 20% of the girls. The percent of boys entering residential care at ages sixteen-seventeen drops to 17%; for girls, these ages account for the highest percent (35%) of placements.

Age	Boys	Girls	All
5-8	7%	2%	5%
9-12	32%	18%	27%
13-15	37%	32%	37%
16-17	17%	35%	23%
18+	7%	12%	8%



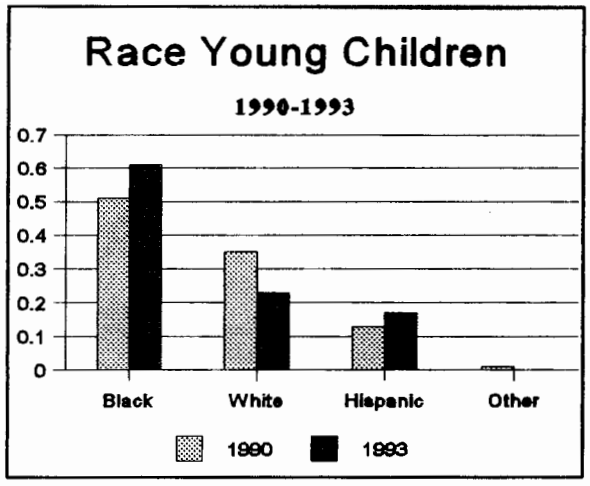
Race: Almost two thirds were minority; half were black. More than three quarters of the younger* children were minorities; more than three fifths were black.

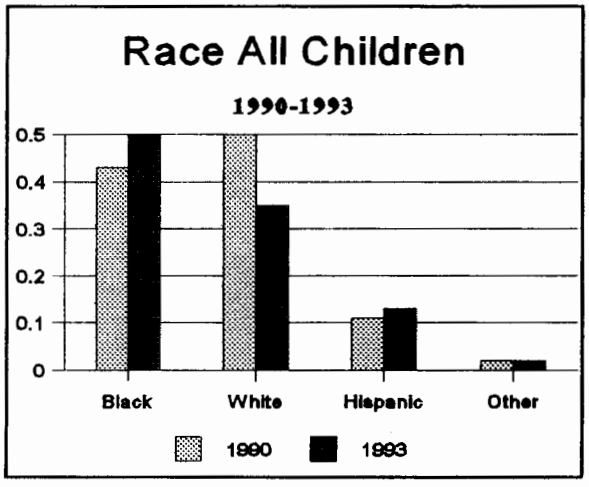


	Boys		Girls	
	Young	Old	Young	Old*
Black	59%	47%	65%	49%
White	23%	40%	23%	45%
Hispanic	18%	11%	12%	11%
Other	-	2%	-	3%

*In charts, tables, and writing, "young" indicates ages 5-12 years; "old" indicates ages 13 and over.

In the three years since the 1990 NJACRF survey, there has been an increase in the percent of minority (particularly Black) children and a decrease in the percent of white children in residential care; this was particularly true of the younger population. In 1990, two thirds of the younger children were minority; by 1993, this increased to more than three quarters. The percent of minority older children increased slightly during this period.

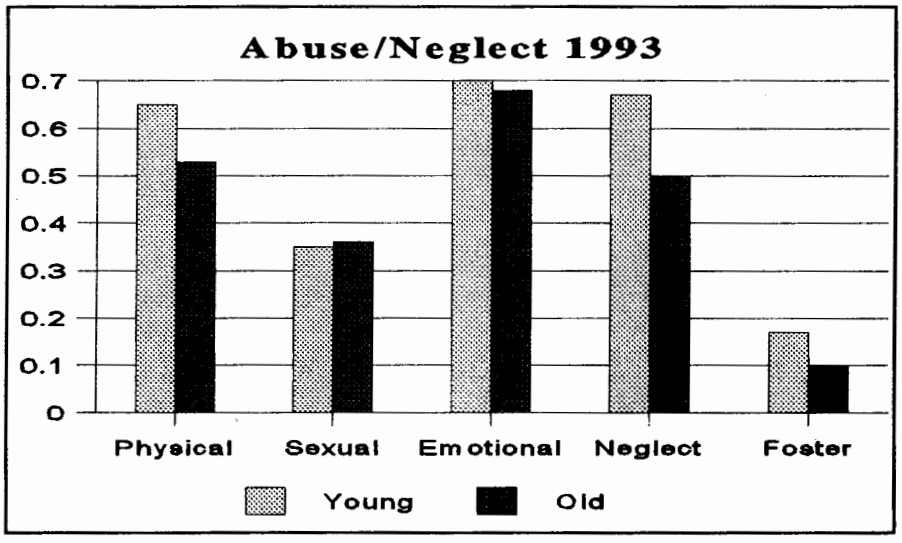




CHILDREN'S RACE 1990-1993								
	Young			Old			Total	
	1990	1993		1990	1993		1990	1993
Black	51%	61%		39%	45%		43%	50%
White	35%	23%		47%	41%		43%	35%
Hispanic	13%	17%		11%	11%		11%	13%
Other	1%	-		2%	3%		2%	2%

Abuse/Neglect: The majority of the children had been abused and/or neglected. In most categories, a higher percent of the younger population had been abused and/or neglected. Girls were more likely to be victims of sexual abuse and were more vulnerable to abuse in foster care. 12% (17% of young children) were abused in foster care.

ABUSE/NEGLECT 1993									
	Young				Old				
	Boys	Girls	Total		Boys	Girls	Total		Total
Physical abuse	64%	67%	65%		51%	57%	53%		56%
Sexual abuse	28%	67%	35%		26%	53%	36%		36%
Emotional abuse	70%	70%	70%		60%	80%	68%		69%
Neglect	67%	67%	67%		49%	54%	50%		55%
Abuse/foster care	16%	23%	17%		8%	13%	10%		12%



Molly was beaten and tortured, including one incident when her legs were broken when her father slammed her body into a door. She was locked for days in a dark basement. Not only did her father rape her repeatedly, he also made her available to his fellow motorcycle gang members. Her mother failed to protect her and then abandoned her to the "care" of her father.

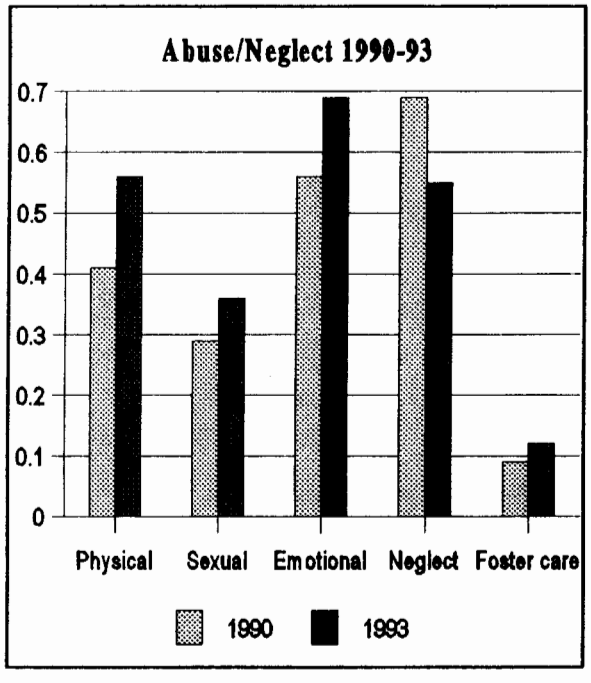
Johnny, age ten, had multiple bruises all over his body as a result of beatings by his aunt and her lover. He had been sexually abused by his father, a drug addict. He has frequent temper tantrums in which he throws himself around the room, saying he is being hit.

The following from a poem titled *Pain* was written by an abused adolescent:

> ***As a dagger pierces through your heart with words that plow***
> ***Through your ear you feel pain. I know how pain feels.***
> ***I know what it sounds like. It's the sound of a woman crying***
> ***From a broken heart and the terrible screams of a dying man.***

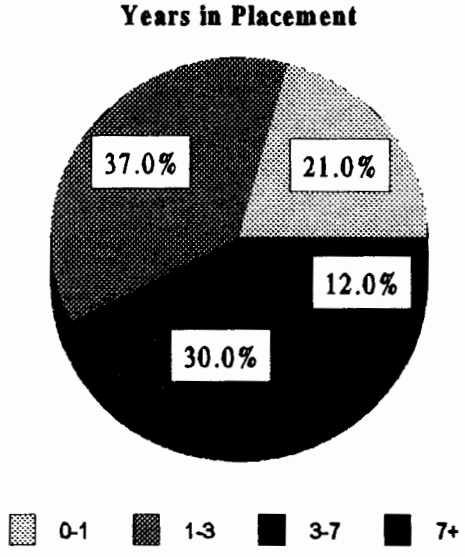
Abuse/Neglect 1990-1993: In the three years since the initial survey, the percent of children who were abused and/or neglected increased in every category. Between 1990 and 1993, the percent of younger children who had been abused in foster care increased from six to seventeen percent.

Abuse/neglect	1990	1993
Physical abuse	41%	56%
Sexual abuse	29%	36%
Emotional abuse	56%	69%
Neglect	41%	55%
Abuse in foster care	9%	12%
Abuse in foster care young children	6%	17%

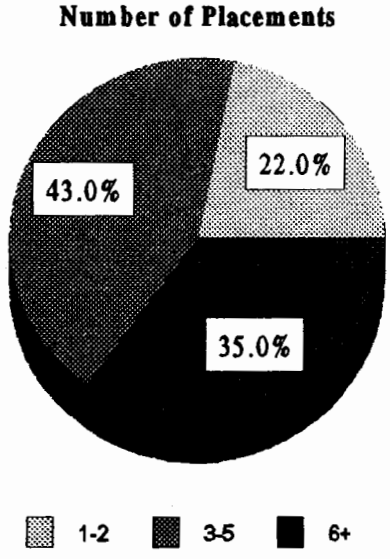


Time in Out-of-Home Placements: Most of the children are veterans of the out-of-home placement system. Four fifths had been in out-of-home placement(s) for at least a year prior to their current placement. More than 40% had been "in the system" for at least three years.

	Young	Old	All
0-1	25%	19%	21%
1-2	18%	20%	20%
2-3	14%	19%	18%
3-5	18%	19%	20%
5-7	14%	9%	10%
7-10	7%	7%	7%
10+	2%	7%	5%
Total 3+	43%	42%	42%



Number of Placements: The majority of children fail their way into an appropriate placement. For only 6% of the children was their current residential placement their first placement. It was at least the the third placement for over three quarters of the children; it was at least the sixth placement for more than a third of the children.

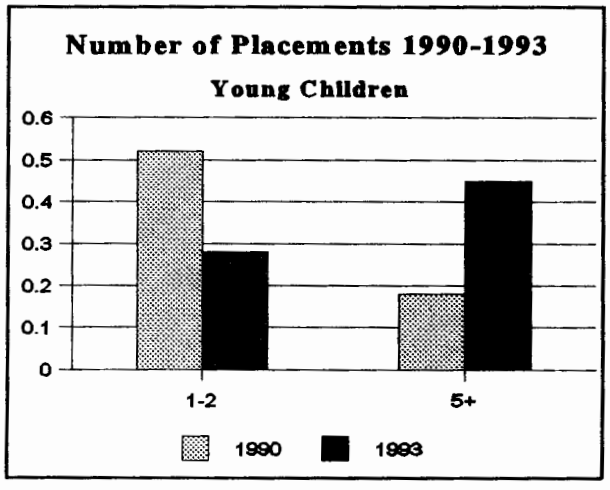


Number of Placements	Young	Old	All
1st	5%	6%	6%
2nd	23%	13%	16%
3rd	16%	16%	16%
4-5	25%	27%	27%
6-8	25%	20%	20%
9-10	4%	7%	6%
11+	5%	10%	8%
Total 3+	**72%**	**81%**	**78%**
Total 6+	**34%**	**36%**	**35%**

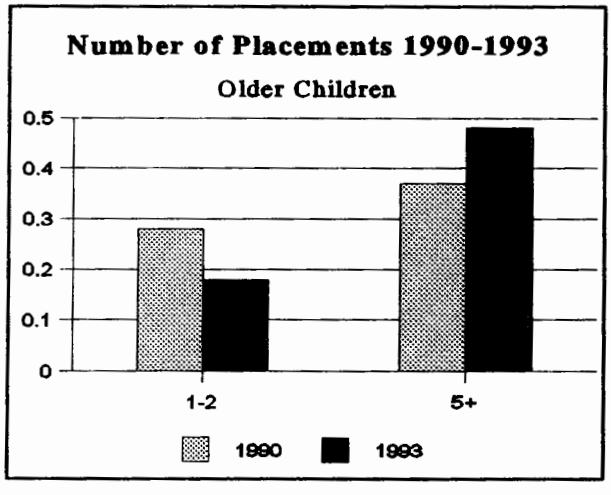
Placed at age three because of severe neglect, by age thirteen, Mary had been in eighteen foster homes as each placement ended in "dismal failure." This continued until she entered a treatment home where she flourished. Her treatment parents plan to adopt her.

Fifteen year old Juan has been in out-of-home placements since he was seven years old. Thus far, he has been in seventeen foster homes, four teaching families, several temporary shelters, psychiatric hospitals (including Brisbane), a substance abuse program and a detention center. He has now been referred for placement in a residential treatment center.

After eight years in the system, fifteen year old Susan had experienced thirty-seven placements. Pregnant with her second child, she ran away from her thirty-eight placement after a staff member resigned, another loss and perceived rejection in her young life.



Changes 1990-1993: Between 1990 and 1993, there was a significant increase in the percent of children experiencing multiple placements. The percent of preadolescents with one or two placements fell from 52% to 28%, while those with five or more placements increased from 18% to 45%. Although not as dramatic, this trend was similar for adolescents.



Comparison Number of Placements 1990-1993								
	1990	1993		1990	1993		1993	1990
# of Placements	Young	Old		Young	Old		Total	Total
1st	10%	5%		11%	6%		11%	6%
2nd	42%	23%		17%	13%		26%	16%
3-4	31%	30%		29%	32%		30%	32%
5-6	12%	21%		14%	21%		13%	21%
7-10	5%	19%		17%	17%		13%	16%
11+	1%	5%		8%	10%		5%	8%
1-2	**52%**	**28%**		**28%**	**18%**		**37%**	**22%**
5+	**18%**	**45%**		**37%**	**48%**		**31%**	**46%**

Life's pages
shattered and torn
Home was where life was meant to be
or so I could have sworn.
My tears and agony
shattered and torn,
life's lonely pages.
These tattered, battered
pages dictated to me.
One house to another
yet, I never had a home.
This house and these girls,
will they be like a family?
So, once again, I'll dry by eyes
and give life a chance.
In time my heart will mend
my shattered and torn pages,
so, in time, I will love again.

Written by an adolescent and dedicated to the staff and girls in her group home.

Background-Other Systems: Education: Most of the children were known to other child serving systems. Over four/fifths of the children were classified by school child study teams; the majority were classified emotionally disturbed.

Education Classifications			
	Young	Old	Total
Emotionally Disturbed	72%	67%	64%
Perceptually Impaired	4%	7%	6%
Neurologically Impaired	4%	3%	3%
Multiply Handicapped	13%	4%	7%
Mentally Retarded	-	1%	1%
Total-All Classifications	88%	78%	81%

Psychiatric Hospitalization: Almost half the children had at least one psychiatric hospitalization; almost a quarter had multiple hospitalizations. The younger children were more likely to have had one or more psychiatric hospitalizations.

	Young	Old	Total
Prior Psychiatric Hospitalization	59%	41%	48%
Multiple Psychiatric Hospitalizations	28%	22%	24%

Jan, age fourteen, was unable to remain in the community for any length of time without being hospitalized for repeated psychiatric crises. After several hospitalizations, Jan entered a group home and responded well to its structure. She entered a private day school, maintained her medication regime with a community psychiatrist, visited home on a regular basis and did not suffer any additional psychotic episodes. Her mother learned how to manage her daughter's behavior. Jan was successfully reunited with her mother.

Joe had a long history of emotional and behavioral problems. He was first hospitalized in a CCIS in 1988. He was placed in an out-of-state residential program but was discharged for negative behavior. He was then hospitalized at another private hospital. After six weeks at another out-of-state facility, he was discharged. Following screening at a CCIS, he was admitted to Brisbane in 1991. After fourteen months, he was stabilized so that he could be placed residentially. While at Brisbane, Joe had one-to-one supervision and could be maintained in school for only a half-day. At the in state private residential center, he attends school all day and requires no special supervision.

Court Involvement: Delinquency/Juvenile Family Crisis: 28% of the younger children and 43% of the adolescents were known to the court through juvenile/family crisis. 9% of preadolescent and 40% of the adolescent boys had delinquency records.

	Young Children	Older Youth	Young Boys	Old Boys	Total
Juvenile Family Crisis	28%	43%	31%	42%	38%
Delinquency	7%	29%	9%	40%	22%

After being at Jamesberg, Tyrone was placed in a residential center. In public testimony, he said: "My father left when I was seven. Mom doesn't show much attention. I frustrated easy; I had lots of assaults. Anger goes up and down. If I'd stayed at Jamesberg, I would have had no help. The staff really care; they help us with our problems. I think about what it will do to us without places like this and if we're stuck in detention and Jamesberg."

Jennifer was abandoned at age five by her drug abusing parents who had failed to provide even basic care. A chronic runner with fifteen failed placements, she was well on her way to a criminal career with two arrests for drug dealing, and one for shooting her victim in the leg. When she entered the group home at age fifteen, she was an angry, aggressive, untrusting young woman. Some months later, the staff overheard her saying, "I love it here. This is the first place I've been where I've felt good about myself." Her future is more helpful.

Multiple Systems: The children's problems and needs cut across multiple systems. In addition to DYFS, they "belong" to the mental health, juvenile justice, substance abuse, special education, and/or developmental disabilities' systems.

	Young	Old	Old boys	Total
Psychiatric hospitalization	59%	48%	43%	48%
Juvenile/Family Crisis	28%	43%	42%	38%
Delinquent	7%	22%	40%	22%
Substance Abuse	-	17%	17%	12%
Developmental Disability	13%	11%	11%	11%
Educationally Classified	88%	78%	89%	81%

Albert had several placements, including detention and a group home, prior to entering a residential facility. He was raised "all over" being moved from foster homes to relatives and from school district to school district. His alcoholic father died several years ago. His drug-addicted mother abandoned him. He is classified emotionally disturbed, and was treated by multiple mental health workers. He was arrested for burglary. He also has an alcohol problem.

Children's Behaviors and Problems: With histories of severe abuse/neglect, multiple failed placements, and highly dysfunctional families, the children, not surprisingly, have many serious problems. Most children have significant difficulties in two critical life areas: social/inter-personal and school. They are explosive and assaultive, destructive and angry, suicidal and depressed. Rosenfeld and Wasserman found that "while individual children respond to maltreatment in various ways, those [requiring residential treatment] have reacted with marked aggressive or destructive behavior, turned outward or inward. They may assault adults in authority, such as teachers, or they may vandalize property or set fires. If their rage is directed outward, they may attack or even attempt to murder others. Terms such as oppositional, resistive, explosive, conduct-disordered, or disrespectful of adult authority are used to describe them. They may direct their rage inward and injure themselves or attempt suicide. Other[s] . . . show their disturbance in sexually precocious, aggressive, or assaultive behavior directed toward either adults or other children."[12]

When sixteen year old Molly entered a girls' group home, she lacked even the most basic social skills. She ate with her fingers, refusing to use a knife and fork. Her anger spilled over in her physical demeanor as well as in her behavior, finding outward expression with explosive outbursts during which she punched walls and inward expression by carving initials in her arms. After intensive treatment, she was "transformed physically, emotionally, and spiritually."

Mark was referred to a residential treatment center at age thirteen after several unsuccessful foster placements and an attempted suicide. Because of his inability to behave in school, he had been put on home instruction. He had a history of running away and shoplifting. He was involved in several fights and instigated problems with his peers on a daily basis. In addition, he was extremely obese and had heart problems.

Lacking emotional reserves, the children easily explode in response to minimal pressure or frustration. Anger, often poorly controlled, permeates the lives of many children. Over half the boys have explosive behaviors. As described by a director of a residential program, "kicked in doors and broken windows are frequently the result of rage as our boys struggle with frustration, disappointment and ambivalence related to their families or the lack of. Their anger is so close to the surface that violent eruptions are all too common." Without treatment, many are at high risk of becoming violent delinquents.

A teenager expresses his anger and fear of being unable to control himself in the following:

Anger builds up inside my body,
Creating an animal of hate and destruction,
But I will not let this beast be released,
Pushing and fighting just to get out,
But, I am afraid of all my anger.

Having experienced abuse and rejection, these youth view themselves as worthless and are often depressed, suicidal and self-abusive. More than a quarter (over a third of adolescent girls) are depressed; almost a quarter are suicidal. This poem written by an adolescent while in a shelter awaiting yet another placement expresses his despair and sense of hopelessness.

Pointless.....

There are things in life that I don't understand
The brocken hearts and the unlending hands.

The pointless struggles, the meaningless cries,
and last but not least the deceiving lies.

Things in life are never perfect, and I know that they'll never be,
but why so much sorrow when we can be happy.

At fault, it seems I'll always be,
and an unhappy soul with unfilled dreams.

Life's pain and difficulty are inedible,
one's misery is optional.

Pointless.....

Having histories of physical and sexual abuse, many children and youth have sexual acting out/offending behaviors. More than a third of the adolescent boys More than a quarter of the younger boys and a third of the younger girls exhibit sexually inappropriate behaviors. Without timely and appropriate treatment, these victims may become victimizers.

Joe had been repeatedly and brutally raped by his father as his ineffectual mother was unable to protect him. While his family was being "preserved," Joe's acting out behavior escalated. His abuse of his toddler brother resulted in the preschooler going to the hospital nine times in two years for injuries which included a fractured skull, broken bones, and sexual abuse with a kitchen utensil. After several psychiatric hospitalizations and family preservation services, Joe set fire in the house and sexually assaulted his six month brother. At age ten, he was finally referred for residential treatment.

Very young children already exhibit multiple severe problems. More than half are explosive; over a quarter are acting out sexually. Over half have attention deficit/hyperactivity disorder (ADHD).

Christie was four and a half when she entered a residential program after nine failed placements. Abused and neglected, nutritionally deprived, she had limited ability to communicate except through abusive language. Even after residential treatment, her adoptive parents recall the rime after she was placed with them: night terrors of screaming and crying; running away from kindergarten; angry tantrums; abusive language; constant calls from the school.

Pablo's sixteen year old homeless mother asked friends to care for him. They sexually abused him. He was in a series of foster homes and hospitals. He was referred for residential care because he was hyperactive, destructive, set fires, and tried to kill himself. He was ten.

Edward and John saw their father pummel their mother until she was bloody. He threatened to kill them and drink their blood if she dared to leave. He also threatened to set fire to the house to kill them, and later did indeed set fire to the kitchen. Although they have escaped the abusive situation, the scars remain. Seven year old John does not speak much. He has trouble completing sentences and performing basic tasks. He can't dress himself. He is unable to use the toilet since the night he watched his father try to drown his mother in one. He has set several fires, including one under his grandfather's bed and one outside his mother's bedroom. Eight year old Edward is much more aggressive. He punches and bangs on walls, and bites and scratches himself. He has threatened to kill himself and his mother. He has been hospitalized several times. He has set at least one fire. He uses anatomically correct dolls to show various sex acts. He has also used the dolls to act out the killing of a family.

Children's Behaviors and Problems					
	Young			Old	
	Boys	Girls		Boys	Girls
Social/Personal	70%	72%		82%	65%
School Problems	71%	53%		78%	60%
Conduct Disorder	32%	16%		54%	21%
Explosive	57%	26%		51%	30%
Destructive to Property	43%	19%		48%	30%
Assaultive	42%	16%		47%	32%
Sex Offender/Acting Out	26%	33%		36%	29%
Runaway	22%	5%		34%	27%
Depression	25%	14%		28%	35%
ADHD	55%	37%		28%	6%
Suicidal	29%	16%		19%	26%
Substance Abuse	-	-		17%	18%
Developmental Disability	12%	19%		11%	12%
Arson	14%	-		11%	-
Medical	6%	9%		7%	7%
Thought Disorder	11%	2%		7%	8%
Organic Mental Disorder	3%	14%		7%	6%
Homicide	5%	-		5%	3%
Pregnant/Mothering	-	-		-	11%
On Psychotropic Medication	47%	40%		43%	25%
Psychiatric Hospitalization	62%	37%		42%	38%
Juvenile Family Crisis	31%	16%		40%	33%
Delinquent	9%	-			12%

THE FAMILIES

In addition to abuse/neglect, the survey looked at three other issues concerning families: family structure, parental behaviors/conditions, and visiting.

Family Structure: Thirty percent of the children did not have at least one birth parent as "family." Parental rights had been terminated for 17% of the families (23% of those with preadolescent children). Another 6% were from adoptive families, while relatives were the family for 7% of the children. Of the 70% in which the child's family was identified as one or both birth parents, 16% of the families were intact, 59% were single parents, 14% were reconstituted, and 11% were multi-generational.

Family Structure			
	Young	Old	Total
Intact	9%	12%	11%
Single parent	40%	42%	41%
Reconstituted	9%	10%	9%
Multi-generational	4%	9%	8%
Adoptive	5%	6%	6%
Term Par. Rghts.	23%	15%	17%
Relative/other	7%	8%	7%
Mother deceased	7%	7%	7%
Not available	19%	25%	21%
Father deceased	9%	6%	8%
Not available	28%	38%	31%
Unknown	15%	13%	15%

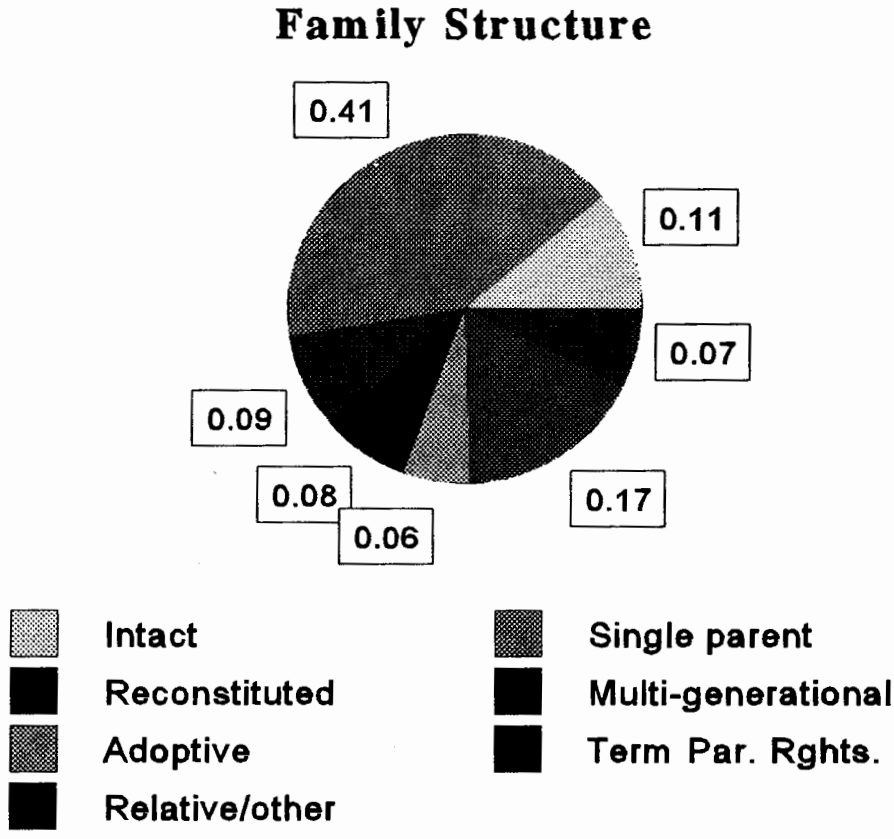
Many children were orphans, --orphans in fact or orphans of the living. In addition to the 17% of the children for whom parental rights had been terminated, a fifth of the children had, de facto (whereabouts unknown; dead), no mother. Almost a third of the children had essentially no father as a part of their lives; of the 31% defined as not available, 8% were deceased and 15% were unknown. In addition, to being more likely

to have had families whose parental rights had been terminated, younger children were also more likely to have parents who were dead, missing or unknown. (In 1990, 10% of the children had "no parents; e.g., dead, unavailable or unknown.)

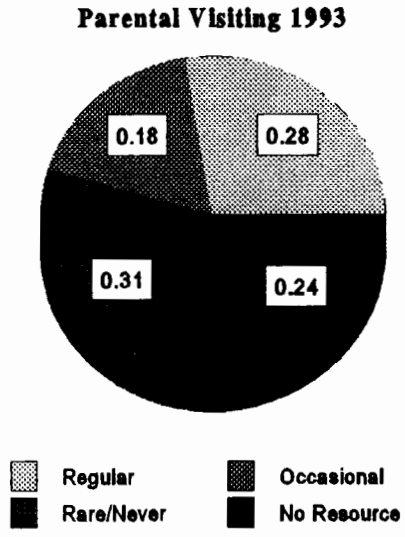
Carlos's mother was accidentally killed by a stray bullet three years ago. His father has AIDS and has less than a year to live. Carlos has become uncontrollable--fighting, destroying property, threatening suicide. He cannot be contained when he is at home. After visiting his father, he cries and sobs for hours. He is ten years old.

Ben was known to DYFS for a year prior to his placement due to his mother's abuse and neglect. When his mother disappeared, Ben was placed by DYFS. Seven years later, his mother resurfaced, but refused to have anything to do with her children. His father is missing.

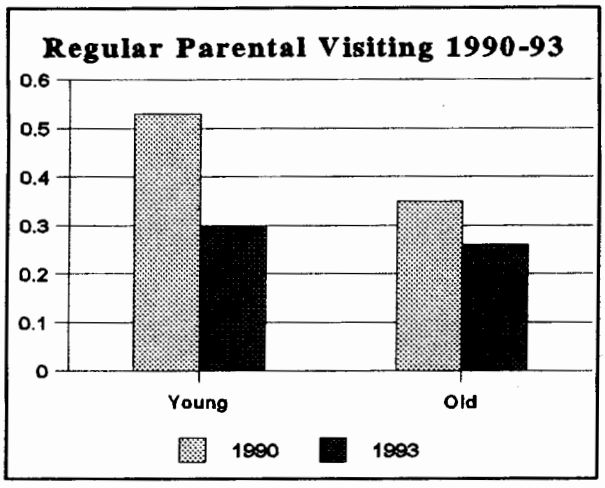
Bobby entered a residential treatment center when he was six. His mother had been killed when he was two; his father was in jail. To say that Bobby had been cared for by a succession of relatives and foster parents would be to greatly exaggerate the word "care."



Parental Visiting 1993			
	Young	Old	All
Regular*	30%	26%	28%
Occasional	17%	18%	18%
Rare/Never	22%	35%	31%
No Resource	31%	21%	24%



Since 1990, fewer children had parents who visited regularly. In 1990, over half the parents of younger children visited regularly; by 1993, less than a third visited regularly. The percent of parents of older children who visited regularly also declined.

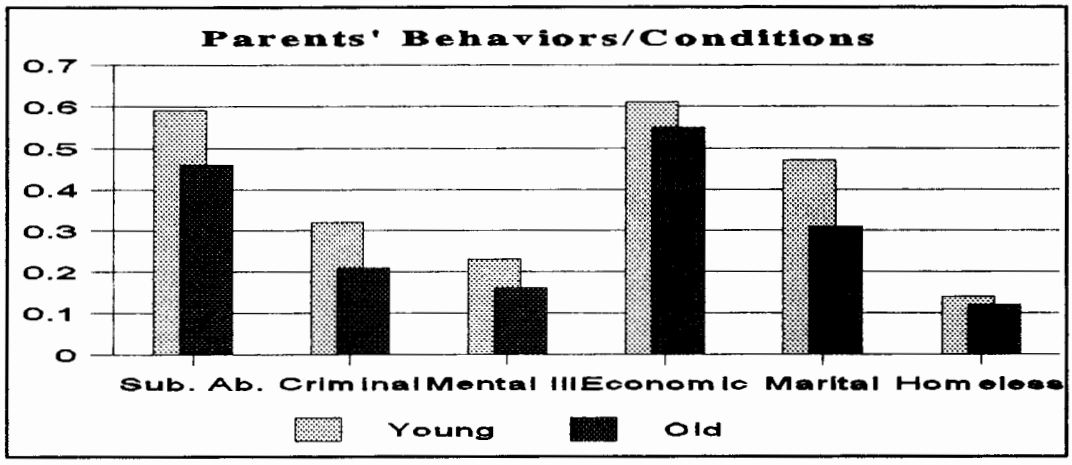


Regular Parental Visiting 1990-1993			
	Young	Old	All
1990	53%	35%	41%
1993	30%	26%	28%
Change	-23%	-9%	-13%

*Regular": visiting followed an established schedule. The frequency could vary. "Occasional": holiday or other infrequent visits; the child could not depend on parental visits. "Rare/never": parent had not visited in several months or at all. No visiting resource: no family member for a child to visit. Visiting included visits at the facility and/or in his or her home

Parental Behaviors/Conditions: Some families of children in residential care are committed to their children, advocate for necessary services, and participate actively in their treatment. However, the majority have multiple problems. The younger children's families have a higher incidence of all of the problems/conditions. The incidence of

behaviors may be understated. Many (at least a third) of the parents are not available or unknown; in other cases, parental rights have been terminated. Referral material may not contain information on parents, particularly on families of children who have been in the system for many years. Therefore, providers may not have information on some parents.



	Substance Abuse	Criminal Behavior	Mental Illness	Economic Stress	Marital Problems	Homeless
Young	59%	32%	23%	61%	47%	14%
Old	46%	21%	16%	55%	31%	12%
Total	50%	24%	18%	57%	33%	13%

Mark's father, an alcoholic, left the family years ago and had infrequent contact with them. The youngest of five children, Mark blames himself for his father's absence and often runs away to look for him. A brother is in jail for attempted murder; a sister has become involved with drugs. His mother, is on dialysis three times a week and is legally blind.

Until he was placed at age seven, Billy lived in a broken down station wagon with his mother and various "uncles." Sometimes his mother lived in the wagon; at other times she was in jail or a psychiatric hospital. Billy was malnourished, frightened, depressed and suicidal.

Raymond's parents never married. His father, who had several arrests, said, "I was a drunk. I wasn't there when he needed me." His mother, an alcoholic and drug addict, never worked. Family members raised the older children. Ten year old Ray was "always hungry" and stole food from local stores.

DISCHARGE PLANS

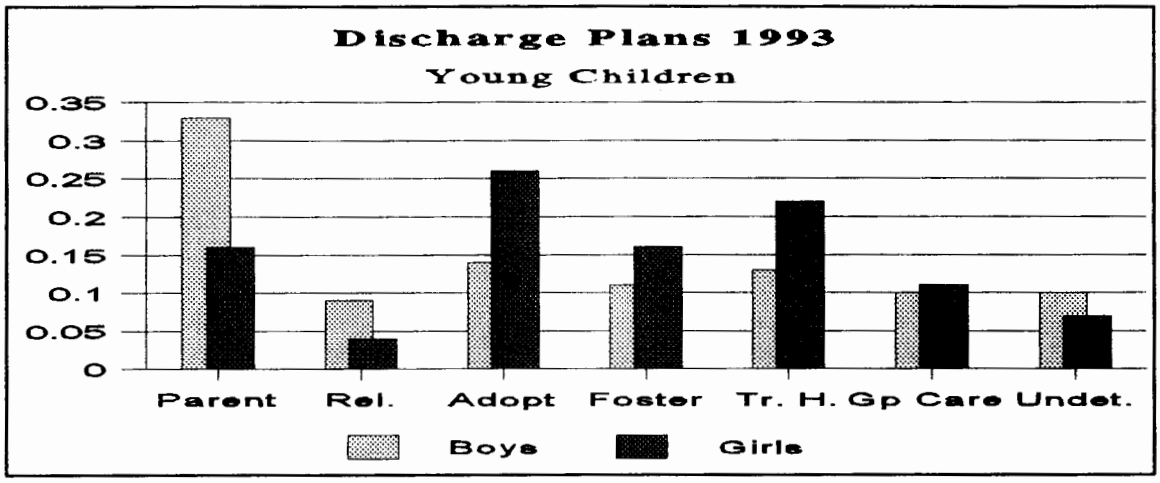
Residential care is not a permanent solution for troubled children. Its "challenge is to create an environment where children can learn to take the risk to love and trust again, where they can develop an inner sense of control and regain a place for themselves in the world."[13]. For most--but not all-younger children, the appropriate goal is a family setting. While some adolescents are able to return home or move to a specialized or foster family placement, many "have had it with parents-biological, adoptive, or foster-and the feeling is usually mutual. These kids do not trust adults, especially parents. They cannot tolerate the intensity of family life."[14] The appropriate discharge plan for many youth is a community program which will help them develop the skills to live independently.

Young children: The plan for the majority (88%) of preadolescents was discharge to a family setting. Almost three/fifths of the younger children had goals which provided a "permanent" family (placement with a parent, relative or adoptive family). In the years between 1990 and 1993, a decreasing portion (54% to 41%) of preadolescents had a plan of placement with a biological family member. Than only a third of the children had a goal of return to a natural parent must be placed in the context of their histories of abuse/neglect, their length of time in prior out-of-home placements, and the number with parents who did not visit. Over half the younger children had either no family members as a visiting resource or parents who rarely or never visited; 23% of their families had parental rights terminated. In spite of these facts, only 17% had adoption as their goal.

Although the plan for over 40% of the children was to remain "in the system" after completing a residential program, the discharge plan for the majority was placement in a family setting. The development of specialized treatment homes has provided an opportunity for many severely troubled children to move to a family setting following intensive treatment in a group care facility. Some may move out of the system after placement in a treatment home or foster care. A relatively small number required further placement in group care--7% in residential treatment centers and 3% in group homes.

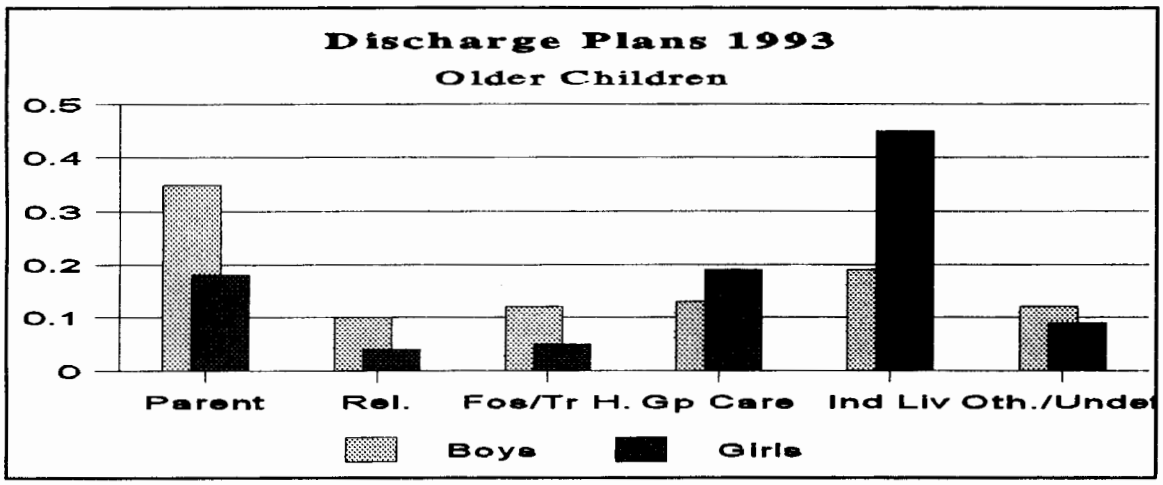
After two years of being moved from one foster home to another, Marcus, age six, was placed in a residential center. Fourteen months later, he moved to a treatment home affiliated with the center. Marcus was later adopted by his treatment home mother.

Following nine failed foster placements, Christie (see p. 17) entered a residential center; the program facilitated her placement in an adoptive home. Although the initial adjustment was "stormy," twelve years later Christie is, according to her adoptive parents, "our daughter, sum and total." She is involved in "just about every activity the family's church has to offer" and volunteers in a program for homeless people and in the church nursery. She participates in many sports, plays three musical instruments, and, in the future, plans to go to college and have a family. "My parents are the ones who raised me, that's a parent--the people who put in the time," Christie commented.



Discharge Plans 1993					
	Young			Old	
	Boys	Girls		Boys	Girls
Parent	33%	16%		35%	18%
Relative	9%	4%		10%	4%
Adoption	14%	26%		-	-
Total Permanent Family*	**56%**	**46%**		**45%**	**22%**
Foster Care	11%	16%		7%	3%
Treatment Home	13%	22%		5%	2%
Total Family Setting*	**88%**	**88%**		**68%**	**28%**
Group Home	1.5%	9%		11%	17%
Residential Treatment Center	7%	2%		3%	2%
Independent Living Program	1.5%	-		9%	9%
Independent Living	1%	-		10%	36%
Adult Residential/Other	-	-		3%	7%
Undetermined	10%	9%		10%	2%

*Percentages exclude children for whom a plan is not yet determined.



Older Children: The plan for half the adolescents was discharge to a family setting, a third to a parent or relative. Although parental rights had been terminated in 15% of the cases and well over half the parents rarely or never visited, few youth had adoption as a case goal. Almost a third of the adolescents' discharge plan was independent living; only 8% were to be placed in an independent living program. By eighteen, at least a fifth of the youth will be living on their own, many with minimal or no family or program supports.

Barbara was placed in a group home from shelter care after her family had exhausted community resources. Her adoptive parents were committed to her, but felt she was punishing them for the abuse she suffered from biological mother. Barbara responded to the therapy. After completing the program, she was reunited with her family with counseling supports. The feel they have their daughter back.

Claire entered the DYFS placement system at age fourteen. She had several failed foster placements before entering a group home. After completing the group home program, she entered the agency's independent living program. Four months later, DYFS closed her case. The agency's aftercare program helped her find housing and provided financial and other support. She works at a supermarket, attends monthly workshops which continue to prepare her for life as an independent adult, and plans to attend a community college.

A young man wrote his former program director: *"Well thanks is in order. It seems like yesterday I was a confused 13 year old mad at the world and put at ___. Well, now ten years later I'm not as confused HA! and my anger is venting into an incredible love shown to me, thanks to you."* He has completed college and plans to obtain a Masters in Social Work and in Divinity. *"My long range goal is to open a house in an inner city for troubled and delinquent boys."*

Discharge Plans 1990-1993					
	Young			Old	
	1990	1993		1990	1993
Parent	37%	32%		26%	31%
Relative	17%	9%		9%	9%
Adoption	13%	17%		1%	1%
Permanent family setting	**67%**	**58%**		**35%**	**41%**
Foster Care	14%	13%		5%	6%
Treatment home	Na	16%		Na	3%
Total Family Setting	**81%**	**88%**		**40%**	**50%**
Residential	11%	7%		16%	3%
Group Home*		3%			13%
Independent Living		2%		37%	31%
Adult Res. Other	6%			5%	5%

*Residential and group home figures were combined in 1990.

Poems written by two adolescents express different views of their futures:

I have feelings deep inside
but they are something I want to hide.
Those feelings I have are only fears
to see what I will be in many years.
A feeling of depression comes over me
not knowing what will become of me.

The Me I Want To Be

There's more to me than meets the eye
and I'm beginning to understand
It's what I think and how I feel
that makes me what I am.

Why do I do the things I do
and say the things I say?
What is important and how do I tell?
I'm learning more each day.

I learn from friends and family.
From work, from play from school.
I've also learned to take some time.
To sit and think things through.

The more I learn the more I grow
and then the more I see just how
much more must I know
to learn the me I'm trying to be.

DISCUSSION

The findings of this survey raise a number of concerns about the impact of recent changes in state policies and practices on New Jersey's most vulnerable children.

Abuse/Neglect: The survey found that most of the children in residential care had serious emotional and behavioral problems associated with familial abuse/neglect. The percent of children with histories of abuse/neglect increased between 1990 and 1993. Other reports also found that children are left overly long in destructive environments until their behaviors compel placement. "More children remain in less stable and nurturing environments much longer before a crisis erupts. Experts say this accounts greatly for the deeply entrenched emotional problems seen in older children now entering foster care for the first time."[15] Stolen Futures found that "for many of the older children, behavior problems were cited as the reason for placement [in foster care]. In almost all of these cases, however, there was a significant prior history of parental abuse or neglect. . . . Some have already suffered abuse or neglect . . . that may damage them for life. . . . When placement was finally considered, many of the older children needed treatment for severe emotional problems."[16] Are families being preserved, in some instances, at the expense of children's emotional and physical health and well being?

National studies have documented that abused and neglected children "constitute a high risk group for serious impairment in many mental health and developmental domains. For these children, the additional combination of separation from their biological parents, multiple out-of-home placements, lack of appropriate care giving by foster parents and/or relatives, and failure to identify and address medical and psychosocial problems, compounds their preexisting problems."[17] Although research has shown that abused children have problems in several life domains, New Jersey does not routinely conduct a comprehensive assessment at the time of placement to determine children's treatment needs or the appropriate placement.

The increase in young children who have been abused in foster care raises questions and concerns. Are foster families being asked to accept children who would be better served in a most intensive therapeutic setting? What services and resources are necessary to enable foster parents to care for the more troubled children entering care?

Multiple Placements: The survey found that residential treatment is rarely the state's placement of choice for abused/neglected children with severe behavior problems. Rather, lacking a standard assessment process, valuing *least restrictive*, and being constrained by insufficient resources, DYFS and DHS, in some instances, are forced to utilize a failure-based approach. As a result, almost all the children experience multiple failures. By the time children reach an appropriate placement, they are older, behaviors are more set, and treatment is more difficult. Professionals recognize that when children experience multiple placements, the feel like failures, are less likely to trust adults, and

are less likely to be able to attach. They expect to fail and act in ways to insure failure. "Each replacement reintroduces separation issues and reinforces previous rejection experiences. Multiple placements increase the child's difficulty in establishing and maintaining a sense of continuity and personal identity. . . . Frequent replacement makes it more likely that the child will manifest emotional problems and that subsequent placements will fail."[18] The increase between 1990 and 1993 in the number of children--particularly preadolescents--with multiple placements is striking.

Delinquency: New Jersey is now ranked third in the nation in the rate of arrests for juvenile violent crime. While considerable public attention has been focused on juvenile crime--particularly violent crime--little notice has been paid to the connection between the lack of appropriate treatment of abused children and later delinquency. "In developing social policies with respect to foster care services for children there has been insufficient recognition of the real and potential value of this system in forestalling the development of criminal careers. The treatment of traumatized and damaged children in foster care has to be seen as a most strategic investment in crime prevention. . . . A child who has had a multiple placement history, who has worn out his welcome in a series of foster homes and is entering the adolescent years, and who has suffered a history of child abuse is a special child in the foster care system who is clearly at risk of becoming a sorely dysfunctional adult."[19]

The Cycle of Violence, a federal study on violence published by the National Institute of Justice, found that the "later the intervention, the more difficult the change process becomes. Specialized attention needs to be paid to abused and neglected children with early behavior problems. These children show the highest risk of later juvenile and adult arrest as well as violent criminal behavior."[20] Being physically abused or neglected as a child increased the likelihood of arrest as a juvenile by 54%, as an adult by 38% and for a violent crime by 38%.[21] This study found that while out-of-home placement did not lead to increased arrests, stability was an important factor. **Children who moved three or more times had significantly higher arrest rates.** They were almost twice as likely to be delinquents, to become adult criminals and to commit violent crimes. Children with a history of multiple placements typically had "a wide spectrum of problem behaviors, including chronic fighting, fire setting, destructiveness, uncontrollable anger, sadistic tendencies . . . and extreme defiance of authority."[22]

The NJACRF survey found that 78% of the children had already experienced at least three placements. Given the connections between multiple placements and criminal careers, the dramatic increase in the percent of preadolescents who had five or more placements does not bode well for their future. Have the state policies which have cut residential treatment center placements contributed to the increase in New Jersey's violent delinquent crime? Have they contributed to the dramatic increase in the number of youth in detention and correctional placements? It is significant and of serious concern that the percent of boys in residential care drops to 17% when there are sixteen to seventeen years

old. Has this age group been diverted from the DYFS residential treatment to the correctional system?

Multiple systems: This survey clearly documents that the problems of many children cut across multiple systems. Significant numbers of children--and their problems--"belong" to the mental health, juvenile justice, substance abuse, special education, and/or developmental disabilities systems in addition to DYFS. These multi-labelled children are the "SAD", "BAD" and can't "ADD" (respectively, child welfare, mental health, juvenile justice and special education) youth whose needs call for "one-stop" intake and a unified non-categorical system of treatment. Many advocates have called for the creation of a Department of Children to unify and bring accountability to the fragmented and uncoordinated "systems." However, New Jersey has continued to develop costly parallel residential systems to respond to the documented multifaceted needs of the youth.

New Jersey is not unique. Beyond Rhetoric, the report of the National Commission on Children, found that the majority of children entering the child welfare system "have multiple physical, emotional, behavioral, and developmental difficulties that require specialized supports and services. Yet the services they need are fragmented and uncoordinated. . . . Because of this fragmentation, children are often served on the basis of their most obvious condition or problem. . . . The needs of these children are often the same and are often broader than the mission of any single agency."[23]

The Families: Much of the current state policy is driven by the **assumption** that children can remain in or return to families with "wrap-around" services--that "permanency planning" is the solution to all children's problems. Fanshel, while supporting the value of permanency planning for many children, found that "it does not seem to apply to about a quarter of children in out-of-home care."[24] "The concepts of permanency planning and family preservation do not specifically address children's immediate and/or long-term health, adaptive functioning, or mental health needs."[25]

There appears to be insufficient recognition by New Jersey policy makers that many children in residential treatment do not have viable families. In addition to having experienced years of severe familial abuse and neglect, 30% of the children's "families" did not include a birth parent. Some of the children are literally orphans: AIDS, drugs and street violence place increasing number of children at risk of losing one or both parents. Many children are left in limbo, between a philosophy which stresses family unification and the reality of apparent who rarely or never visits. 60% of the children have been separated from their families for at least two years before entering residential treatment. Visiting is recognized as a key predictor of family reunification; the reality is that less than three children in ten have a parent who visits regularly. Over half have basically been abandoned.

Only 58% of the younger children and 41% of the older have a goal of a "permanent" family setting--family reunification, placement with a relative or adoption. A state philosophy predicated heavily on family preservation/reunification does not address the needs of children without viable families. Adoption is the goal for only a small number of these children. Not only must the system move more quickly in identifying children who cannot return home and freeing them for adoption, it must provide the treatment and supports to enable adoptions to be successful. The state must also develop a range of alternatives for children for whom adoption is not an appropriate goal. The development of treatment (specialized) foster care has enabled some severely troubled young people to live in a family setting. Other children, unable to tolerate the intimacy of a traditional family may need, and must be permitted to remain in, a small group home.

Independent Living: The goal for about a third of the adolescents is independent living. However, less than a third of these will have the opportunity to participate in a formal independent living program. It is unrealistic to assume that children whose problems are so severe as to warrant placement in residential treatment, who often have learning deficits, and who lack family connections and supports, will at able, at age eighteen, to be successful without supports.

The survey depicts a stark portrait of the children and their families. Often orphans of the living, victims of familial abuse and abandonment, they are further victimized by a system which results in their experiencing multiple failures. It is not surprising that the children have multiple serious behavioral problems which place then at high risk of failure as adults. In just three years, the picture has become bleaker as increasing numbers of children enter the juvenile justice system. With rare exception, the state has not studied the characteristics and needs of the children under its care, nor based planning or philosophy on hard data. This survey raises many questions and issues. There are not simple solutions to very complex problems. Yet behind each of the numbers and facts are invisible, yet real, children who need help to regain whatever is left of their lost childhoods.

> ***The solution of adult problems tomorrow depends in large measure upon the way our children grow up today. There is no greater insight into the future than recognizing when we save our children, we save ourselves.***
>
> Margaret Mead

CONCLUSION

The survey clearly documents that the current system--the old way of doing business--is not working for today's troubled children and youth. Together, residential providers and the Department of Human Services must

- take joint responsibility for developing new ways of doing business to better meet changing needs.
- be prepared to dismantle historical barriers which prevent today's children from receiving the array of services they require.
- be ready to explore new means of collaboration.
- be creative, flexible and open-minded in designing a master plan which provides continuity of care, a seamless system,
- forge a new partnership and a new vision for the future of our children.

The comprehensive changes needed are not solely the responsibility of the providers or the Department of Human Services. A new system also requires the cooperation and involvement of all the Departments serving children, of parents and of advocates. It requires the leadership and commitment of the Governor and legislature. Together, we must take responsibility for the well-being and future of our children.

SPECIFIC RECOMMENDATIONS

The survey identified a number of issues; the following specific recommendations should be considered to address those particular issues.

Abuse/Neglect

- Revise the DYFS risk matrix to include indicators of children's emotional and behavioral problems; consider children's mental health needs when evaluating "risk."
- Amend child welfare legislation to require DYFS to evaluate and consider the *health*, safety and *welfare* of children in determining the need for out-of-home placement.

Placement Decisions

- Develop a screening and evaluation protocol to identify significant mental health, behavioral, developmental, medical and/or academic problems for children entering placement. If problems are identified or suspected, refer the child for a more complete evaluation.
- Maintain and strengthen the Facility Match Bulletin Board (FMBB) to facilitate timely and appropriate placements.
- Provide training to DYFS case managers and CART members on indicators for residential placement.
- Insure that each DYFS district office has at least one staff person with expertise in residential placement to act as a consultant for DYFS case managers.

Multiple Placements

- View multiple placement failures as a symptom of a potential serious mental health problem. Develop an "alert" system to flag for review by the district office manager any child entering his or her third placement. Create a similar procedure at the regional level for any child entering his or her fifth placement. Review the causes of prior negative discharges, identify support services necessary to maintain the current placement and develop appropriate plans to insure stability.
- Establish a task force with provider and community representatives to review the causes of negative discharges/ failures, particularly those involving children who have experienced multiple placements. Review the children's characteristics, the reasons for placement failures, treatment services that could have averted the negative discharges, and the needed types of programs/services.

Multiple Placements/Service Needs

- Utilize the information from the Facilities Match Bulletin Board (FMBB) to determine the type and number of residential programs needed.
- Make non-identifying client information from the FMBB available to NJACRF; provide aggregate information to agencies to encourage and enable them to develop services to respond to changing needs.
- Develop resources to prevent the breakdown of placements when they are in difficulty; such resources could include respite care, one-on-one staffing, and specialized therapy. Develop families willing to be a visiting resource for children who have no family to visit on holidays and weekends.
- Give residential providers the funding and flexibility to meet the needs of more troubled children. As an example, group homes were initially developed to serve mildly disturbed children. A census of twelve **may** have been appropriate for this population. However, group homes serving severely emotionally disturbed youth should have a capacity of no more than 8-10 (while maintaining staffing levels).
- Provide adequate funding to enable providers to recruit, train and retain sufficient qualified staff.

Abuse in Foster Care/Multiple Placements

- Evaluate and upgrade traditional foster care services in order to meet the needs of the more troubled children entering care.
- Develop improved training, support, respite and linkages to a range of community supports for foster parents.

Multiple Systems

- Create a Department of Children to integrate and bring accountability to the current fragmented and uncoordinated "system" of care.
- Hold hearings on the proposal to form a Commission on Juvenile Services. Identify and begin to address the coordination issues created by this proposed new entity.
- Insure that some governmental entity accept responsibility for the multi-problem youth who fall between the ever-widening cracks.
- Develop joint Divisional and Departmental planning for needed residential services.

Families/Discharge Planning

- Make timely decisions in identifying children who cannot return home and freeing them for adoption. Review the issues of parental rights vs. children's rights.
- Provide necessary ongoing supports to enable adoptive families to successfully parent severely troubled children.
- Develop a range of alternatives for children for whom adoption is not an appropriate goal; consider specialized treatment homes and small long-term group homes.
- Fund each residential program to provide (or link with programs which provide) aftercare.

Independent Living/Aging Out

- Enable all adolescents to develop skills to live independently. Evaluate aging-out adolescents to determine their specific needs.
- Make ongoing services available to those adolescents over age eighteen who lack family connections and supports.
- Develop mechanisms to insure that the Divisions of Developmental Disabilities and of Mental Health Services accept responsibility for young adults aging into their systems.

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