NEEDS OF YOUNG CHILDREN

REPORT OF THE

VIRGINIA ADVISORY LEGISLATIVE COUNCIL

to

THE GOVERNOR

and

THE GENERAL ASSEMBLY OF VIRGINIA

House Document No. 24

COMMONWEALTH OF VIRGINIA

Department of Purchases and Supply

Richmond

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VIRGINIA ADVISORY LEGISLATIVE COUNCIL

Richmond, Virginia

February 5, 1976

TO: Honorable Mills E. Godwin, Jr., Governor of Virginia

and

The General Assembly of Virginia

At the direction of the 1974 session of the General Assembly, the Council appointed a committee to study the needs of young children and reported its findings and recommendations to the Governor and General Assembly. Because the committee had not had the time to consider adequately the broad terms of the resolution, the Assembly directed the Council to continue its study by the following resolution:

HOUSE JOINT RESOLUTION NO. 192

To continue the Virginia Advisory Legislative Council study on the needs of young children.

WHEREAS, a study of the needs of young children by the Virginia Advisory Legislative Council was directed in 1974 by the General Assembly concerning the areas of need affecting young children; and

WHEREAS, the Council has conducted a study of these needs including holding six public hearings around the State which assisted it in identifying the numerous needs of young children; and

WHEREAS, the Council has submitted an interim report to the General Assembly setting out these needs and suggesting ways to meet certain of them; and

WHEREAS, the Council has identified more areas of need than it could reasonably find means to deal with, among which are foster care and quality child care services; and

WHEREAS, the Council has had insufficient time to formulate the structure and guidelines for an office or agency to plan, administer and advocate services for children; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring,

That the Virginia Advisory Legislative Council continue its study on the needs of young children.

The Council shall make its recommendations on an office or agency for children and on any desirable improvements and innovations in State services for children.

The Council shall conclude its study and make a final report to the General Assembly no later than October one, nineteen hundred seventy-five.

The Council directed the same committee it had appointed in 1974 to continue its study. The chairman of this committee was Delegate Vincent F. Callahan, Jr. of McLean and the members were Delegate Dorothy S. McDiarmid of Vienna, Delegate John D. Gray of Hampton, Delegate Evelyn M. Hailey of Norfolk, Delegate Norman Sisisky of Petersburg, Senator James T. Edmunds of Kenbridge, Senator Paul W. Manns of Bowling Green, Charles G. Caldwell of Harrisonburg, Arthur R. Giesen of Verona, Mary H. Steinhardt of Hollins, Betty H. Peters of Hampton, Martha Hamilton of Richmond, Peggy Swanson of Annandale, Louella Pangle of Strasburg, Dr. Harrison Spencer of Abingdon, and Virginia M. Babcock of Appomattox.

Serving on the committee in ex officio status were Dr. Patricia Hunt, Director of the Bureau of Child Health, State Department of Health; Peggy Smith, Executive Assistant and Planner, State Department of Welfare; James T. Micklem, Director of the Division of Special Education, State Department of Education; and Judy Lau, Executive Director, Virginia Commission for Children and Youth. Another State organization, the Community Coordinated Child Care Council (4-C's Council), made valuable contributions to the committee's work.

In the process of conducting its inquiry, the committee had several meetings with State officials, conducted six public hearings in all areas of the State, and broke into subcommittees which had numerous working sessions. The committee members gathered a great deal of information from many sources and assimilated it in an effort to form recommendations which would have the effect of improving the condition of Virginia's youngest citizens.

PHILOSOPHY

Children are remarkable beings. From helpless babies, they develop, in a few short years, into active individuals who can reason and think abstractly. In the course of their intricate development process, very young children learn innumerable things, including a complex language, the concept of numbers, and how to read. They are also adaptable and able to overcome many obstacles to their development.

It cannot be emphasized too much, and the point will be made again in this report, that these early years are vitally important in

the life of an individual. Whatever happens, or does not happen, will have a profound effect on that person in later years. This holds true for physical, intellectual, mental, and emotional considerations. Wordsworth's observation, "The Child is the father of the Man," expresses this truth well.

Given this premise, it is essential that children have every opportunity to develop their capacities when they are very young. It is even more essential that those who have a problem have it discovered early and given help. With such early help, the child can overcome a large part, if not all, of the effects of the problem. Equally important are early prevention measures designed to keep problems from developing.

The State has programs that address the problems of children, but in most cases the help is rendered too late to achieve maximum effectiveness. The various reading and math programs in the schools designed to improve skills and prevent dropouts and the counseling activities in the courts, for example, are attacking problems which have roots in the early years of the child's life. Unattended, those problems over the years have become more complicated and more firmly established, and thus harder to solve.

Not only is it easier and more humane to meet the needs of children early, it is also much cheaper to the State in the long run. For example, studies have shown that many delinquent youths have problems of a physical or perceptual nature which are directly related to learning difficulties in school, which, in turn, often lead to delinquent behavior.[1] It would have been much cheaper if the State could have detected these problems early and treated them before the children turned to anti-social behavior. It is highly probable that a large amount of costly institutionalization could have been avoided. The same is true for a large number of retarded and emotionally disturbed children. Similarly, if the State would provide services to "high-risk" families, many of those families could be kept intact and many foster care placements could be avoided. The young child could be spared the long-lasting effects of separation from his family and the State would avoid the cost of foster care, which includes cash payments as well as the provision of those services the child needed before coming into foster care. More examples could be given from such fields as education and health.

This is our philosophy—that more attention must be given to the developmental needs and problems of very young children. By no means is this a newly discovered idea, and Virginia has officially recognized the importance of the concept as evidenced by a recent gubernatorial statement, "... it is important to see that children under school age receive the kind of care that will enable them to begin their formal education without handicaps."[2] The rest of this report will provide substance to this basic thesis.

RECOMMENDATIONS

The sponsors of the Council's enabling resolution recognized the importance of the first years of a child's life and specified that

the study be directed to the needs of young children. There were no guidelines as to what was meant by "young." At its first meeting, the Committee decided that, in order to keep the study as manageable as possible, it would limit itself primarily to the needs of children from the ages of 0-8, with consideration of older children where appropriate.

As the study progressed, however, the Committee found it increasingly difficult to abide strictly by this limitation. It is difficult, and in many cases, unrealistic, to separate the needs and problems of one age group from those of another. In addition, programs for children are generally administered for children of all ages, and it would be impossible to break out those components concerned only with ages 0-8. Because of these factors, the findings and recommendations of this report will be applicable to children of all ages, and, in fact, to all categories of children; none were excluded from consideration because of their "special" needs, except delinquent children or "youthful offenders," whose needs are the subject of another, current legislative study committee. Nevertheless, because of past programmatic neglect of young children, we wish to state that our primary emphasis is on the children aged 0-8 and our primary concern is for them, with the understanding that older children also have needs which should be addressed.

Our recommendations are presented by subject area, with a brief statement of the findings in that area and explanation of the recommendations.

PARENTING EDUCATION

Throughout its inquiry, the Committee constantly faced one fact—the importance of parents in the development of a child. There is general agreement that parents are the single most important factor in a young child's life.

Obviously, parents are vitally important in meeting such physical needs of their children as proper nutrition and medical care before and after birth. In those cases in which the parents simply cannot afford adequate physical care, it is sometimes available from the government. But, all parents, including those who can afford private care, must have an awareness of their children's needs before they can take steps to meet them. They have to know and encourage good eating habits and have to realize the importance of periodic medical checkups, for instance. They need to be generally aware of the nature of child development so they will know when something is wrong and seek early diagnosis and treatment.

Infants and very young children, however, have many needs other than the obvious ones of food, physical protection and medical attention. They have deep emotional, psychological, and intellectual needs. These are not needs of secondary importance, the accomodation of which can be considered a luxury; they are essential to the growth of a normal, healthy human being.[3]

A key aspect of human development is the crucial importance

of the first two or three years. It is during these years that the base for further mental and emotional development is formed.[4] The course of any individual's development will, to a large extent, be dependent on the degree to which his physical, psychological and social needs as an infant are met. And it is the parents who will probably be the people available to meet them. The parents may send the child to a day care center or nursery school, but in all likelihood this will not happen until the child is about three years old. Furthermore, the placing of a child in an institutional environment does not ensure that child the nurture he or she needs.

If such significant development has taken place before children are admitted into the educational or regulated day care system, or if the State has little influence over the contents of the system that handles small children, what can the State do to meet the developmental needs of these children? This is the question that continually confronted the Committee. There is one obvious answer that has been advocated by thinkers from Plato to B. F. Skinner—assumption by the State of the function and responsibility of raising children. That solution is as impractical as it is unacceptable. Another possible solution is for the State to attempt to educate parents as to the needs of their children. This is the course that the Council recommends.

Parenting is a fairly new concept. Although it was once felt that being a parent was inborn, it is now recognized that the growth and development of a child is a very complex process and that the more that people understand of this process, the better parents they become. Since the prenatal period and the first two or three years after birth are crucial to the child's development, it is essential that parents become aware of the potential needs of their children, before they are born, so they can prepare the best possible environment for their development. Present conditions of small families and mobile population mean that many young parents have seen little of actual childrearing and have no one to turn to with their questions. The schools can play an important role in this process of educating people to be parents. It is important to remember that small children are aware of many aspects of human development and family relationships, although they do not understand all they perceive. Thus, it is important that instruction in human development and parenthood be an integral part of the curricula of the school division, beginning with kindergarten.

As children reach high school age and look forward to taking on adult roles, they become especially receptive to, and intellectually able to handle, courses on human development and the art of parenting. The Committee was pleased to find that some high schools in the State do have such courses in their curricula, but feels that it is important that all high schools do so. As potential parents, high school students need to be taught that infants and young children have basic physical, social, and psychological needs which can be best met by their parents. Most importantly, they need to realize that becoming a parent is perhaps the most important step they will ever take—a step they should not take until they are ready to assume the responsibility for the development of another human being. This responsibility, while rewarding, is an awesome one and

involves many difficulties which young people need to realize before they choose to become parents.

The Council RECOMMENDS THAT EDUCATION FOR PARENTHOOD BE A PART OF THE CURRICULA OF EACH SCHOOL DIVISION IN THE STATE, INITIATED IN THE KINDERGARTEN WITH HIGH SCHOOLS REQUIRED TO OFFER SPECIFIC COURSES. THESE COURSES WOULD INCLUDE UNITS ON HUMAN GROWTH AND DEVELOPMENT AND SUPERVISED EXPERIENCES WITH YOUNG CHILDREN.

The Council also recognizes the very fine job that some community colleges and four-year institutions are doing in respect to parent education. We have emphasized the high schools because most people have not become parents at that age and many will not go to college. We particularly commend those colleges which sponsor day care centers. This is useful both from the aspect of providing a much needed child care facility and of providing experience for parenting education students. In addition to training parents, these institutions have the resources to train providers of child care, both in family day care homes and in day care centers.

Therefore, the Council RECOMMENDS THAT COLLEGES EXPAND THEIR PROGRAMS OF PARENT EDUCATION IN ORDER TO HELP PARENTS RAISE THEIR CHILDREN BETTER AND TO TRAIN MORE KNOWLEDGEABLE PROVIDERS OF CHILD CARE.

CHILD CARE

Need

The full extent of the need for more child care facilities in Virginia is not accurately known. However, as shown in more detail in Appendix B, there is a large gap between the number of licensed spaces available and the estimated number of children who need care and supervision during a part of the day. Furthermore, there are indications that there is an increasing demand for day care centers.

The Council does not believe that it is the proper function of the State to establish and administer a system of day care centers. The planning, financing, and administering roles should lie primarily with the local governments which are better able to assess local needs and problems. In fact, several localities, among them Fairfax County, Roanoke, Richmond, and Portsmouth, have begun the planning necessary to implement a more effective day care system. The State's role consists of providing technical assistance and establishing an overall policy in regard to the quality of child care allowed. This last function is accomplished through the setting of minimum standards and the licensing of facilities to insure they comply with these standards.

Licensing

Through licensing, the State acts to protect the health, safety

and welfare of its citizens. In considering day care licensing, it is, therefore, necessary to determine if the law and regulations cover as many children as possible who need protection. This is not a simple question. If the regulations are unenforced or, indeed, are unenforceable, they may create an illusion of protection when in truth protection is not provided. Since the short supply of day care centers causes parents to place children in unlicensed situations, do unnecessarily strict or irrelevant regulations lead to fewer children being protected at all because they discourage the opening of new centers? Do overlapping regulations by different agencies and levels of government have the same effect? On the other hand, are the increasing exemptions in the law reasonably related to the need for protection or are they providing unwarranted loopholes? And finally, are there approaches other than licensing which may be more effective in improving conditions under which children are cared for? These are some of the issues in the consideration of the licensing of both day care centers and home-based day care.

Home Day Care

Studies show that most children who are cared for outside their homes are in family day care—a private family home caring for less than ten children.[5] Before 1972, the State attempted to license all family day care. However, the enormous investment in staff which would have been necessary to enforce such a program as well as the difficulty of ferreting out those taking care of the children convinced State officials that a new approach should be tried. The definition of a day care home was changed so that only persons caring for four or more children are now subject to licensing. Since the average number of children per home is estimated at 1.6, this change drastically reduced the work load.[6] But it does raise the philosophical issue of why three or fewer children in care are not afforded equal, or indeed any, protection.

The fact is that family day care does not readily lend itself to licensing. Operators seldom know that there is a licensing law. Ordinarily they enter the work as a convenience to neighbors or as an extension of what they do for relatives (which is not licensed) or as a way to pick up some extra income. If they do know about licensing, they may see no compelling reason to comply since enforcement of the regulations is a rare occurrence. They may view the regulations as unreasonable since they are frequently taking care of their own children too, and see nothing wrong with their home conditions. The result of these forces is that the vast majority of all children in day care are without any kind of governmental protection or oversight.[7]

It is not the finding of the Council that home day care is necessarily of poor quality. Under ideal conditions, it can be the closest thing to the care of a loving mother. On the other hand, serious abuses such as the drugging of infants with paregoric to keep them quiet and alcoholism of the caretaker have occurred. Not as dangerous, but still far from the ideal, are situations in which children sit in front of a television set all day. The point is that little is known by the Committee or anyone else in Virginia about the quality of care children are receiving in unlicensed family care homes, whether or not exempt from licensing.

Alternatives to licensing which would bring the family care providers to light are being discussed around the country. One alternative is "registration", although it does not mean the same thing to everybody in the field. One form being experimented with in three counties in Michigan is actually a form of self-licensing in which all the regulations remain in force and the provider signs an affidavit that she is in compliance. Spot checks are then carried out. Another approach is to give up the idea of enforcement as unworkable in favor of bringing advice and help actively to the providers. Under this concept registration would simply entail giving one's name and address and the number and ages of children for which care is provided. The follow-up would include giving the operators information on such topics as safety, civil liability in case of fire and accident, nutrition on a limited budget and emotional needs of children. Furthermore, a certificate could be awarded to those operators who completed training courses and otherwise demonstrated that they were offering a superior program. By furnishing these and other voluntary training services, localities would offer home day care providers the opportunity to improve their services. Another benefit of registration would be the provision of information to the State and to localities for planning purposes.

The Division of Social Services of the Department of Human Services of the City of Roanoke has been conducting voluntary classes for home day care providers. Of the first group contacted, seventy-two percent enrolled in the eleven-session course and absences were minimal, indicating a real interest on the part of the providers in such services. The new Fairfax County Office for Children, which intends to start a registration program, will also offer various services to home day care providers.

Based on the foregoing considerations, the Council believes it is time to try another approach to safer, more beneficial care for that great majority of children who are not in centers.

The Council RECOMMENDS THE ESTABLISHMENT OF LOCALLY BASED REGISTRATION SYSTEMS AS A MORE LIKELY METHOD OF BRINGING IMPROVEMENTS IN HOME DAY CARE THAN LICENSING. AN AGENCY CHOSEN BY THE LOCAL GOVERNMENT, POSSIBLY THE WELFARE DEPARTMENT OR A SPECIALLY CREATED OFFICE FOR CHILDREN, SHOULD ENGAGE IN A VIGOROUS PROGRAM TO LOCATE AND ASSIST OPERATORS AND ISSUE CERTIFICATES AVAILABLE ON A VOLUNTARY BASIS.

In order to expedite the registration approach, the Council FURTHER RECOMMENDS THE FOLLOWING EXEMPTIONS FROM MANDATORY HOME DAY CARE LICENSING: (1) HOMES CARING FOR FOUR CHILDREN IF NONE IS UNDER TWO YEARS OF AGE AND (2) HOMES CARING FOR FIVE CHILDREN IF NONE IS UNDER THREE YEARS OF AGE.

Child Care Centers

Licensing of child care centers as defined by law is the

responsibility of the Department of Welfare. Since 1974 the Department's Division of Licensing has been engaged in a revision of its regulations. The evaluation of those regulations was beyond the scope of this study. Instead, the Committee addressed the broad policy questions of who should be licensed and whether licensing is an appropriate means for raising the quality of care.

The first question to consider is that of who should be subject to licensing. Section 63.1-195 of the Code of Virginia exempts private schools, nursery schools, occasional child care on an hourly basis, hospitals' centers for their employees, Sunday Schools, and summer camps from the definition of child care centers which have to be licensed.

One result of the exemptions has been to free educational institutions from regulation. The language reads "except ... (2) a public or private school unless the Commissioner determines that such private school is operating a child-care center outside the scope of regular classes; (3) a school operated primarily for the educational instruction of children from three to five years of age at which children three or four years of age do not attend in excess of four hours per day and children five years of age do not attend in excess of six and one-half hours per day; ...." (§ 63.1-195)

These exemptions are of concern to the Department of Welfare, the operators of child care centers which must meet the regulations and the public. There is evidence that full day care is being given to children as young as two years of age by facilities that call themselves schools or claim to have only half day programs.[8] Enforcement is very difficult, especially since the Commissioner of Welfare is apparently reluctant to judge whether a program is in fact "educational". The basic question is why it makes a difference in matters of health, safety and welfare of the preschool child whether a program is considered "educational" or not. From one point of view every facility for young children is "educational" in the sense that they are learning something, beneficial or otherwise, all the time. Furthermore, the use of an "educational" program does not obviate the child's needs for adequate supervision, nutrition, air, cleanliness and space.

The exemption of facilities that do not give a full day of care is based on the premise that a half day of care or occasional care does not have the same impact on the child as a regular full time care situation. Certainly the regulations should be different depending on whether the children nap and eat a full meal at the facility. However, as in the case with "educational" facilities, it is difficult to see any justification for denying these children the basic protections from fire or accident and of adequate supervision that children in full care centers receive.

The exemption of hospital based centers, enacted in 1975, arose out of objections to the regulations by a single institution. Eight other hospitals in the State were meeting the requirements. This exemption raises serious questions as to whether this will become the first of a series of exemptions gutting the law. It is especially disquieting since there is a trend toward the provision of child care facilities by industries that employ a large number of women, and

these might start applying to the General Assembly for special exemptions.

Whatever exemptions are allowed, they should apply only to programmatic regulations; they should not apply to basic health and safety standards. At the present time fire and health inspections of child care facilities are a function of the licensing process of the Department of Welfare. If a facility for some reason is exempt from licensing by the Department of Welfare, it more than likely will not be inspected by fire and health officials. The State Fire Marshall has told the Committee that, while all facilities for ten or more children are required by law to conform to the State Fire Safety Regulations, it is the practice of his office, due to limited staff, to inspect only those facilities subject to licensing by the Department of Welfare. Health department officials in both the Richmond and Northern Virginia areas have indicated to persons making inquiry that there were no health regulations applicable to child care facilities exempt from licensing by the welfare department. Not only does this practice deprive children in legitimately exempted centers of basic protection, it also creates an incentive to operators to avoid licensing by choosing one of the exempt categories.

The Department of Health does have authority under general public health statutes to inspect these facilities and require compliance with some broad standards. However, some local officials are vague when asked about this power and indicate that their inspections are usually conducted upon request of the welfare department. Of course, if that department does not have to license a particular facility, then it will not request a health inspection.

The Council believes that the local health departments and fire marshalls should have the clear responsibility to develop and implement standards for all facilities which house children away from their own home. That such standards need to be vigorously enforced is illustrated by the conditions existing in licensed centers at the time of an inspection by officials of the United States Department of Health, Education and Welfare. Their report (Audit No. 50300-03, June, 1974) described centers which had uncovered sewer lines in a classroom, live and dead roaches in food preparation areas, locked exit doors, open electrical wires accessible to children, and broken glass in play areas. It should be emphasized that only a few centers were visited. It would be fair to assume, we think, that such conditions are not isolated examples and, if they occur in licensed centers, similar, or worse, conditions could well exist in unlicensed facilities.

At this point, it is necessary to address, and dispose of, an argument that the Committee encountered from proprietary day care center operators. This group opposed any extension of the regulations by arguing, among other things, that parents were aware of the conditions of the centers in which they placed their children and, therefore, would not put them in facilities that were not adequate. However, when one looks at the record and finds a licensed facility that was continually cited over a period of years for such violations as uncovered sewer lines in the classroom and still had enough children to operate, it is apparent that not all parents

take the trouble to investigate the facilities in which they place their children or have alternatives they can use.

The Council RECOMMENDS THAT THE LAW REQUIRE THAT ANY FACILITY, WHATSOEVER, CARING FOR CHILDREN BE INSPECTED BY LOCAL FIRE AND HEALTH AUTHORITIES TO DETERMINE THAT IT MEETS CERTAIN MINIMUM STANDARDS OF FIRE AND HEALTH SAFETY.

These standards should be appropriate to the care situations. For example, they would differ on the basis of whether meals are served or naps taken. Also regulations should not rule out the use of properly adapted existing buildings. But they should eliminate truly hazardous situations. The climate of licensing should be one of assistance in meeting regulations rather than one of harrassment.

It was the consensus of the Committee that the law's current provisions contain exemptions which are not consistent with, nor relevant to, the needs of children. Furthermore, these exemptions present problems of equity and enforceability. The Committee considered three alternative approaches to this problem. They were:

1. No exemptions to licensing of child care centers. The rationale would be that all children need certain basic protection when not in their parents' care.

2. Exemptions based only on age and/or number of hours of care. By exempting short time and occasional care since both have less effect on the children, the Department of Welfare would be free to perform the essential task of regulating full-time care.

3. Exemptions based on the type of program offered by the facility. The argument can be made that "bona fide" educational facilities have a different purpose than child care centers, and it would be inappropriate to apply child care standards to them. Furthermore, the Department of Welfare is not the proper agency to develop standards for educational institutions.

Of these alternatives the Council RECOMMENDS THAT ONLY THOSE FACILITIES CARING EXCLUSIVELY FOR CHILDREN FIVE YEARS OF AGE AND OLDER AND THOSE CARING FOR CHILDREN UNDER FIVE YEARS OLD FOR A PERIOD OF FOUR HOURS OR LESS BE EXEMPTED FROM COMPLIANCE WITH CHILD CARE LICENSING REQUIREMENTS.

We wish to emphasize strongly that we would prefer that there be no exemptions to the requirements. However, recognizing the financial impossibility of providing sufficient personnel to inspect and license these centers, the Council chooses to recommend a limited law, although broader than the present one, which could be enforced, rather than a law which could be enforced only partially, at best.

The second policy question the Committee considered was that dealing with the goals of licensing. Should governmental licensing standards be viewed as ensuring a basic minimum level of care or

should they be used as a means of fostering high quality standards concerning both the programmatic and environmental aspects of facilities?

It was the view of the Committee, and others,[9] that licensing standards should be only those essential to the child's health, safety and welfare. Of course, the higher those standards, the better off the child is in terms of his care. However, the Committee recognized that there is a shortage of day care available to low-income and middle-income families and that high standards could very likely have the effect of driving the cost of regulated day care beyond the reach of these families. This would result in the placing of children in unregulated facilities where the conditions are likely to be less desirable.

Thus far, the State has limited itself to this proper role of establishing minimal standards. Some of the requirements have been controversial, particularly the indoor space requirements. However, Virginia now has the lowest space requirements of any state, twenty square feet, and proposes to go to only twenty-five square feet. In contrast, forty states require thirty-five square feet. The equally controversial staff-to-child ratios are not out of line with what are required by other states.[10] It is apparent that licensing is now being used to ensure that minimum conditions are met, rather than to foster high quality facilities.

While the Council feels that a license, a permit to operate, should be predicated only on compliance with these minimum conditions, it also feels that there should be some means of publicly evaluating a facility's programs. On the license granted to the child care facility, the Department of Welfare should certify whether that facility is custodial or developmental in nature. There would be no separate program standards for a custodial center to meet. It would have to comply only with the minimum health, safety, and welfare regulations currently in effect. However, to be adjudged developmental, a center would have to meet additional, strict programmatic standards developed by the Department in consultation with the Virginia Commission on Children and Youth, the Virginia Association of Early Childhood Education and the State Department of Education. Such a certification requirement would enable parents to evaluate better the claims of many day care operators that theirs are educational facilities. For those who desire a truly developmental program for their young children and are able and willing to pay for it, certification will help to ensure that they get what they want.

Therefore, the Council RECOMMENDS THAT THE LICENSES ISSUED TO CHILD CARE CENTERS SPECIFY WHETHER THAT CENTER MEETS CUSTODIAL OR DEVELOPMENTAL STANDARDS. THESE LATTER STANDARDS WILL BE DEVELOPED BY THE DEPARTMENT OF WELFARE IN CONSULTATION WITH THE VIRGINIA COMMISSION ON CHILDREN AND YOUTH, THE VIRGINIA ASSOCIATION OF EARLY CHILDHOOD EDUCATION AND DEPARTMENT OF EDUCATION AND COMPLIANCE WITH THEM WILL BE OPTIONAL.

The obligations of the State in the child care field ought to include help in improving child care as well as the licensing of facilities and certification of programs. While the cost of new programs to assist parents and operators may prevent their establishment in the next biennium, every effort should be made to use existing programs to this end. There should be an active program of making nutrition and child health services available and promoting their use. As population trends create empty school classrooms, ways should be found to make them available for nonprofit child care. Licensing and certification should be regarded as simply one part of a spectrum of services to children who need care.

HEALTH AND NUTRITION

One of the most obvious and important needs of all people is that of good health care. It is especially important for young children because many serious medical problems can be prevented or ameliorated if diagnosed and treated early and because the medical problems of young children can affect other aspects of development. For example, a child with undetected and untreated hearing or visual problems will not be a good learner in school. His or her education will suffer and there may well be psychological and social problems arising out of frustration in school.

The State Department of Health has a variety of programs designed to meet the health needs of children in Virginia. Those programs are described briefly in Appendix B to this report. From its investigations, the Committee has concluded that the need is not for any new programs, but for greater financial support, and better coordination, of the existing ones.

Particularly important is the regional infant intensive care program that the Department has begun. This program is designed to provide highly specialized, intensive treatment to newly-born infants who are seriously ill or who may have serious problems in the first year. Besides saving lives, this type of treatment could, in many cases, prevent the occurrence of conditions, such as severe retardation, that result in wasted human potential and costly institutionalization. Before the beginning of the project, there was minimal utilization of the limited intensive care facilities that did exist. The Department has initiated a demonstration project on the Eastern Shore, with nursery facilities being provided by King's Daughters Children's Hospital in Norfolk. The plans call for expansion of this program on a regional basis until every area of the state has access to an infant intensive care nursery. The Council heartily endorses this effort and urges the General Assembly to provide sufficient funds.

We wish to commend the Department of Health for the emphasis it has placed on child health and for the development of mechanisms for the delivery of health services to children whose families cannot afford the necessary care, whether it be routine or specialized. Through a combination of administrative initiative and legislative mandate, both State and federal, Virginia has an adequate structure for meeting the health needs of its young

children. To utilize this structure fully, however, the Department needs to solve some administrative problems and the legislature needs to provide adequate financing.

The administrative problems have largely been ones of coordination. For example, the Early and Periodic Screening, Diagnosis and Treatment component of the Medicaid program requires the close cooperation of local welfare and health departments. In the past, there have been some problems, but these seem to be in the process of being worked out, as evidenced by the almost 100% increase from 1973 to 1974 in the number of persons screened. As soon as the problems are fully resolved, this program, coupled with the availability of well-baby and other child health clinics and private physicians, should ensure the availability of medical checkups to all children.

Although it does not feel that any new programs are necessary, the Council feels that some improvements are needed and makes the following recommendations:

1. THAT THE STATE BOARDS OF EDUCATION AND HEALTH ESTABLISH A STATE STANDARD PROGRAM OF PUBLIC SCHOOL HEALTH SERVICES.

In response to a General Assembly directive, the Departments of Health and Education conducted a joint study in 1974 on nursing services needed in the State's public schools. This study reinforces the Committee's findings that the school health system in the State is a patchwork affair, with no degree of consistency from locality to locality. In some counties, health directors provide medical direction. In others, it is the school superintendent, a nurse, or no one. Some use school nurses responsible to the principal; others use public health nurses. Many of those health directors who provide direction do not feel they have any clear legal responsibility or authority to do so.[11]

Aside from the question of responsibility, there is the matter of the quality of medical care. For example, in 1974 fifteen school systems used no medical personnel in vision examinations and only sixteen out of seventy-seven respondents to a survey used the method recommended by health organizations. Furthermore, at least eighteen counties indicated that they do not refer hearing screening failures to the health department for further diagnosis and treatment.[12]

In addition to these problems cited in the departments' report, the Committee became aware of some other problems in the school health program. One is the familiar one of coordination. Both the local health department and the school system have health records on children in their area. In many cases, however, these records are not shared. One of the reasons is a legitimate concern for the confidentiality of those records. But another reason is simply a lack of cooperation.

The Committee also detected some tension between the agencies. It should be emphasized that this is not true in every

instance—in many cases, there is a good working relationship. But in a significant number of cases, administrators of the school system feel that there should be nurses present in the school at all times, while the health department feels that nurses could be more efficiently used in a program in which school health would be a component of an overall public health system.

The concept of a school health program is a good one, for through the mandatory preschool examination and various examinations in the schools, children are assured of at least a minimal screening. Therefore, because of extant problems, the Council recommends the adoption by the two boards of a joint program operating under regulations promulgated jointly by them, the major recommendation of their own report.

2. THAT THERE BE MANDATORY FLUORIDATION OF ALL PUBLIC DRINKING WATER IN THE STATE.

In all reports of screening results, dental problems occur very frequently. One of the single most effective means of preventing or reducing dental problems is fluoridation of the water supply. Although Virginia currently ranks very high in the nation in the percentage of its public water that is fluoridated, seven percent of the people using public water systems drink unfluoridated water. Therefore, the Council recommends that all governmental entities be required to fluoridate their water supply.

3. THAT THE STATE AGENCIES HAVING PROGRAMS FOR CHILDREN AND FAMILIES INCORPORATE NUTRITION COUNSELLING INTO THEIR PROGRAMS.

Nutrition is an integral aspect of good health. Good nutrition can prevent many medical problems from developing and can reduce the severity of many of those which do occur. A low family income can be a major cause of a child's malnutrition, but studies have shown that many malnourished children come from homes with incomes large enough to provide a good diet. Furthermore, researchers have found that the nutritional level of a low-income family does not necessarily improve with the provision of food stamps.[13] So the problem is as much one of education as it is one of money. Indeed, one observer states, "When the outcome is adjusted for other variables, the only factor that systematically appears to improve diets is a program of nutrition education...."[14] Both those who can buy their own food and those who receive assistance in the form of food stamps need to be taught the elements of good nutrition and their importance. We urge that the nutrition education television series developed by the Agricultural Extension Service and shown in some parts of Virginia be expanded. We also strongly urge the Department of Welfare to include nutritional counselling as a part of its food stamp program, in both the outreach and distribution phases.

4. THAT THE REQUIREMENT FOR NEONATAL INSURANCE BE AMENDED TO INCLUDE POLICY RENEWALS.

The 1974 session of the General Assembly passed, upon the recommendation of the Council, a bill requiring that all new family

health insurance policies include coverage of newborn children. Since some policies covered infants only for conditions developing a certain period after birth or provided limited coverage of congenital problems, the Council felt that required coverage from birth was necessary to protect families from the very high costs of caring for children born ill and to ensure those children the care they need. The legislation which passed was a step in the right direction. However, the General Assembly exempted policy renewals from this requirement, and a large number of families are still left unprotected. We recommend, therefore, that all health insurance policies have this provision.

FOSTER CARE

One of the basic needs of all children is that for a stable and permanent familial relationship. Such a relationship provides a sense of belonging and security, enabling a child to form strong emotional ties to other people. These factors are vital to a person's normal development.[15] The natural family normally performs these functions. Too frequently, however, the family structure breaks down and the parents can no longer care for the children. This can happen for a number of reasons—parental physical or mental illness, alcoholism, desertion, drug addiction, child abuse, and the child's own behavior problems. When this breakdown occurs, the child can be placed by authorities in foster care. Foster care is supposed to be a temporary care arrangement for the child until a permanent arrangement can be made, either with the natural parents, with adoptive parents or in a permanent foster placement.[16]

The Committee's study of foster care in Virginia has shown, however, that although foster care is intended to be temporary, many children will spend the rest of their years to maturity in foster care, without the benefits of the permanency, stability and continuity in life which are essential to a normal development. The returns from a questionnaire sent to social workers formed the basis of the Committee's findings. That questionnaire, with its cumulative totals, is included in Appendix B, along with a more detailed analysis. Generally, the returns show that the "average" foster child is an adolescent who has been in foster care in more than one home for several years, will probably not return to his parents, and has had little or no contact with his parents in over a year. Nevertheless, his parents still retain their legal rights to him, thus making him unavailable for adoption.

It is clear that foster care in Virginia, as in other states, is a long-term, unstable placement. Most foster care children are trapped in a sort of limbo, legally tied to parents who cannot, or will not, take care of them. The reasons for the existence of such a situation are complex. From the survey, they appear to be related to some degree to the reluctance of the courts to terminate parental rights and to the failure of social workers to petition for such action because of a conviction the courts would deny the request. This situation exists in many cases even though it is obvious that the natural parents cannot resume custody of their child and termination of parental rights by the court would free the child for adoption or a more permanent placement.

To gain a true understanding of foster care, one must go beyond the statistics and look at the children. Through no fault of their own the family structure has broken down and the children, for their own good, must leave the people with whom they have established the strongest emotional ties. They are placed with strangers and are uncertain as to what the future holds for them. Since the natural parents are always in the background and there is likely to be more than one foster placement, foster care children find it difficult to form emotional bonds.

In light of this situation the Council recommends:

1. THE ESTABLISHMENT OF A SYSTEM OF PERIODIC MANDATORY REVIEW BY THE JUVENILE AND DOMESTIC RELATIONS DISTRICT COURTS OF ALL FOSTER CARE CASES.

The objective of foster care workers should be to leave a child in foster care the shortest period of time possible, either returning him to the natural home or freeing him for adoption or some form of permanent placement. To accomplish this requires working with the natural parents in an effort to solve the problems that led to foster care in the first place and keeping abreast of the child's status. All too often, however, as social workers themselves admit, children are placed in foster care with no clear plan for their future. Furthermore, unless problems arise, foster children often do not receive the attention of the social worker. They drift along, neglected by the welfare agency until some crisis occurs and some action, such as another placement, has to be taken.

In order to ensure that foster children are not lost and forgotten by the system that is responsible for their welfare, there should be a periodic review of their status and of steps being taken to find a permanent place for them. To effectuate this review process the caseworker should establish goals for the child and his or her family and develop a service plan to assure that the goals will be achieved. The Council recommends that the agency which places the child in foster care be required to prepare a plan in consultation with the child, the child's parents and any other person standing in loco parentis at the time the agency obtained custody. The plan should describe, among other things, the services and support to be offered the child and parents, the participation and conduct which will be sought from the parents, the visitation to be permitted between the child and his or her parents and the nature of the placements to be provided the child. The plan should be designed to return the child home or to place him in an adoptive home or permanent foster care placement. Such a foster care plan keyed to the individual circumstances of each child and family lays the foundation for later review of the child's status by the juvenile and domestic relations district court. The juvenile court would review the case of every foster care child who has not been placed in an adoptive home or a permanent foster care placement twelve months after the filing of the foster care plan with the court. The court places the child in foster care and needs to become more involved with what happens to that child thereafter.

A review procedure has support from social workers in this

State (see Appendix B) and has been tried successfully elsewhere. An analysis of the New York procedure reveals that court review of foster care cases had not only the direct effect of rendering definite decisions about cases, but an indirect effect of stimulating agencies to take steps toward disposition of cases, as well. The courts appeared to act as "catalytic" agents and, in many cases, hastened the moving of children out of the foster care system.[17]

2. MORE SPECIFIC GUIDELINES FOR THE TERMINATION OF PARENTAL RIGHTS.

Crucial to the rapid settlement of foster children into the permanent settings that are needed for healthy development is the termination of parental rights when the children are clearly unable to return to their natural parents. Judges are often reluctant to terminate those rights, however, without more specific guidelines than now exist in the law. Furthermore, the chances for successful utilization of a program of periodic review will be enhanced by having a definite time frame in which the goals must be accomplished.

While some flexibility is needed to deal with individual cases of neglect, abuse, entrustment or abandonment of children and any consequent termination of residual parental rights and responsibilities, evidence of certain conditions in the natural home can provide guidance for such decisions. Where parents suffer long-term mental or emotional illness; addiction to liquor, narcotics or other dangerous drugs; willfully refuse to cooperate in future planning for the child; or fail to maintain regular contact with the child, without good cause, for specified periods of time and fail to make reasonable progress towards eliminating the conditions which led to their child's foster care placement, serious consideration should be given to terminating their rights to the child. Depending upon the conditions which led to the child's placement in foster care and upon the actions of the parents, termination proceedings should commence within six to twelve months. The proposed legislation contained in Appendix A of this report sets forth in detail the procedures to be followed and guidelines to be utilized by the juvenile court in the termination of parental rights.

It is important to emphasize that termination of parental rights is a decisive action and one not to be taken lightly. If possible, it would be best to leave the child with his natural family and provide services to the whole family in an effort to alleviate those problems that led to the crisis and the placement in foster care. Often, however, caseworkers remove the child rather than work with the entire family, because removal is the easier and more convenient course of action. Similarly, when the situation necessitates placement in foster care, the caseworker should continue to do everything possible to return the child to the natural family. This is not always the practice, however, as agencies often render more services to the children and foster families than to the natural families.[18] Every possible effort should be made "to enhance ... [the] capacity [of the natural parents] for good child care and enrich their potential for good parenting."[19] If this effort fails, and this should be a factor the judge considers, then, and only then, should parental rights be

terminated.

These provisions for foster care plans, foster care review and termination of parental rights, when taken together, can substantially improve the lot of the foster child. They would ensure that there would be affirmative planning for the foster child's future, that there would be a follow-up on that plan, and that positive steps would be taken based on the results of the plan.

It is apparent that, if enacted, these review and termination procedures would not significantly benefit most of the children now in foster care. As the results of the questionnaire show, over half of those for whom parental rights have not been terminated probably would not be adopted, if those rights were immediately terminated, because of their age, race, or a handicap or unwillingness on the part of the child to be adopted. For the most part, these children are relatively old and have been in foster care for a number of years. This hypothesis is substantiated by the New York experience. The courts ordered continued foster care, after review, significantly more often for older foster children than for younger children.[20]

If termination of parental rights had been a more viable alternative and if their cases had been reviewed systematically soon after they were placed in foster care, a significant number of children would not be in foster care now. These recommended provisions are designed to help children who may require foster care in the future so that "temporary" foster placement does not become permanent care for them as well.

The Council further recommends:

3. TRAINING FOR FOSTER PARENTS WITH EMPHASIS ON CARING FOR SPECIAL NEEDS CHILDREN.

Foster care presents many problems other than the usual ones of raising children. Children in foster care are often confused, hurt, or angry. They usually have emotional problems of some degree and they sometimes exhibit behavior problems. Because many people who become foster parents are not equipped to deal with these types of problems, some welfare departments have programs for the training of foster parents. If all departments could provide such training, more people might become foster parents and the improvement in the skills of foster parents would beneift the foster child.

According to the results of the survey, there is a large group of foster children with one or more handicaps. As we have noted, taking care of a foster child is a difficult task in and of itself but when the child is handicapped, the difficulties are multiplied. These children have special needs which foster parents ordinarily will not be equipped to meet.

Many local departments of welfare do not have the expertise to screen and train prospective parents of handicapped foster children, but they can use the expertise of other agencies. To do so would require a coordination among different agencies that, as will be

pointed out elsewhere in this report, is often lacking. However, it can be done. One example of such coordination is a program recently begun by the Region X Community Mental Health and Retardation Services Board. The board trains persons willing to become foster parents of mentally retarded children. The welfare departments agree to place children with these parents and the board and agencies negotiate the amount of money paid to the parents. The Council commends these agencies for this creative arrangement and strongly encourages other local welfare departments to use the skills and knowledge of other agencies to improve the life of handicapped foster children.

4. A STUDY BY THE DEPARTMENT OF WELFARE OF THE FEASIBILITY OF ESTABLISHING MORE GROUP HOMES IN THE STATE.

In the month of January, 1975, two hundred ninety-five foster children were in institutions outside the State at readily identifiable cost to the State of $227,500 per month. That was only a part of the cost, since it represents only the amount paid out of the foster care funds directly to the institutions. In many cases, agencies were able to use Medicaid funds to pay part of the expenses and there were also travel costs of the child and administrative costs. The bulk of this money, that paid to the institutions, was money going out of the State.

The children were placed in these institutions for a number of reasons. Many had emotional or mental problems, varying from mild to severe, which needed treatment. Others were older children who could not adjust to a foster home setting and for whom there was no room at any of the private facilities in Virginia.

In many respects, the ideal situation would be the establishment of a number of group homes in the State. Most importantly, this would provide the group setting that some children need, while avoiding the impersonality of an institution. Secondly, it would be closer to the child's home area and any possible return to his family could be better facilitated. In addition, the social worker could better evaluate the care being given, a function difficult to perform when the child is hundreds of miles away in an institution.[21] In addition to these advantages, the group homes would not cost any more, and perhaps less, than institutions, which can cost over $1,000 per child a month. Such facilities would allow taxpayers' money to remain in the State and would reduce such ancillary expenses as travel.

Welfare departments now have the authority, but the legislature has never provided the necessary funds, to operate such facilities. In order to decide whether the cost to the State or private citizens of establishing these homes would be justified, it is necessary to determine how many of those foster children now in out-of-state institutions could be placed in a group home and how many actually need specialized care and treatment available only in institutions. Such a determination would require almost a case-by-case evaluation by the Department of Welfare. The Council is excited by the prospect of bringing these children home and recommends that this study be made.

5. INCREASING THE PAYMENTS MADE TO FOSTER PARENTS.

Foster parents should not have to bear a financial burden as well as the pnysical and emotional ones of caring for an additional child, who very well may have behavior problems. Yet most do. Monthly maintenance payments to foster parents range from $80 to $100 with additional funds dispensed for clothing, school supplies, and personal items. In many cases, the payments in the past have not been enough to cover the expenses of providing for a child, and it is not uncommon for a foster parent to supplement the payment received from the agency. In fact, there is at least one case on record where the foster parent was able to claim the foster child as a dependent for tax purposes since he provided more than half of the child's support. Out of a sense of justice to these people who give so much of themselves to be foster parents, the State should cover the full expense of the foster child.

SPECIAL EDUCATION

The Committee considered briefly the subject of the education of handicapped children and their needs. It did not go into the matter in depth because there has been much previous study in this area, and the Committee did not wish to duplicate efforts that had already been made.[22]

This is not to say that this is a field in which we have little concern. Far too many children with handicaps are not having their needs met or are going too long without treatment. The main emphasis of this report is the importance of meeting needs early in a child's life and this is even more true in the case of a handicapped child. If the handicap can be detected and treatment begun early, the child can often do much to overcome the effects of the handicap and be a productive person.

Several years ago, the General Assembly enacted one of its most significant pieces of legislation in terms of impact upon children. The statute requires the State Board of Education to "prepare and place in operation a program of special education designed to educate and train handicapped children between the ages of two and twenty-one ...." Furthermore, "handicapped" is very broadly defined.[23] To properly implement this mandate, the Department of Education, in cooperation with other agencies, notably the Departments of Health and Mental Health and Mental Retardation, will have to establish a mechanism to find handicapped children, diagnose their handicaps, devise an educational program for them, and follow through with that program. And all of this will be done for very young children, when the treatment will be most effective.

The Board of Education has declared that the program must be fully implemented in the 1976-77 school year. We give this program the strongest possible endorsement. We strongly urge that there be no further delay in its implementation and that the General Assembly provide the necessary funds. The money appropriated will be a true investment in the lives of these children who need help—an investment that will return substantial dividends in the

future.

COORDINATION AGENCY

One of the Council's primary responsibilities is to "recommend the best location for an office or agency to plan for and administer any State program and to coordinate the activities of the State departments now engaged in some aspect of child welfare programs."[24] In order to enable the Council to fulfill this responsibility, the Committee, in the course of its investigations, examined its findings from the perspective of trying to determine the extent of the need, if any, for coordination.

In its public hearings and meetings with various agency officials, the Committee discovered that there are many individual projects and programs at both the State and local levels which are rendering valuable, needed services to the children of this Commonwealth. A few of these programs are mentioned elsewhere in this report and the Council recognizes the efforts of many people throughout the State to meet the pressing needs that exist. At the same time, however, without denigrating their value, we emphatically feel that these individual efforts need to be brought together to form an efficient system of services for children.

The Council has found that there are two types of problems that prevent services from being delivered as effectively as possible. First, there are management problems at the departmental and programmatic level. Second, there is a lack of central overview necessary for the interdepartmental coordination of service delivery. This inadequacy often results in little or no long-term planning.

The following are some of the management problems:

1. Crisis-oriented service delivery—Those children in immediate need have to be helped. Consequently, the great bulk of services are oriented toward meeting crises rather than toward trying to resolve the fundamental problems which led to the crises. For example, the State has programs in delinquency prevention which are aimed at teenagers. However, the problems which lead to delinquency start at a much younger age and are, as a study by the Richmond juvenile and domestic relations court staff shows,[25] often physical, perceptual or psychological in nature and are detectable and treatable early. The State's new child abuse program, while commendable, is still a response to crisis. Its intent is to deal more effectively with child abusers, not identify and deal with the problems and conditions that lead to abuse before it occurs.

Admittedly, this type of orientation is as typical of the State as a whole as it is of the individual departments. Still, where it is possible, there is a lack of emphasis on the prevention of crises. Social workers often prefer to remove a child from its family and place it in foster care rather than try to help that family work out its problems. Schools by and large have not institute

It should be pointed out here that criticisms such as the foregoing and those to follow should be applied generally, not universally. There are many outstanding exceptions to them.

2. Service arrangments for providers—In too many cases, the needs of the providers of services, rather than those of clients, form the basis of delivery arrangments. This is evident in the reluctance of health officials to schedule clinics at night or on weekends, when clients would more likely be able to attend. Also, appointments, such as for the Medicaid Early and Periodic Screening, Diagnosis and Treatment clinics, are often made without any consultation with clients so as to allow for adjustment of work schedules and arrangments for child care.

3. Inadequate data—Data related to services to children in this state is largely nonexistent. What does exist is fragmentary and cumbersome. Examples can be drawn from every department. During the major portion of the Committee's study, the Department of Mental Health and Mental Retardation could not furnish current statistics on the number of children in its institutions, and it had no data on the services to children delivered by community mental health organizations. Until the summer of 1975, the Department of Welfare had no statistical handle on its foster care program. The data that now exists was obtained partly through the initiative of a subcommittee of the Committee and an organization of foster care workers. The Department of Health has computerized much of the data from its programs and can produce accurate and current information. However, since some of the charts and tables in the Department's annual report can be easily misinterpreted, they should be used only by persons thoroughly familiar with the programs, according to Department officials.

4. Inadequate program evaluation—With so little data in hand, it is very difficult for agencies to evaluate what they are doing. The foster care program is a prime example. Many of the problems that exist, which have already been discussed in this report, cannot be solved until the Department of Welfare has a more accurate idea of their extent. There may be other problems in the whole program which will show up only when the Department has all the data and can thoroughly review it. In another example, Department of Health officials say that the official reports of their child development clinics do not truly reflect the extent of that program's services and the waiting list for the clinics.

5. Inadequate establishment of needs and priorities— This problem flows from the existence of the previous two. When an agency does not have the data necessary to evaluate programs and determine their effectiveness, it cannot discover the needs that exist and establish priorities. One of the biggest needs of families with small children is that for good child care facilities. However, the State does not know the extent, the nature, nor the location of this need. Some localities, such as Fairfax County, have undertaken needs assessments. Consequently, they know the need for day care, the kinds needed, and where it is needed, and they can plan accordingly. Nothing comparable exists on the State level.

One result of this inability to plan and establish priorities is that those children who are represented by organized groups who can command attention or those who happen to live in areas with lots of resources tend to get services while others lose out. One example is the mentally retarded for whom there are influential, private organizations throughout the State who do a tremendous service. On the other hand, the organizations that exist for the learning disabled are not nearly so visible.

The second major type of problem is one of coordination among agencies. Although it is a vague term, the need for coordination is real from at least two perspectives. In the first place, children often have needs which cannot be met by one agency alone. For example, the foster child with a vision problem and a learning disability requires the services of the Departments of Welfare, Health, and Education and the Commission for the Visually Handicapped. In the second place, policymakers have recognized this existence of cross-cutting needs and have instituted programs which require agency coordination in their administration. The federal Medicaid screening program requires cooperation between local health and welfare departments, while the state-mandated education of all handicapped persons between the ages of two and twenty-one necessitates coordination among the Departments of Health, Education, and Mental Health and Mental Retardation on the State and local levels.

It became increasingly apparent to the Committee that there is insufficient coordination among the agencies that deliver services to children. Not only do programs fail to complement each other when necessary, there is considerable overlapping and duplication of functions as well. The testimony of numerous individuals actually engaged in service delivery corroborated the Committee's own findings.

Some of the reasons for this lack of coordination are:

1. Turf protection—This refers to an agency's reluctance to relinquish exclusive responsibility for a program traditionally within its jurisdiction. While probably the most prevalent obstacle to coordination, it is the most subtle. Although many persons experienced in the politics of children's service programs cited it as a major problem, it is hard to cite concrete examples since no agency heads will admit that their motives consisted of anything other than serving the best interests of their clients. Some examples did come to the Committee's attention, however, notably a welfare department's unwillingness to cooperate with a Chapter 10 board's efforts to train people to be foster parents of mentally retarded children. The department simply did not wish to give up any control of its foster care program.

2. Reluctance to assume new function—With the initiation of new programs requiring the participation of more than one agency, some agencies have been reluctant to deliver unfamiliar services not explicitly designated to them. For example, the Medicaid screening program started off slowly because health and welfare departments were unable to work out their respective responsibilities in areas such as follow-up of broken appointments and the provision of

transportation to clients.

3. Structure of government—The structure of Virginia's executive branch presents a barrier to coordination. It is organized on the basis of type of service rather than being oriented to type of receipients. As a result, Virginia's human services agencies have responsibility for particular services to all client groups, not just children. While this is a perfectly acceptable administrative arrangement, it does present problems since, as pointed out above, many children require services from different disciplines. Furthermore, the human service departments are not all responsible to the same administrative Secretary who has the coordinative responsibility. For example, services to developmentally disabled children could conceivably be provided by the Departments of Health, Welfare and Mental Health and Mental Retardation under the Secretary of Human Affairs; the Department of Education under the Secretary of Education; and the Division of Youth Services under the Secretary of Administration.

In the light of all these considerations, it is clear that there is no single entity which has the sole responsibility of monitoring services to children and which has the power to effect changes over the whole of State government. To fill this void, the Council RECOMMENDS THE CREATION OF A DIVISION OF CHILDREN IN THE OFFICE OF THE GOVERNOR. The director of the Division would be appointed by the Governor. Because the Council recognizes the importance of participation by citizens who can bring a different perspective and provide links to the private sector, an advisory council for the Division is recommended, the members of which would also be appointed by the Governor. The membership of this Council should come from a wide range of disciplines and include consumers and child development professionals.

This Division would have the following functions and duties:

1. Program monitoring—The Division would monitor programs delivering services to children for the purposes of obtaining information independently of the agencies and of insuring that services promised or mandated were delivered.

2. Program evaluation and recommendations—The Division would evaluate State and local programs, as well as programs in the private sector delivering services to children, as to whether they were best meeting the needs of the children they were serving. Also evaluated on the basis of acceptability and effectiveness would be the standards regulating these services. Based on these evaluations, the Division would make recommendations to the appropriate Secretaries and agency heads for improving or expanding existing programs and for tying together programs at different levels of government or in different areas of the State. The availability of financial and other federal support would be communicated to pertinent agencies or organizations.

3. Legislative analysis and recommendations—The Division would make appropriate legislative recommendations to the Governor and General Assembly. Federal legislation having a

potential impact upon the children of the Commonwealth would also be followed and evaluated.

4. Public information—Furnishing information to professionals and the public-at-large of opportunities available for children to fulfill their needs and solve certain problems would be an important function of the proposed division. Information on improvements, research and changes in programs, professional techniques and laws, both at the State and national levels which would be of interest to professionals and citizens would be disseminated by the Division.

5. Fiscal assessment—The Division would review the proposed budgets of State agencies and make recommendations to the Governor and the Governor's Budget Advisory Committee concerning those items which affect children. In exercising this function, the Division would particularly make recommendations designed to strengthen the coordination of services to children delivered by different departments.

6. Technical assistance in the field—Personnel and information would be made available to support efforts made in the field to initiate or improve programs and services for children.

7. Data bank—The Division would establish a computerized data bank containing statistics on the programs serving children, including the costs of the programs and the number of people served.

8. Advocacy for families and children—This function essentially sums up the functions and duties previously enumerated. "Child advocacy" has been defined by the American Public Health Association as "the participation in public decisions on behalf of children. True participation requires power to change thought, laws, attitudes, services, behavior and use of money. It also requires responsibility for follow-through and for adverse effects of change."[26] The Division would in all of its operations be responsible for promoting and advocating the best interests of children.

It should be noted that there is no mention in any of the preceding discussion of the direct delivery of services. It is not intended that this Division take over the responsibilities of any State or local agency to provide services to children on a daily basis. The Division would provide assistance and coordination to these agencies but would not assume the operation of their programs.

The enactment of a Division of Children on the State level which would perform the functions and have the responsibilities previously discussed would make certain existing State agencies unnecessary. The Virginia Commission for Children and Youth, the Community Coordinated Child Care Council and the Delinquency Prevention Service in the Division of Youth Services currently deliver services that would duplicate those of the proposed Division. This agency would encompass the activities of each of these agencies, and others, and their continuation as separate entities would no longer be required. We recognize the large contribution to

the welfare of children of many interested citizens who have participated in these organizations. It is our hope that their skills and dedication will not be forgotten, but be further put to use in the development of a more effective mechanism for delivering services to children.

CONCLUSION

It cannot be said enough that children are our most precious resource. They are the potential human resources of the future. It goes without saying that whatever the State can do to enhance that potential, the more benefits the State will receive.

Many of the problems affecting youth and adults could have been prevented. And many of these problems result not only in human tragedies, but in nonproductive citizens and anti-social and/or destructive persons, as well. These are the reasons why society has a vested interest in the way its citizens develop. More attention has to be given to the needs of young children, for it is those vital first few years that largely shape a person's future. The problems have to be treated then and, even in those cases with no manifest problems, positive, active measures need to be taken to enable the child to develop his or her full potential.

We firmly believe that the steps we have recommended will go far toward ensuring that the needs of young children will be more fully met in this State. If the needs of young children continue to be met inadequately, the resultant costs to the State in the future will be much greater than the relatively low cost of implementing these proposals.

Following this report are appendices containing the recommended legislation and more detailed findings of the Council regarding the needs of young children and the extent to which Virginia is meeting those needs.

The Council extends its thanks to the members of the Committee, and others, who contributed their talents and a great deal of effort and time to the conduct of this study.

The Council respectfully submits this report to the General Assembly and respectfully urges the adoption of the recommended legislation.

Respectfully submitted,

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Willard J. Moody, Chairman

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Edward E. Lane, Vice Chairman

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George E. Allen, Jr.

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.....

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Lawrence Douglas Wilder

.....

Edward E. Willey

*Senator Gartlan dissents from so much of this report as it relates to foster care and termination of residual parental rights.

FOOTNOTES

1. Allan Berman, "Learning Disabilities and Juvenile Delinquency: A Neuropsychological Approach," a paper presented to the Second Western Regional Conference of the Association for Children With Learning Disabilities, February 2, 1973; Charlene B. Baum, "Interim Report of the Thirteenth District Juvenile and Domestic Relations Court Project on Juvenile Offenders and Disabilities," (Richmond: October, 1975).

2. Linwood Holton, address to the Governor's Conference on Day Care Needs; Richmond, Virginia; May 2, 1973.

3. See Margaret A. Ribble, The Rights of Infants: Early Psychological Needs and their Satisfaction , Second Edition (New York: Columbia University Press, 1965) and Ashley Montagu, Touching (New York: Columbia University Press, 1971).

4. See Maria Montessori, The Absorbent Mind (Madras, India: The Theosophical Publishing House, 1949).

5. Seth Low and Pearl G. Spindler, Child Care Arrangements of Working Mothers in the United States , Children's Bureau Publication 461-1968 (Washington: Government Printing Office, 1968); Report of the Child Care Advisory Council to the Fairfax County Board of Supervisors , April 21, 1975, p. 18. (Hereinafter referred to as Fairfax County Child Care Report.)

6. Fairfax County Child Care Report, p. 21. See § 63.1-195 of the Code of Virginia for definition of "family day-care home."

7. As of March 31, 1975, the Department reports that 2,616 children were cared for in licensed day care homes. The Fairfax County study discovered that 9,900 children were cared for in sitters' homes in that county alone.

8. Fairfax County Child Care Report, p. 23.

9. Ibid. , p. 14.

10. United States, Bureau of Child Development Services, Day Care Licensing Study, Summary Report on Phase I: State and Local Day Care Licensing Requirements , DHEW Publication No. (OCD) 73-1066 (Washington: United States Government Printing Office, 1973).

11. Commonwealth of Virginia, Essential Nursing Services for Virginia's Public Schools (Richmond: Department of Purchases and Supply, 1974), pp. 9-12.

12. Ibid. , pp. 12, 16.

13. See Kenneth W. Clarkson, Food Stamps and Nutrition

(Washington, D. C.: American Enterprise Institute for Public Policy Research, 1975).

14. Ibid. , p. 76.

15. See Joseph Goldstein, Anna Freud, and Albert J. Solnit, Beyond the Best Interests of the Child (New York: The Free Press, 1973).

16. See Robert L. Geiser, The Illusion of Caring (Boston: Beacon Press, 1973).

17. Trudy Bradley Festinger, "The New York Court Review of Children in Foster Care," Child Welfare , April, 1975, pp. 242-243.

18. Ibid. , p. 241.

19. Vincent DeFrancis. "Termination of Parental Rights: Balancing the Equities," (Denver, Colorado: American Humane Association, Children's Division, 1971), p. 3.

20. Festinger, p. 217.

21. Recent reports of highly questionable practices in some of these institutions give added weight to the desire that these places be readily accessible to the placing agency for monitoring. See The Washington Post , September 9, 1975, p. C3.

22. See, for example, Commonwealth of Virginia, Mental Retardation Care-Report of the Virginia Advisory Legislative Council , House Document No. 25, 1974.

23. §§ 22-10.3 and 22-10.4 of the Code of Virginia.

24. House Joint Resolution No. 70, Acts of the General Assembly of the Commonwealth of Virginia , Session 1974, p. 1480.

25. Baum, "Interim Report..."

26. The Nation's Health , October, 1973.

APPENDICES

A. Recommended Legislation

Resolution concerning parenting education

Bill relating to day care

Resolution concerning day care certification

Bill relating to fluoridation of water

Bill relating to neonatal insurance

Resolution pertaining to school health services

Bill relating to foster care

Resolution relating to group homes

Bill creating Division for Children

B. Summary of Programs for Young Children

APPENDIX A

HOUSE JOINT RESOLUTION NO.....

Directing the State Board of Education to develop for inclusion as a part of the curricula of each school division in the State a course on parenthood and human growth and development.

WHEREAS, parents are the single most important factor in a child's life; and

WHEREAS, learning to be a good parent is an educational process which the public schools are in a unique position to promote and support; and

WHEREAS, it is recognized today that the social, physical and psychological needs of children which can best be met by parents can be taught to parents and potential parents with significant improvement in the quality of home life; and

WHEREAS, instruction in the art of parenting and in human development should be an integral part of the curricula of all school divisions, beginning with kindergarten; now, therefore, be it

RESOLVED, by the House of Delegates, the Senate concurring, That the State Board of Education is directed to develop units on parenthood and human growth and development to be correlated with all areas of the elementary school curriculum and to develop a course on parenting at the high school level to be offered as an elective in all school divisions in the State by the 1977-78 school year.

A BILL to amend and reenact § 63.1-195, as amended, of the Code of Virginia relating to the definitions of "child-care center" and "family day-care home."

Be it enacted by the General Assembly of Virginia:

1. That § 63.1-195, as amended, of the Code of Virginia is amended and reenacted as follows:

§ 63.1-195. Definitions.—As used in this chapter:

"Person" means any natural person, or any association, partnership or corporation;

"Child" means any natural person under eighteen years of age;

"Foster home" means the place of residence of any natural person in which any child, other than a child by birth or adoption of such person, resides as a member of the household;

"Child-placing agency" means any person, other than the parent or guardian of the child, who places, or obtains the placement of, or who negotiates or acts as intermediary for the placement of, any child in a foster home, or adoptive home;

"Child-caring institution" means any institution, other than an institution operated by the State, a county or city, and maintained for the purpose of receiving children for full-time care, maintenance, protection and guidance separated from their parents or guardians, except:

(1) [Repealed.]

(2) A bona fide educational institution whose pupils, in the ordinary course of events, return annually to the homes of their parents or guardians for not less than two months of summer vacation;

(3) An establishment required to be licensed as a summer camp by §§ 35-43 to 35-53; and

(4) A bona fide hospital legally maintained, as such;

"Group home" means a child-caring institution operated by any person at any place other than in an individual's family home or residence, which does not care for more than twelve children;

"Independent foster home" means a private family home in which any child, other than a child by birth or adoption of such person, resides as a member of the household and has been placed therein independently of a childplacing agency except (1) a home in which are received only children related by birth or adoption of the person who maintains such home and legitimate children of personal friends of such person and (2) a home in which are received a child or children committed under the provisions of §

16.1-178 (2) or (4 1/2);

"Child-care center" means any facility operated for the purpose of providing care, protection and guidance to a group of children separated from their parents or guardian during a part of the day only except (1) a facility required to be licensed as a summer camp under §§ 35-43 through 35-53; ~~(2) a public school or a private school unless the Commissioner determines that such private school is operating a child-care center outside the scope of regular classes; (3) a school operated primarily for the educational instruction of children from three to five years of age at which children three or four years of age do not attend in excess of four hours per day and children five years of age do not attend in excess of six and one-half hours per day; (4) a facility which provides child care on an hourly basis which is contracted for by a parent occasionally only; (5) a facility operated by a hospital on the hospital's premises, which provides care to the children of the hospital's employees, while such employees are engaged in performing work for the hospital; and (6) a Sunday School conducted by a religious institution or a facility operated by a religious organization where children are cared for during short periods of time while persons responsible for such children are attending religious services~~ *(1a) a facility which cares for ~~children~~ not less than five years of age; and (1b) a facility which cares for children less than five years of age not in excess of four hours per day.*

"Child-welfare agency" means a child-placing agency, child-caring institution, independent foster home, child care center or family day-care home;

"Family day-care home" means any private family home in which ~~more than three children~~ *:*

(1) four or more children, any of whom are under two years of age; or

(2) five or more children, any of whom are under three years of age; or

(3) six or more children are received for care, protection and guidance during only a part of the twenty-four hour day, except children who are related by blood or marriage to the person who maintains the home; provided, however, that in case of a complaint in such a home where less than ~~four~~ *six* children reside, the Commissioner may cause an investigation to be made as provided in § 63.1-198 and may require such home to comply with the provisions of this chapter applicable to family day-care homes if he finds that such home is not conducive to the welfare of the children received therein.

HOUSE JOINT RESOLUTION NO.....

Directing the State Department of Welfare to develop guidelines for the issuance of certificates designating licensed child care centers in the Commonwealth as meeting custodial or developmental standards.

WHEREAS, the present governmental licensing standards for child care centers in Virginia are directed at insuring a minimum level of care through basic health, welfare and safety requirements; and

WHEREAS, guidelines are needed to foster high quality standards for both the programming and environmental aspects of such facilities; and

WHEREAS, stringent licensing requirements intended to upgrade the educational quality of child care facilities may drive the cost of regulated day care beyond the reach of low-income to middle-income families; and

WHEREAS, certification of a licensed child care center as custodial or developmental in nature would encourage the implementation and improvement of developmental programs and enable parents to better evaluate the type of child-caring facility they wish to place their child in; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the State Department of Welfare is directed to develop standards and guidelines for the certification of licensed child care centers as meeting custodial or developmental requirements. The center meeting developmental requirements would have separate program standards to fulfill in addition to the minimum health, safety and welfare regulations required of custodial child care centers. A center which elects to be certified as developmental would meet strict programmatic standards to be developed by the Department in consultation with the State Department of Education, the Virginia Association of Early Childhood Education and other appropriate professional groups.

A BILL to amend and reenact § 62.1-45 of the Code of Virginia and to amend the Code of Virgnia by adding a section numbered 62.1-46.1 providing for the fluoridation of public drinking water.

Be it enacted by the General Assembly of Virginia:

1. That § 62.1-45 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding a section numbered 62.1-46.1 as follows:

§ 62.1-45. Definitions.—As used in this chapter the words and terms hereinafter set forth shall have the meanings respectively set forth, unless the context clearly requires a different meaning:

(a) "Waterworks".—All structures and appliances used in connection with the collection, storage, purification and treatment of water for drinking or domestic use and the distribution thereof to the public or more than twenty-five individuals, or in the case of residential consumers to more than fifteen connections, except only the piping and fixtures inside the buildings where such water is delivered.

(b) "Water supply".—Water that shall have been taken into waterworks from all wells, streams, springs, lakes and other bodies of surface water, natural or impounded, and the tributaries thereto, and all impounded ground water, but the term "water supply" shall not include any waters above the point of intake of such waterworks.

(c) "Owner".—An individual, group of individuals, partnership, firm, association, institution, corporation, municipal corporation, county or authority, which supplies water to any person within this State from or by means of any waterworks.

(d) "Pure water".—Water fit for human consumption and use which is sanitary, and normally free of minerals, organic substances and toxic agents in excess of reasonable amounts for domestic usage in the area served and normally adequate in supply for the minimum health requirements of the persons served.

(e) "Board".—The State Board of Health.

(f) "Domestic usage".—Normal family use, including laundering, bathing, heating and cleaning.

(g) "Fluoridation".—The addition of fluorine salts to drinking water, usually one per million, to reduce the incidence of dental decay.

§ 62.1-46.1. Fluoridation of water supplies.—All water supplies and waterworks in the State shall be fluoridated pursuant to guidelines developed by the State Board of Health. Any county, city, or town which provides for fluoridation of its water supplies and waterworks by local ordinance shall conform to the guidelines developed by the Board.

2. That this act shall be effective on and after July one, nineteen hundred seventy-seven.

A BILL to amend and reenact § 38.1-348.6 of the Code of Virginia relating to the coverage of newly born children in accident and sickness insurance policies.

Be it enacted by the General Assembly of Virginia:

1. That § 38.1-348.6 of the Code of Virginia is amended and reenacted as follows:

§ 38.1-348.6. Coverage of newborn children required.—All individual and group accident and sickness insurance policies providing coverage on an expense incurred basis and individual and group service or indemnity type contracts issued by a nonprofit corporation which provide coverage for a family member of the insured or the subscriber shall, as to such family members' coverage, also provide that the accident and sickness insurance benefits applicable for children shall be payable with respect to a newly born child of the insured or subscriber from the moment of birth. The coverage for newly born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child and payment of the required premium or fees must be furnished to the insurer or nonprofit service or indemnity corporation within thirty-one days after the date of birth in order to have the coverage continue beyond such thirty-one-day period. The requirements of this section shall apply to all insurance policies and subscriber contracts delivered ~~or~~, issued for delivery *, reissued or renewed* in this State on and after November one, nineteen hundred seventy-five.

2. That the amendments made pursuant to this act are effective on and after November one, nineteen hundred seventy-six.

HOUSE JOINT RESOLUTION NO.....

Directing the State Board of Education and the State Board of Health to establish a standard State program of public school health services.

WHEREAS, there is a need for health services in the public schools of the Commonwealth; and

WHEREAS, local school divisions and local health departments may both be involved in delivering such health services, but there is no uniform program in the State which provides what agency is responsible for providing, guiding and promoting these services; and

WHEREAS, cooperative planning is necessary between the education and health disciplines to assure economical and quality health care services in the public schools of the Commonwealth; now, therefore, be it

RESOLVED, by the House of Delegates, the Senate concurring, That the State Board of Education and the State Board of Health are directed to establish a standard State program of public school health services. The Boards should cooperate in developing guidelines and the areas of responsibility for each agency in order that a coordinated, effective program of health care services be implemented in the public schools of the Commonwealth by the 1977-78 academic school year.

A BILL to amend and reenact §§ 16.1-141, 63.1-56, 63.1-195 and 63.1-204, as amended, of the Code of Virginia and to amend the Code of Virginia by adding sections numbered 16.1-178.3, 16.1-179.1, 16.1-179.2, 16.1-179.3 and 63.1-206.1, the amended and added sections relating to judicial review of children placed in foster care pursuant to foster care plans and entrustment agreements and to termination of residual parental rights and responsibilities.

Be it enacted by the General Assembly of Virginia:

1. That §§ 16.1-141, 63.1-56, 63.1-195 and 63.1-204, as amended, of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding sections numbered 16.1-178.3, 16.1-179.1, 16.1-179.2, 16.1-179.3 and 63.1-206.1 as follows:

§ 16.1-141. Definitions.—When used in this chapter, unless the context otherwise requires:

(1) "The court" or the "juvenile court" or the "juvenile and domestic relations court" means the juvenile and domestic relations district court of each county or city;

(2) "The judge" means the judge, or the substitute judge of the juvenile and domestic relations district court of each county or city;

(3) "Child," "juvenile" or "minor" means a person less than eighteen years of age;

(4) [Repealed.]

(5) "Adult" means a person eighteen years of age or older;

(6) "Department" means the Department of Corrections and "Director" means the administrative head in charge thereof or such of his assistants and subordinates as are designated by him to discharge the duties imposed upon him under this law;

(7) "This law," "the law" means the Juvenile and Domestic Relations District Court Law embraced in this chapter;

(8) "Juvenile probation officer" may be called a "counsellor" or "probation officer"; ~~and~~

(9) "State Board" means the State Board of Corrections ~~.~~;

(10) "Abused or neglected child" means any child whose parents or other person responsible for his care:

1. creates or inflicts, threatens to create or inflict, or allows to be created or inflicted upon such child a physical or mental injury by other than accidental means, or creates a substantial risk of death, disfigurement or impairment of bodily or mental functions;

2. neglects or refuses to provide care necessary for his health; provided, however, that no child who in good faith is under treatment solely by spiritual means through prayer

in accordance with the tenets and practices of a recognized church or religious denomination shall for that reason alone be considered to be an abused or neglected child;

3. abandons such child; or

4. commits or allows to be committed any sexual act upon a child in violation of the law;

(11) "Legal custody" means a legal status created by court order which vests in a custodian the right to have physical custody of the child, to determine where and with whom he shall live within the State, the right and duty to protect, train and discipline him and to provide him with food, shelter, education and ordinary medical care, all subject to any residual parental rights and responsibilities;

(12) "Residual parental rights and responsibilities" means those rights and responsibilities remaining with the parent after the transfer of legal custody or guardianship of the person, including but not limited to the right of visitation, consent to adoption, the right to determine religious affiliation and the responsibility for support;

(13) "Child welfare agency" means a child-placing agency, child-caring institution or independent foster home as defined in § 63.1-195;

(14) "Foster care" or "temporary foster care" means the provision of substitute care and supervision, for a child committed or entrusted to a local board of public welfare or child welfare agency or for whom the board or child welfare agency has accepted supervision, in a temporary living situation until the child can return to his or her family or be placed in a permanent foster care placement or in an adoptive home;

(15) "Adoptive home" means the place of residence of any natural person in which a child resides as a member of the household and in which he or she has been placed for the purposes of adoption or in which he or she has been legally adopted by another member of the household; and

(16) "Permanent foster care placement" means the place of residence in which a child resides and in which he or she has been placed pursuant to the provisions of §§ 63.1-56 and 63.1-206.1 with the expectation and agreement between the placing agency and the place of permanent foster care placement that the child shall remain in the placement until he or she reaches the age of majority. A permanent foster care placement may be a place of residence of any natural person or persons, a group home, an institution or any one placement deemed appropriate to meet a child's needs on a long-term basis.

§ 16.1-179.1. Foster care plan.—A. In any case where legal custody of a child is hereafter given to a local department of public welfare or social services or a child welfare agency pursuant to subsections (3) or (5) of § 16.1-178 or pursuant to § 63.1-56 or § 63.1-204 such department or agency shall prepare a foster care plan for such child, as described hereinafter. The representatives of such department or agency shall consult with the child's parents and any other person or persons standing in loco parentis at the time the department or agency obtained custody concerning the matters which should be included in such plan. The department or agency shall file such plan with the juvenile and domestic relations district court within sixty days following the order of disposition unless the court, for good cause shown, allows an extension of time, which shall not exceed an additional sixty days. For each child placed in foster care on or before June thirtieth, nineteen hundred seventy-six a foster care plan shall be filed with the court by July one, nineteen hundred seventy-seven.

B. Such foster care plan shall in Part A thereof describe (i) the programs, care,

services and other support which wll be offered to such child and his or her parents and other prior custodians, (ii) the participation and conduct which will be sought from the child's parents and other prior custodians, (iii) the visitation and other contacts which will be permitted between the child and his or her parents and other prior custodians and (iv) the nature of the placement or placements which will be provided for such child. Such plan shall be designed to lead to the return of such child to his or her parents or other prior custodians within the shortest practicable time which shall be specified in the plan; provided, however, if the department or agency determines that it is not reasonably likely that the child can be returned to his or her prior family within a practicable time, consistent with the best interests of the child, in Part B of such plan such department or agency shall (i) include a full description of the reasons for this conclusion, (ii) determine the opportunities for placing the child in an adoptive home or permanent foster care placement and (iii) design the plan to lead to the child's successful placement in an adoptive home or permanent foster care placement within the shortest practicable time. The department or agency may include with such proposed plan a proper pleading seeking the termination of residual parental rights pursuant to § 16.1-179.3.

C. A copy of Parts A and B of the foster care plan shall be sent by the court to the attorney for the child, the child's parents or any other person standing in loco parentis at the time the department or agency obtained custody and such other persons as appear to the court to have a proper interest in the plan. A copy of Part A of the foster care plan shall be sent by the court to the foster parents. Any party receiving a copy of the plan may, for good cause shown, petition the court for a review of the plan.

D. The court in which the foster care plan is filed shall be notified immediately if the child is returned to his or her parents or other persons standing in loco parentis at the time the department or agency obtained custody.

§ 16.1-179.2. Foster care review.—A. This section shall apply to all children under the legal custody of a local department of public welfare or social services or a child welfare agency (i) who were the subjects of a foster care plan filed with the court pursuant to § 16.1-179.1 and (ii) who have not been returned to their prior family or placed in an adoptive home or permanent foster care placement within twelve months following the filing of a foster care plan.

B. The department or agency, or an authorized representative thereof, having legal custody of a child or children subject to this section shall file with the court the petition hereinafter described for each such child within twelve months after the filing of a foster care plan for such child.

Such petition shall:

1. be filed in the court in which the foster care plan was filed for such child; provided, however, that upon the order of such court, such petition may be filed in the court of the county or city in which the department or agency having legal custody has its principal office or where the child resides;

2. include a copy of the foster care plan previously filed for such child;

3. state, if such is reasonably obtainable, the current address of the child's parents and, if the child was in the custody of a person standing in loco parentis at the time the department of agency obtained legal custody, of such person or persons;

4. describe the placement or placements provided for such child while in foster care and the services or programs offered to such child and his or her parents and, if applicable, the persons previously standing in loco parentis;

5. describe the nature and frequency of the contacts between the child and his or her parents and, if applicable, the persons previously standing in loco parentis;

6. set forth in detail the manner in which the foster care plan previously filed with the court was or was not complied with and the extent to which the goals thereof have been met;

7. set forth the disposition sought and the grounds therefor; provided, however, that if a continuation of foster care is recommended, a foster care plan for such period of continued foster care shall also be included.

C. Upon receipt of the petition the court shall schedule a hearing for review of the foster care plan and shall provide notice of the hearing and a copy of the petition to the following, each of whom shall be a party entitled to participate in the proceedings:

1. the child, if he or she be twelve years of age or older;

2. the attorney at law representing the child as guardian ad litem;

3. the child's parents and, if the child was in the custody of a person standing in loco parentis at the time the department obtained custody, such person or persons; provided, however, no such notification shall be required if the judge shall certify on the record that the identity of the parent or guardian is not reasonably ascertainable. An affidavit of the mother that the identity of the father is not reasonably ascertainable shall be sufficient evidence of this fact, provided there is no other evidence before the court which would refute such an affidavit;

4. the foster parent or parents of such child;

5. the petitioning department or agency; and

6. such other persons as the court may, in its discretion, direct.

D. At the conclusion of the hearing, the court shall, upon the proof adduced and in accordance with the best interests of the child, enter any appropriate order of disposition consistent with the dispositional alternatives available to the court at the time of the original hearing.

E. The court shall possess continuing jurisdiction over cases reviewed under this section for so long as a child remains in temporary foster care or, when a child is returned to his or her prior family subject to conditions imposed by the court, for so long as such conditions are effective. The court may rehear the matter whenever it deems it necessary or desirable, or upon the petition of any party entitled to notice in proceedings under this section; provided, however, that the court shall rehear the matter once every twelve months for so long as the child has not been returned to his or her prior family or placed in an adoptive home or permanent foster care placement.

§ 16.1-179.3. Termination of residual parental rights.—A. The residual parental rights of a parent or parents may be terminated by the court as hereinafter provided in a separate proceeding or in a proceeding for neglect or abuse if the petition or later pleading specifically requests such relief. The court may terminate the residual parental rights of one parent without affecting the rights of the other parent. The summons or, if residual parental rights are sought to be terminated in a neglect or abuse proceeding by a pleading subsequent to the petition, the notice of hearing shall be served upon the child, if the child is twelve or more years of age, the parents, guardian, legal custodian or other person standing in loco parentis and such other persons as appear to the court to be proper and

necessary parties to the proceedings. Written notice of the hearing shall also be provided to the foster parents of the child if they have had physical custody of the child for more than twelve months informing them that they may appear at the hearing to give testimony and, within the discretion of the court, otherwise participate in the proceeding. The summons or notice of hearing shall clearly state the consequences of a termination of residual parental rights.

B. The residual parental rights of a parent or parents of a child found by the court to be neglected or abused may be terminated if the court finds, based upon competent evidence, that it is in the best interests of the child and that:

1. the neglect or abuse suffered by such child presents a serious and substantial threat to his or her life, health or development; and

2. it is not reasonably likely that the conditions which resulted in such neglect or abuse can be substantially corrected or eliminated so as to allow the child's safe return to his or her parent or parents within a reasonable period not in excess of one year.

Proof of any of the following shall constitute prima facie evidence of the conditions set forth in subparagraph B.2. hereof:

a. the parent or parents are suffering from a mental or emotional illness or mental deficiency of such severity that there is no reasonable expectation that such parent will be able to undertake responsibility for the care needed by the child in accordance with his or her age and stage of development;

b. the parent or parents have habitually abused or are addicted to intoxicating liquors, narcotics or other dangerous drugs to the extent that proper parenting ability has been seriously impaired and the parent has not responded to or followed through with recommended and appropriate treatment which could have improved the capacity for adequate parental functioning;

c. the parent or parents have willfully refused to cooperate in the development of a foster care plan designed to lead to the child's return to the parent or parents; or

d. the parent or parents have not responded to or followed through with appropriate and reasonable rehabilitative efforts on the part of social, medical, mental health or other rehabilitative agencies designed to reduce, eliminate or prevent the neglect or abuse of the child as evidenced by the continuation of substantial or repeated acts of neglect or abuse after the provision of such services.

C. The residual parental rights of a parent or parents of a child found by the court to be neglected or abused or placed in foster care as a result of an entrustment agreement entered into by the parent or parents or other voluntary relinquishment by the parent or parents may be terminated if the court finds, based upon competent evidence, that it is in the best interests of the child and that:

1. the parent or parents have, without good cause, failed to maintain contact with and to provide or substantially plan for the future of the child for a period of twelve months after the child's placement in foster care notwithstanding the reasonable and appropriate efforts of social, medical, mental health or other rehabilitative agencies to communicate with the parent or parents and to strengthen the parent-child relationship; or

2. the parent or parents have been unwilling or unable within a reasonable period to remedy substantially the conditions which led to the child's foster care placement, notwithstanding the reasonable and appropriate efforts of social, medical, mental health or

other rehabilitative agencies to such end.

Proof of any of the following shall constitute prima facie evidence of the conditions set forth in subparagraphs C.1. or 2. hereof:

a. the parent or parents have failed, without good cause, to communicate on a continuing or planned basis with the child for a period of twelve months; provided, however, that occasional or incidental greeting cards, notes or letters to the child shall not be deemed to be sufficient communication; or

b. the parent or parents have failed or have been unable to make reasonable progress towards the elimination of the conditions which led to the child's foster care placement in accordance with their obligations under and within the time limits or goals set forth in a foster care plan filed with the court or any other plan jointly designed by the parent or parents and a social, medical, mental health or other rehabilitative agency.

D. The residual parental rights of a parent or parents of a child found by the court to be neglected or abused upon the ground of abandonment may be terminated if the court finds, based upon competent evidence, that it is in the best interests of the child and that:

1. the child was abandoned under such circumstances that the identity of the parent or parents cannot be determined;

2. the child's parent or parents, guardian or relatives have not come forward to identify such child and claim a relationship to the child within six months following the issuance of an order by the court placing the child in foster care; and

3. diligent efforts have been made to locate the child's parent or parents without avail.

E. Notwithstanding any other provisions of this section, residual parental rights shall not be terminated if it is established that the child, if he or she be fourteen years of age or older or otherwise of an age of discretion as determined by the court, objects to such termination.

§ 16.1-178.3. Standards for entrustment.—Where a parent or other custodian seeks to be relieved of the care and custody of any child pursuant to subsection (1)(d) of § 16.1-178, or where a public or private agency seeks to gain approval of an entrustment agreement pursuant to § 63.1-56 or § 63.1-204, the court shall grant the requested relief only if it finds that: (i) suitable alternative placements exist for such child, (ii) the child is in need of such alternative placement and (iii) a transfer of legal custody and placement outside the child's present home would not detrimentally affect the child's life, health or development.

§ 63.1-56. Accepting children for placing in homes or institutions; care and control.—A local board shall have the right to accept for placement in suitable family homes or institutions, subject to the supervision of the Commissioner and in accordance with rules prescribed by the State Board, such persons under eighteen years of age as may be entrusted to it by the parent, parents or guardian, or committed by any court of competent jurisdiction. Such local board shall, in accordance with the rules prescribed by the State Board and in accordance with the parental agreement or other order by which such person is entrusted or committed to its care, have custody and control of the person so entrusted or committed to it until he is lawfully discharged, has been adopted or has attained his majority; and such local board

shall have authority to place for adoption, and to consent to the adoption of, any child properly committed or entrusted to its care when the order of commitment or entrustment agreement between the parent or parents and the agency provides for the permanent separation of such child from his parent or parents. Such local board shall also have the right to accept temporary custody of any person under eighteen years of age taken into custody by law-enforcement officers pursuant to § 16.1-194(3) where such person has been abandoned, abused or neglected.

Whenever a local board accepts custody of a child pursuant to an entrustment agreement entered into under the authority of this section, such local board shall petition the juvenile and domestic relations district court of the city or county for approval of such agreement within a reasonable time, not to exceed thirty days, after its execution; provided, however, that such petition is not necessary when the agreement stipulates in writing that the entrustment shall be for less than ninety days and the child is returned to his or her home within that period.

Prior to placing any such child in any foster home, the local board shall enter into a written agreement with the foster parents setting forth therein the conditions under which the child is so placed. No child shall be placed in a foster home outside this State by a local board without first complying with the appropriate provisions of § 63.1-207 or Chapter 10.1 of this title. The placement of a child in a foster home, whether within or without the State, shall not be for the purpose of adoption unless the placement agreement between the foster parents and the local board specifically so stipulates.

A parent who has not reached the age of twenty-one shall have legal capacity to execute an entrustment agreement including an agreement which provides for the permanent separation of the child from the parent and shall be as fully bound thereby as if the parent had attained the age of twenty-one years.

§ 63.1-195. Definitions.—As used in this chapter:

"Person" means any natural person, or any association, partnership or corporation;

"Child" means any natural person under eighteen years of age;

"Foster care" means the provision of substitute care and supervision, for a child committed or entrusted to a local board of public welfare or child welfare agency or for whom the board or child welfare agency has accepted supervision, in a temporary living situation until the child can return to his or her family or be placed in a permanent foster care placement or in an adoptive home;

"Foster home" means the place of residence of any natural person in which any child, other than a child by birth or adoption of such person, resides as a member of the household;

"Child placing agency" means any person, other than the parent or guardian of the child, who places, or obtains the placement of, or who negotiates or acts as intermediary for the placement of, any child in a foster home, or adoptive home;

"Child caring institution" means any institution, other than an institution operated by the State, a county or city, and maintained for the purpose of receiving children for full-time care, maintenance, protection and guidance separated from their parents or guardians, except:

(1) [Repealed.]

(2) A bona fide educational institution whose pupils, in the ordinary course of events, return annually to the homes of their parents or guardians for not less than two months of summer vacation;

(3) An establishment required to be licensed as a summer camp by §§ 35-43 to 35-53; and

(4) A bona fide hospital legally maintained, as such.

"Group home" means a child-caring institution operated by any person at any place other than in an individual's family home or residence, which does not care for more than twelve children;

"Independent foster home" means a private family home in which any child, other than a child by birth or adoption of such person, resides as a member of the household and has been placed therein independently of a child placing agency except (1) a home in which are received only children related by birth or adoption of the person who maintains such home and legitimate children of personal friends of such person and (2) a home in which are received a child or children committed under the provisions of § 16.1-178(2) or (4 1/2).

"Permanent foster care placement" means the place of residence in which a child resides and in which he or she has been placed pursuant to the provisions of §§ 63.1-56 and 63.1-206.1 with the expectation and agreement between the placing agency and the place of permanent foster care that the child shall remain in the placement until he or she reaches the age of majority. A permanent foster care placement may be a place of residence of any natural person or persons, a group home, an institution or any one placement deemed appropriate to meet a child's needs on a long-term basis.

"Child care center" means any facility operated for the purpose of providing care, protection and guidance to a group of children separated from their parents or guardian during a part of the day only except (1) a facility required to be licensed as a summer camp under §§ 35-43 through 35-53; (2) a public school or a private school unless the Commissioner determines that such private school is operating a child care center outside the scope of regular classes; (3) a school operated primarily for the educational instruction of children from three to five years of age at which children three or four years of age do not attend in excess of four hours per day and children five years of age do not attend in excess of six and one-half hours per day; (4) a facility which provides child care on an hourly basis which is contracted for by a parent occasionally only; (5) a facility operated by a hospital on the hospital's premises, which provides care to the children of the hospital's employees, while such employees are engaged in performing work for the hospital; and (6)

a Sunday School conducted by a religious institution or a facility operated by a religious organization where children are cared for during short periods of time while persons responsible for such children are attending religious services.

"Child welfare agency" means a child placing agency, child caring institution, independent foster home, child care center or family day care home;

"Family day care home" means any private family home in which more than three children are received for care, protection and guidance during only a part of the twenty-four hour day, except children who are related by blood or marriage to the person who maintains the home; provided, however, that in case of a complaint in such a home where less than four children reside, the Commissioner may cause an investigation to be made as provided in § 63.1-198 and may require such home to comply with the provisions of this chapter applicable to family day care homes if he finds that such home is not conducive to the welfare of the children received therein.

§ 63.1-204. Acceptance and control over children; placing children for adoption.—A licensed child welfare agency shall have the right to accept, for any purpose not contrary to the limitations contained in its license, such children as may be entrusted or committed to it by the parents, guardians, relatives or other persons having legal custody thereof, or committed by any court of competent jurisdiction. The agency shall, within the terms of its license and the agreement or order by which such child is entrusted or committed to its care, have custody and control of every such child so entrusted or committed and accepted, until he is lawfully discharged, has been adopted, or has attained his majority.

Whenever a licensed child welfare agency accepts custody of a child pursuant to an entrustment agreement entered into under the authority of this section, such child welfare agency shall petition the juvenile and domestic relations district court of the city or county for approval of such agreement within a reasonable time, not to exceed thirty days, after its execution; provided, however, that such petition is not necessary when the agreement stipulates in writing that the entrustment shall be for less than ninety days and the child is returned to his or her home within that period.

A licensed child-placing agency, or local board of public welfare may place for adoption, and is empowered to consent to the adoption of, any child who is properly committed or entrusted to its care when the order of commitment or the entrustment agreement between the parent or parents and the agency or board provides for the permanent separation of such child from his parent or parents. Notwithstanding the terms of §§ 63.1-233 and 63.1-237, a valid entrustment agreement for the permanent separation of such child shall not be revocable by either of the natural parents after fifteen days from the date of execution of the agreement, or if the child is not at least twenty-five days old at the end of the fifteen-day period, then after the child reaches the age of twenty-five days, and such agreement shall divest the natural parents of all legal rights and obligations with respect to the child, and the child shall be free from all legal obligations of obedience and maintenance with respect to

them, provided that such rights and obligations may be restored to the natural parent or parents and the child by court order prior to entry of final order of adoption upon proof of fraud or duress; and further provided that either parent or both parents, if married, may revoke such agreement and the child may be returned if the child has not been placed in the home of adoptive parents at the time of such revocation.

For the purposes of this section, a parent who is less than eighteen years of age shall be deemed fully competent and shall have legal capacity to execute a valid entrustment agreement, including an agreement which provides for permanent separation of the child from such parent, and shall be as fully bound thereby as if such parent had attained the age of eighteen years. An entrustment agreement for permanent separation of the child shall be valid notwithstanding that it is not signed by the father of a child born out of wedlock if the identify of the father is not reasonably ascertainable, or if such father is given notice of the entrustment by registered or certified mail to his last known address and such father fails to object to the entrustment within twenty-one days of the mailing of such notice. An affidavit of the mother that the identity of the father is not reasonably ascertainable shall be sufficient evidence of this fact, provided there is no other evidence which would refute such an affidavit.

§ 63.1-206.1. Permanent foster care placement.—A. A local department of public welfare or social services or a licensed child-placing agency shall have authority pursuant to a court order to place a child over whom it has legal custody in a permanent foster care placement where the child shall remain until he or she reaches the age of majority. No such child shall be removed from the physical custody of the foster parents in the permanent care placement except with the consent of the foster parents or upon order of the court or pursuant to § 16.1-247. The department or agency so placing a child shall retain legal custody of the child.

B. Unless modified by the court order, the foster parent in the permanent foster care placement shall have the authority to consent to surgery, entrance into the armed services, marriage, application for a motor vehicle and operator's license, application for admission into college and any other such activities which require parental consent and shall have the responsibility for informing the placing department or agency of any such actions.

C. Any child placed in a permanent foster care placement by a local department of public welfare or social services shall be entitled to the same services and benefits as any other child in foster care pursuant to §§ 63.1-55 and 63.1-56 and any other applicable provisions of law.

D. The State Board of Welfare shall establish minimum standards for the supervision and evaluation of permanent foster care placements.

E. The rate of payment for permanent foster care placements by a local department of public welfare or social services shall be in accordance with standards and rates established by the State Board of Welfare. The rate of payment for such placements by other licensed child-placing agencies shall be in accordance with standards and rates established by the individual agency.

F. If the child has a continuing involvement with his or her natural parents, the natural parents should be involved in the planning for a permanent placement. The court

order placing the child in a permanent placement shall include a specification of the nature and frequency of visiting arrangements with the natural parents.

G. If the residual parental rights of the parents of a child placed in a permanent foster care placement have not been terminated, such parent or parents may petition the court for the return of legal custody; provided, however, no such relief shall be granted unless the parent or parents can demonstrate that it would be in the best interests of the child to be returned to their custody.

HOUSE JOINT RESOLUTION NO.....

Directing the State Department of Welfare to study the need for more group homes in the Commonwealth to care for foster children and handicapped children presently being sent out of the State.

WHEREAS, in January, nineteen hundred seventy-five, two hundred ninety-five foster children were being cared for in institutions outside the Commonwealth at a cost of more than $227,500 per month; and

WHEREAS, children continue to be placed in out-of-state institutions for treatment of emotional and mental problems and for inability to adjust to foster home settings when space in private facilities in Virginia is not available; and

WHEREAS, residential facilities for these children in the Commonwealth would facilitate working with the child's parents and natural home setting, would allow the social worker responsible for the child to better evaluate the treatment and progress of the child and would cost no more than out-of-state institutions which can exceed $1,000 per month in tuition; now, therefore, be it

RESOLVED, by the House of Delegates, the Senate concurring, That the State Department of Welfare is directed to determine how many foster children are presently being cared for in out-of-state institutions, how many actually need specialized treatment that is available only in such institutions and how many could be kept in Virginia if a system of group homes were available as an alternative placement. The Department shall determine whether it would be economically feasible and advantageous for purposes of treatment to establish and fund a system of group homes for caring for foster children and handicapped children now being sent out of state. The Department is directed to submit its report and any appropriate legislation to the nineteen hundred seventy-seven session of the Virginia General Assembly.

A BILL to amend the Code of Virginia by adding in Title 2.1 a chapter numbered 26, containing sections numbered 2.1-377 through 2.1-380; and to repeal §§ 9-112 through 9-115 of the Code of Virginia, the added and repealed sections relating respectively to the creation of a Division for Children, its powers and duties; and the establishment of the Virginia Commission for Children and Youth.

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Title 2.1 a chapter numbered 26, containing sections numbered 2.1-377 through 2.1-380 as follows:

Chapter 26.

Division for Children.

§ 2.1-377. Division for Children created; policy board established.—There is hereby created a Division for Children in the office of the Governor. The Governor shall appoint a director of the Division who shall hold his position at the pleasure of the Governor and shall be paid such compensation as the Governor may fix. The Governor shall also appoint fifteen citizens to a Board for the Division for Children as follows: of the members first appointed, three shall be appointed for a term of one year, four for a term of two years, four for a term of three years and four for a term of four years; subsequent appointments shall be for terms of four years each except for the unexpired terms. No member shall be eligible to serve more than two successive four-year terms. Six of the members appointed to the Board shall be as follows: an attorney at law, educator, pediatrician, parent of a child under eighteen years of age, member of the House of Delegates and member of the Senate of Virginia. Members of the Board shall receive no compensation for their services but shall be paid their necessary expenses incurred in the discharge of their duties. It shall be the duty of the Board to assist the Division for Children in policy-making decisions and to serve as an advocate for children on a statewide basis.

§ 2.1-378. General powers of the Division.—The Division shall have the following general powers:

A. To employ staff as may be necessary to enable the Division to carry out the purposes of this chapter.

B. To make and enter into all contracts and agreements necessary or incidental to the performance of its duties and the execution of its powers under this chapter, including, but not limited to, contracts with the United States, other states, agencies and governmental subdivisions of Virginia.

C. To accept grants from the United States government and agencies and instrumentalities thereof and any other source. To these ends, the Division shall have the power to comply with such conditions and execute such agreements as may be necessary, convenient or desirable.

§ 2.1-379. Powers and duties of the Division.—In carrying out all of its powers and duties, the Division for Children shall be responsible for promoting and advocating the best interests of all children. The Division shall have the following powers and duties:

A. To develop a program to inform the public of opportunities available for children to fulfill their needs and solve certain problems through existing State and local services and to make available such other information as would be of value to professionals and other citizens working in the juvenile field.

B. To provide technical assistance in the field through personnel and resource material in order to support efforts to initiate or improve programs and services for children.

C. To establish a computerized data bank containing statistics on the programs serving children, including, but not limited to, the costs of the programs and the number of people served.

D. To make appropriate recommendations for legislative changes to the Governor and General Assembly and to follow and evaluate federal legislation having a potential impact upon the children of the Commonwealth.

E. To review the proposed budgets of State agencies delivering services to children and make recommendations to the Governor concerning those items which effect children.

F. To evaluate State and local programs which deliver services to children to determine their effectiveness and to make recommendations to the appropriate government officials concerning the future financial support and continuation of such programs and the establishment of new ones.

G. To monitor the programs delivering services to children to ensure that services promised or mandated are delivered.

§ 2.1-380. Cooperation of other agencies.—To effectuate the purposes of this chapter, the Director may request from any department, division, board, bureau, commission or other agency and the same shall provide such information, assistance and cooperation as will enable the Director properly to exercise his powers and perform his duties hereunder.

2. That §§ 9-112 through 9-115 of the Code of Virginia are repealed.

Appendix B

Summary of Programs for Young Children

Although the birth rate, and consequently the number of small children, is decreasing, there are still about a half million children under age eight in Virginia. Over 15% of these live in families having incomes defined as under the poverty level. As will be shown throughout this summary report, the scope of the needs of these children is not fully known, but for the most part, the agencies have found more demand for the services they offer than they can meet.

This summary does not completely cover all the programs which affect young children in Virginia. Such a report would require much more time than it has been possible to devote to this study. What this portion of the report contains is a brief description of the major programs and how many children they serve and the relevant needs of those children. For convenience, the programs and needs are discussed in the context of their administering agencies.

WELFARE

The Department of Welfare administers the traditional child welfare programs in which it provides services in the areas of foster care, day care, adoption, and protection. In addition, there are financial assistance programs to eligible families and other family-related services, which benefit the child.

Probably the biggest service program is that of foster care. In June, 1975, there were 12,353 children receiving foster care, of which 9,281 were receiving financial assistance.[1] There are two types of funding mechanisms for foster care programs. Regular foster care financing is shared equally by the State and local governments. The Aid to Dependent Children—Foster Care program serves children of ADC-eligible parents and receives approximately sixty percent funding from the federal government. In June, 1975, payments from the regular fund amounted to $851,438 and those from ADC-FC, $486,304, for a monthly total of $1,337,742.[2] For the year ending June 30, 1975, the State disbursed about $11,270,000 in foster care payments.[3] These totals include those children in institutions, already discussed in the body of the report. However, these figures do not represent the total expenditures for foster care. Not included are expenses for medical care, salaries of foster care social workers, and other administrative expenses. Officials in the Department of Welfare estimate that the entire program costs about $19 million a year.

In its efforts to understand the foster care situation better, the Committee was substantially aided by the Adoption Development Outreach Planning Team (ADOPT). This organization, composed of foster care and adoption workers and supervisors had developed a questionnaire, which the Committee distributed to foster care workers. (In addition to preparing the questionnaire, this group aided the Committee in analyzing the returns and providing insight

on foster care problems.) The questions were directed mainly to the status of foster children—the extent to which there had been efforts to make permanent dispositions of their cases.

The questionnaire, with the cumulative totals, is at the end of this summary report. It represents 10,432 children who were on the foster care caseload with local welfare departments as of May 31, 1975. Since the Department of Welfare reported a caseload of 12,353 in June, 1975, this data represents over 80% of the approximate caseload—a very good return for a questionnaire.

Because of time and expense limitations, the survey was not designed to collect data on individual children, but on the aggregate caseload of each caseworker. Thus, unfortunately, no statistical correlations can be made. Nevertheless, the aggregate data can shed significant light on the nature of foster care in Virginia. The children are relatively old—70% are nine years old or more. The parents retain legal rights with more than 80% of them, although social workers feel that 70% of this latter group will probably not return to their parents. Finally, sixty percent of those in foster care with parental rights intact have been in foster care for two years or more, over a third of them having been in foster care for at least five years. Futhermore, of those who will probably not return home, almost half have no contact with their natural parents and more than half have had more than one foster care placement. The "average" foster child, then, is an adolescent who has been in foster care in more than one home for several years, will probably not return to his parents and has had little or no contact with his parents in over a year. Despite this situation, the natural parents still retain their legal rights to him.

Astonishingly, caseworkers reported attempts to free for adoption only a meager 4.6% of those children in their custody without adoptive rights! (This and subsequent analyses must be viewed with considerable caution, since there are strong indications in the returns that many caseworkers misinterpreted the questions. Therefore the answers are suspect.) The most frequent reason given for failure in the attempts that were made was the parents' unwillingness, even though they had shown little interest in the children or could not take care of them, to give up their rights and their successful fighting of court proceedings aimed at termination of those rights. The next most frequently given reason was the inability to locate the parents.

According to the questionnaire, the agencies have not attempted to free for adoption the bulk of the foster care children for many reasons. There were some for whom adoption was not a possibility, some who were close to parents or foster parents, and some who simply did not want to be adopted. No attempt was made for a large number of the remainder because the agencies felt that they would fail. The largest group in this latter category consisted of those whom social workers had felt the court would be unwilling to free because of previous parental contact. This contact could have consisted of anything from regular visits to a single Christmas or birthday card. There was also a large number of parents unable or unwilling to assume custody, but nevertheless blocking termination

proceedings. And there are over two hundred children whose parents cannot be located.

In the entire area of child welfare services, the Department of Welfare rendered aid to a total of 36,787 children in 1973-74 and at the end of June, 1975, there were 23,059 children under the care of the Department. The number of children involved in some of the other services in the same month were: adoption placement, 619; adoption study or supervision, 2,692; and protective services, 6,551.[4] It should be pointed out that "children" in this context includes all persons under twenty-one years of age.

As for financial assistance to low-income families, there were 57,091 families with 126,002 children participating in the Aid to Dependent Children program in June, 1975. For that month, they received a total of $10,706,365, or an average of $187.53 per family.[5] About forty percent of this was State funds.

Another area in which the Department participates is that of day care, in which it is charged with promulgating regulations concerning the operation of day care centers and homes as defined by State law and with licensing and inspecting those facilities. Although the full extent of it is not accurately known, there is a definite need in Virginia for more child care facilities. A report in 1971 on the statewide need for child care estimated that there were about 112,000 to 137,000 children under five years old whose mothers were in the work force.[6] The census data tends to confirm this estimate. In 1970, there were 74,625 husband-wife families in Virginia which had children under six years old and of which both parents were in the labor force.[7] When one considers that many of these families had more than one child under six and then adds the large number of children under six who are in families with only one parent, the total easily surpasses 100,000.

To meet the need of those children whose parents are in the work force, there were, as of March 31, 1975, 32,433 spaces for children in licensed child care centers and homes throughout the State, mostly in centers.[8] Clearly, these centers do not even approximate meeting the need shown by the figures just presented. It is also clear that since these parents are working, the children are being taken care of. How? Tables 1 and 2 on the next page indicate the probable answer.

Table 1

CARE ARRANGEMENTS FOR CHILDREN OF WORKING MOTHERS, UNITED STATES

Arrangement	Percent 1965	1970
In home	47	50
In another home	30	34.5
Group care	5	10.5
Other	18	5

Sources: Derived from: Seth Low and Pearl G. Spindler, Child Care Arrangements of Working Mothers in the United States . Washington: Government Printing Office, 1968. Children's Bureau Publication 461-1968; and Westinghouse Learning Corporation - Westat Research, Inc., Day Care Survey, 1970: Summary Report and Basic Analysis , Washington, 1971.

Table 2

DISTRIBUTION OF CHILD CARE ARRANGEMENTS OF EMPLOYED PARENTS FOR CHILDREN AGES 0-5 FAIRFAX COUNTY, 1975

Arrangement	Number of Children	Percent Distribution
Center or nursery school	4400	28
In-home care	1600	10
Sitter's home	9900	62

Source: Report of the Child Care Advisory Council to the Fairfax County Board of Supervisors, April 21, 1975 , p. 18.

The majority of the children are cared for in facilities other than day care centers. However, these figures also demonstrate that in the past ten years, the use of group centers has grown more than any other arrangement. Although there has been no recent comprehensive national survey of child care arrangements, there are other indications that center care is growing in usage.[9]

The need is greater than these figures indicate. The data is for preschoolers only. Children between the ages of six and nine, at least, need care and supervision during non-school hours and vacations when their parents are working. In addition, the above figures relate to children whose parents are in the work force. Undoubtedly, there are many children for whom one parent must stay home because no suitable child care is available, although the family needs the extra income that parent could earn.

In the absence of hard data, one can only speculate, on the basis of separate indicators, on the need for more day care centers, as opposed to other arrangments, to meet the needs of the growing numbers of children whose parents work. A limited survey has shown that parents are more likely to be dissatisfied with sitter care arrangements than with center care and would choose centers if they were able.[10] A study of day care in Richmond showed that centers had waiting lists containing over 200 children.[11] Finally, with the growing realization by parents that the preschool years are crucial in the development of the child, licensed centers with a staff with at least minimal training will be more in demand as a means of insuring that children are left in a healthy environment. Put together, all these factors demonstrate the need for more day care centers now and in the future.

In addition to licensing and inspecting centers, the Department contracts with private operators for the provision of day care to children of ADC families and to other child welfare cases. There were 16,893 children receiving this service in September, 1975 at a cost of $760,622, of which about eighty percent was federal funds.[12]

The Department is also responsible for training the providers in these federally funded programs. This training is to be in "general program goals as well as specific program areas; i.e. nutrition, health, child growth and development, including the meaning of supplementary care to the child, educational guidance and remedial techniques, and the relation of the community to the child."[13] Persons in the department say that this requirement is one of the least enforced. At least one local agency, Roanoke City, conducts what seems to be a good training program, although the State department has no idea of the extent or quality of the training, if any, being done in the rest of the State.

The last session of Congress amended the basic welfare law, the Social Security Act, by adding Title XX, which will have a significant impact on the delivery of social services in the states. This new title gives more latitude to the states in determining what services will be offered and who shall be eligible to receive them. In the past, HEW administrative regulations were fairly restrictive in what they allowed to be offered as services and in the definition of

those services. The new law establishes only certain goals which are to be met by states participating in the program, allowing the states to decide what specific services to render in an effort to achieve those goals. Also, only fifty percent of the federal funds have to be spent on category-related recipients, such as ADC, SSI, or Medicaid recipients. The rest of the money can be used to provide services to those who are in need, but who do not fall into any of the categories. Previously, these latter persons were ineligible for most services. Since the new provisions only became effective October 1, 1975, it is still too early to assess their impact.

Another area in which the Department of Welfare serves children is that of protective services. At its 1975 session, the General Assembly enacted legislation requiring all cases of suspected abuse and neglect to be reported to the local welfare department. The department, in turn, would be responsible for investigating the complaint, rendering rehabilitative services in cases of valid complaints, and taking the child into custody where necessary. In addition, the State Department of Welfare was directed to establish a central registry of all reports of child abuse.[14]

During its first ten days of operation, the Bureau of Child Protective Servies in the State Department of Welfare received more reports of suspected child abuse than were reported to the State Health Department during the six months previous to the Bureau's becoming operational on July 1, 1975. As of September 9, 1975, there had been 2,885 written reports filed with the central registry, of which more than 72 percent could be considered valid after further investigation.[15]

The Department also administers a food stamp program which benefits children. This and other food programs are described in more detail later.

EDUCATION

The Department of Education, in addition to the regular public schools for those six and over, supervises two programs for young children—kindergarten and special education. The kindergarten program is mandated in the Standards of Quality developed by the Board of Education and approved by the General Assembly. The Standards declare, "Each school division shall provide kindergarten education for all eligible children whose parents wish them enrolled or be prepared to offer this program by September, 1976." Of a total of 139 divisions, 111 provided kindergarten programs to all eligible children in the 1974-75 school year and as of September, 1975, one hundred twenty-two divisions had kindergarten for all children.[16] During the 1974-75 school year, there were 64,628 children in kindergarten at some point in the year.[17]

The schools provide special education classes, or tuition grants, to those children needing them. The department also has a mandate to educate and train preschool handicapped children. This program, already discussed in the previous section of this report, will fully go into effect in September, 1976. In 1974-75, there were 1,067 preschool children enrolled in special education programs. There

were 19,835 children aged ten and under (291 under five) referred to school psychologists for evaluation and assessment and 23,436 children aged ten and under (837 under five) referred to a visiting teacher/school social worker for sociological assessment and evaluation.[18]

In addition to the services provided for the visually handicapped by the Department of Education, the Virginia Commission for the Visually Handicapped is charged with providing a program "designed to meet the educational needs of visually impaired children between the ages of birth and twenty-one...."[19] According to testimony to the Committee by a representative of the Commission, it has established ten education specialist and four orientation and mobility positions to provide services to preschool children. These personnel work with each child who has a visual handicap. In addition, ten school divisions operate itinerant teacher of the visually handicapped programs.

HEALTH

The Department of Health is in the position of being able to have the most influence over the well-being of a great many young children in the State. It delivers direct medical services to children of indigent families through a system of general and specialized clinics and through the administration of the Medical Assistance Program (Medicaid). It also makes an effort to aid in general child development.

In addition to "ordinary" health needs, a child has certain developmental needs. These are related to the need for stimulatiom, security, human contact, language development, and general cognitive development, among others. Although this would seem to be the area of educators and indeed is included in the curricula of schools of education, the most important time of a child's development occurs in the early years, before it is old enough to enter the public school system. Virginia's schools have limited programs for children below five and those that do exist are for handicapped children. The Department of Health has stepped into this vacuum and provided, through public health nurses, the services in child development that do exist. Dr. Mack Shanholtz, Commissioner of Health, has noted, "All child health clinics are provided with procedures and are offered personnel training for growth and development screening and in infant stimulation guidance for parents."[20]

As for the directly medical aspects of the Department's activities, the local departments operate clinics which provide services to indigent mothers and children. Although this service is available statewide, there has been, in the past, some degree of inconsistency because local health departments were generally free to establish their own priorities and programs. However, the State department has recently adopted a management by objectives approach whereby all local health departments must develop their objectives and programs in coordination with the objectives established at the State level. High on the list of objectives set by the State department for 1976-78 is an expansion over the 1974-75 totals in number of children seen in the programs for child health

supervision.[21] Table 3 shows the services received by children from the local health departments in fiscal year 1974.

Table 3

CLINIC SERVICES: MATERNAL-CHILD HEALTH, FY '74*

Program	Clinic Visits	Patients Served
Crippled Children	40,954	22,977
Maternal-Child Health	360,647	
Maternity Services	65,181	10,677
Family Planning	102,311	70,000 (est.)
Child Health	124,143	40,937**
**Immunization and other	69,012	
Dental Services	185,489	

*Data from 1973 Statistical Annual Report, Virginia State Health Department.

**Includes 11,153 children under age one (16% of the State's newborns).

***Total persons immunized in FY '74, all programs: 182,466.

The budget for the Bureaus of Maternal and Child Health for fiscal year 1975 was $5,863,163; $4.5 million of that was federal funds authorized by Title V of the Social Security Act. The money was allocated in the following manner: $1.7 million for the components of the Program of Projects, to be described later; $2.6 million for the child development clinics and administration; and $1.5 million for a Maternal and Child Health hospitalization program.[22] This latter program "provides inpatient care for medically indigent women who have complications during pregnancy or during delivery...." It also serves indigent high risk infants.[23]

The Child Development Clinics are the major service program administered at the State level. These clinics diagnose and treat children "suspected of developmental disorder including developmental delay and specific developmental discrepancies which may result in real or apparent mental retardation, hyperactivity, learning problems, and occasionally a combination of these and other health and social problems."[24] These centers use staffs consisting of pediatricians, social workers, psychologists, and nurses.

Presently, there are twelve clinics in different regions of the State, three of them new in 1975. In 1974-75, the nine existing clinics saw a total of 2,543 children, 1,677 of these being eight and under. About a third of the new patients were seen only one time, the rest coming back for one or more subsequent visits.[25] These figures do not reflect the consultations with those patients who were not admitted.

Currently, there are over 700 children on the waiting lists of

these clinics and, in some, there is as much as a year's delay between the time of a child's application and his or her first appointment.[26] Needless to say, an untreated developmentally disabled child can suffer considerable damage in a year. The Department estimates that there are 7,000 children born each year in Virginia with developmental disabilities. Within three years, it hopes to be able to handle annually that large a caseload. That means they may be able to keep from falling further behind but will not be able to catch up on the backlog of untreated cases.

The other clinics administered by the State department are those included in the "Program of Projects." These projects are meant to offer specialized services where they are needed and, as of July 1, 1974, had to be included in every State child and maternal health plan in order to qualify for Title V funds. The types mandated are mother and infant care, children and youth, and dental care.

Women in low-income brackets, who ordinarily receive little or no prenatal care, have a high incidence of complications during pregnancy and deliver prematurely much more frequently than the average woman. Their babies are much more susceptible to brain damage, mental retardation and a host of other handicapping conditions. The major object of the maternal and infant care project is to find those high risk patients early in pregnancy and provide them with comprehensive medical services.[27]

The Maternal and Infant Project established a center in Richmond, which had a budget of $543,500 in fiscal year 1975. The center treated about 1,100 women and 1,300 infants in fiscal year 1974, and while it would be unrealistic to assign full credit to the center, the city's formerly high infant mortality and fetal death rates have decreased significantly in recent years. For example, six years after the project was implemented, the city's infant mortality rate had declined about 40 percent and was below that for the State as a whole, a reversal of the earlier situation. Under the same auspices as the Maternal and Infant Project is the department's Intensive Infant Care Program, discussed in the main body of this report.

There are two Children and Youth Projects in the State—Norfolk and Charlottesville. They are designed to "provide comprehensive health services for children in low-income families" and include the following services: daily clinics providing screening, diagnosis, and treatment; nursing and follow-up; payment of hospitalization; complete dental care for all project patients; nutrition education, evaluation and consultation; special clinics such as speech, eye, etc.; and transportation for all patients needing it. Each project also has developmental testing with stimulation programs for those who exhibit developmental delay/discrepancy, family planning classes, and prenatal classes.[28] Nationwide experience with these projects has revealed that there is a real need for health care among these children. Screening examinations have shown that a significant number of children from low-income families suffer from chronic illnesses, dangerously low hemoglobin levels, excessive amounts of lead in their blood, learning disorders, emotional disturbances, and neurologic handicaps.[29] They need the comprehensive services of a Children and Youth Project.

Obviously, such comprehensive services are expensive. The project in Charlottesville has a current budget of $750,000 and the one in Norfolk, $665,300. However, these projects do not reach the entire target population in even those areas, to say nothing of the children in other regions. In April, 1975, the Charlottesville project had 2,898 children registered for comprehensive services, about 35 percent of the 7,863 who were eligible. In the much larger area of Norfolk, 4,800 children were registered out of an eligible population of 34,576. Also, both projects provided screening and consultation services to non-project children.[30]

The third phase of the program of projects required by Title V is a dental program for school or preschool children. Dental problems show up regularly in every type of screening program. The Health Department has reported that by the age of two, half of all children have some decayed teeth and by age fifteen, the average child has eleven teeth decayed, missing or filled. Not only do these children have dental needs, but a large percentage of them do not see a dentist. The Department estimates that only one-third of the children from families with incomes below $5,000 and only 40 percent of those from higher income families have seen a dentist.[31]

The plan foresees that dental projects will be somewhat mobile, going into an area, performing necessary restorations, extractions, etc., and leaving the patients in need of only routine examinations. When all those eligible have been treated, the project would move to another area. However, in practice, the one Dental Project for Children has remained in one county, namely Greene County. According to present plans, the project will remain there for some time because there are no private dentists in the county, the water in the county is unfluoridated, and fifty percent of the residents of the county are indigent. If the project did not remain in the county, these indigent residents would receive little or no treatment.[32]

The Department operates another clinical program for children through its Bureau of Crippled Children. These clinics are for children who have birth defects or conditions caused by disease, accident or otherwise. The following are the types of clinics and services offered: orthopedic, cerebral palsy, amputee, rheumatic fever, congential cardiac, child neurology, facial deformities, eye surgery, defective hearing, pediatric surgery, pediatric urology, pediatric neurosurgery, plastic surgery, burn surgery, cystic fibrosis, pediatric neurosurgery, plastic surgery, burn surgery, cystic fibrosis, rheumatoid arthritis, and hemophilia. In fiscal year 1974, there were 22,977 children who received services from one or more of these programs. In fiscal year 1975, the bureau's budget was $3,611,141.[33]

In addition to the various clinics, the Health Department administers Medicaid, which pays certain medical expenses of eligible individuals and their families. As of September 1, 1975, there were 151,675 persons under 21 eligible for Medicaid benefits. Although the members of this group constituted 51% of the entire eligible population, payments to medical providers in their behalf for 1974-75 ($ 22,788,436) amounted to only 18% of total Medicaid payments that year.[34]

One aspect of Medicaid which has enormous potential is the requirement that early and periodic screening, diagnosis and treatment be made available to all eligible persons under the age of twenty-one.[35] This requirement provides fresh impetus for providing routine checkups for present and potential medical problems to children of low-income families who would not ordinarily get them. The findings of this program have been significant—a large number of children screened have been found to need medical care. In a national study of several states, including Virginia, conducted soon after the program began, 77% of a sample of 1,350 children screened had medical problems of some degree.[36] In Virginia, 30% of those screened in 1974 were deemed to have problems serious enough to warrant further treatment or follow-up.[37]

The program has encountered some problems, chiefly administrative ones resulting from a lack of coordination with other agencies in the implementation of a new program. The problems were mentioned in the body of this report and there are indications that the agencies are aware of them and taking corrective steps.

One potential health problem that the Department is at somewhat of a loss as to how to solve is the low immunization rate among young children. It surveyed a sample of the two-year olds in the State in November, 1974, and found that only 52% of them had been immunized against all the serious childhood diseases. The diseases and their individual immunization rates were: polio (69.1%), DPT (81.3%), measles (80.6%), rubella (71%), and mumps (40.2%). Health officials say that an immunization rate of 85-90% is necessary to prevent epidemics of any of the diseases.[38] The Department has conducted large publicity campaigns and all children can receive immunization at no cost from the public health department. The major obstacles are ignorance on the part of parents as to the possible seriousness of the diseases and a stigma that is associated with the public health departments.

The Department of Health's Bureau of Child Health has a small nutrition staff which furnishes limited training and consultation to other agencies concerned with child and maternal health and nutrition or works with special cases, such as children suffering from PKU, a metabolism disorder. The only food program administered directly by health departments is the WIC program which provides food to pregnant women and premature infants, but is available in only one jurisdiction in Virginia.

The major programs which provide food are administered through the Departments of Education and Welfare. The United States Department of Health, Education and Welfare has found that the free or low-cost meals provided through the schools to children of low-income families contain a substantial proportion of the total nutrient intake of many of these children.[39] In the school year 1974-75, the subsidies to Virginia for these programs amounted to almost $50 million.[40]

Another food program for young children is the Special Food Service Program for Children which provides grants for food services for school and preschool children in public and nonprofit private institutions, including day care centers caring for children

from low-income families. The responsibility for the administration of this program rests with the State Department of Education. If the State agency does not wish to administer it, as is the case in Virginia, the federal Department of Agriculture assumes responsibility.[41] Virginia was allocated $1,314,494 for use in this program in fiscal year 1975.

The other major program designed to improve the nutrition of families is, of course, the food stamp program administered by the Department of Welfare. With this program, families buy, at a discount, coupons redeemable for food. For the month of June, 1975, 86,388 households (66% of them non-public assistance) bought $10,319,002 worth of coupons for $4,091,729, which represented a subsidy of over $6 million in the food budgets of these families.[42] In testimony before a legislative study committee, the Commissioner of Welfare estimated that the program could be increased by 40% if all those eligible participated.[43]

The food programs are an example of the preventive services for which the Department of Health stresses the need. A connection between malnutrition and learning has been well established. Of course, it is very difficult to determine the extent and severity of malnutrition in this country, or to separate the effects of malnutrition from other influences. However, it is resaonable to say that hungry children have learning and behavior problems, such as apathy and a short attention span, that prohibit them from acquiring the experiential base necessary in learning.[44]

And there are hungry children. Despite the difficulties, the federal government has attempted to determine to some extent the nature of malnutrition in this country. In a survey of several states conducted by HEW, officials found a higher-than-expected incidence of conditions associated with malnutrition. They found, for example, that one-third of the children under six years old tested had low blood hemoglobin levels which could indicate anemia or iron deficiency.[45] On a less scientific, but no less credible, level, day care center operators told the Committee about the obviously hungry children they care for.

This idea of preventive care and medicine is highly relevant to the consideration of the needs of young children, as so many of the medical and related psychological and social problems from which people suffer can be prevented in childhood. In the case of high risk infants, discussed earlier, if present knowledge and methods now available were applied to their care in intensive care nurseries, the incidence of handicapping conditions could be reduced from 50% to 10% of the survivors. Since institutionalization is the usual future of these chidren and the cost of institutionalizing just one such infant for the duration of its life is about a quarter of a million dollars, an investment in early preventive measures can be justified in monetary terms to say nothing of the human considerations involved.[46] Health Department officials have pointed out that "two-thirds of chronically handicapping conditions of disabled adults were preventable by care in the first fifteen years of life, 20-30% in the first five years."[47] Up to 80% of one kind of adult visual problem, amblyopia, could have been prevented or reduced and 50-85% of adult hearing impairment

could have been prevented.[48]

Put into monetary terms, it is apparent that the State could, in the long run, easily save money by investing in programs which detect and treat problems early in life. If one assumes that 60% of those receiving disability benefits have problems that could have been prevented (that is the national average), in fiscal year 1970 alone, Virginia spent $33,293,169 "for support and care of chronically disabled persons whose conditions were preventable or correctable in childhood from birth to fifteen years."[49]

The Department of Health provides a large amount of services to the children of this State. There is available to every child at least a minimum of health care, although more comprehensive health and developmental services are provided only on a limited basis. Federal law would seem to have at least the intent that these latter services be provided statewide. The law provides that, "...no payment shall be made to any state..., unless the state makes a satisfactory showing that it is extending the provision of services..., to which such state's plan applies in the state with a view to making such services available by July 1, 1975, to children and mothers in all parts of the State."[50] The various components of the program of projects—the children and youth projects, the maternal and infant projects, etc.—are required to be a part of the plan, but obviously were not available to all children and mothers of the State by July, 1975. Dr. Shanholtz explains, "The Maternal and Child care services provided by the Health Department through its local and regional programs are now available statewide. This is not to say that the current programs meet the total need for care as is being met in the special projects.... We are in compliance with federal requirements as they have been written. However, to provide comprehensive medical services for women and children statewide as intended by the federal legislation for the Program of Projects would be impossible without a substantial increase in funds. Neither the federal government or our State legislature are likely to appropriate funds of the necessary magnitude."[51]

MENTAL HEALTH

The Department of Mental Health and Mental Retardation provides services to mentally ill and emotionally disturbed children through three services: inpatient care at the State mental health institutions, outpatient care in State-operated clinics, and outpatient care in clinics operated by the Department and Community Mental Health and Mental Retardation Services Boards (Chapter 10 Boards). Currently, these public facilities serve an average of 2,626 children and youth in any one month. (About 120 of these are five years old and below and almost 1,250 are twelve years old or less.)[52]

Out of a total budget of $114 million, the Department spends about $3.9 million on mental health services to children and youth.[53] The Department estimates that there are about 60,000 persons below the age of eighteen in Virginia who are in serious need of psychiatric help and that about 150,000 more need some degree of psychotherapeutic help. But only about 3,747, about 6.2% of those in need, are being helped at any one time and this is costing nearly $13 million.[54] (These figures include categories of children and funds which were included in other sections of

this appendix—foster care, special education, etc.)

The Department also operates institutions for the retarded. Dr. William Allerton, Commissioner of the Department, reported to the Committee that, as of June 1, 1974, there were 1,678 children below the age of twenty-one in the training schools for the retarded, 85 of them aged 1-5. For the fiscal year 1973, the Department's expenditures for preschoolers was $236,885 for Lynchburg Training School and $370,460 for Petersburg Training School.[55] In its public hearings, the Committee heard testimony from many local welfare officials that these training schools had such long waiting lists that they had been told there was no hope of getting retarded children in their custody admitted for several years.

OTHER

There is another program for children that should be mentioned, although it is not administered by any department of the State. This is the child development project of the Appalachian Regional Commission operating in several counties in Southwest Virginia. There are several programs dealing chiefly with handicapped children and high-risk children. Because the children have substantial needs and the services are very comprehensive and individualized, the program is expensive. For the 1974 fiscal year, it spent a total of $1,360,494—the bulk of which was federal ARC funds, but which also included local in-kind funding.[56]

CONCLUSIONS

After more than a year of researching the programs, the Committee is forced to conclude that, although a lot is being done, there is much that needs doing. The main difficulty is that there is a lack of services in every field. However, there is a shortage of funds with which to provide the necessary level of services, and there will probably always be a shortage. Therefore, the efforts that can be made have to be planned and coordinated in order to give the most comprehensive program of services possible to the greatest number of those most needing them.

There are some projects and proposals which seek to offer comprehensive services to children in need, but these programs are too few in number and serve too few children to be of much effect on a large scale. There has to be first an exhaustive study made of the unmet needs, planning based on these findings and the limited resources available, and then cooperative implementation of these plans by all concerned with the welfare of children. Until that happens, there will continue to be a scattering of good programs operating on a limited scale in, at best, semi-isolation from each other, and the needs of many young children will go unmet, to the ultimate detriment of Virginia.

FOSTER CARE SURVEY

The questionnaire was distributed to all caseworkers in the state having foster children among their caseload. The figures represent the caseload as of May 31, 1975.

1. How many children are currently on your foster care caseload?.....10,432

A. Race
- Black.....4,848
- White.....5,470
- Black/White.....121
- Other.....74

B. Sex
- Male.....5,604
- Female.....4,777

C. Age
- Infants (0 through 1 yr.).....576
- Pre-school (2 yrs. through 4 yrs.).....977
- School age
  - (5 yrs. through 8 yrs.).....1,569
  - (9 yrs. through 12 yrs.).....2,393
  - (13 yrs. or older).....4,888

D. Type of custody
- Court--without adoptive rights.....7,978
- Entrustment--without adoptive rights.....654
- Court--with adoptive rights (all parental rights terminated).....1,598
- Entrustment--with adoptive rights (all parental rights terminated).....257

E. Handicaps
- No handicap.....5,972
- Correctible physical handicap.....224
- Non-correctible physical handicap.....172
- Learning problems (disability, slowness, etc.).....1,488
- Mental retardation (I.Q. below 70).....610
- Emotional or behavioral problems that require treatment.....1,249
- Multiple handicaps.....646

F. Family Groups (Siblings in FC now)
- Sets of 2 siblings.....1,195
- Sets of 3 siblings.....587
- Sets of 4 siblings.....326
- Sets of 5 siblings.....172
- Sets of 6 siblings or more.....133

2. Of the children who have been committed or entrusted to your custody without adoptive rights, how many have

- Been in foster care less than 6 months◆....1,087
- Been in foster care 6 months to 1 year◆....1,155

Been in foster care 1 year to 2 years◆.....1,307
Been in foster care 2 years to 5 years◆....2,182
Been in foster care 5 years or more◆.....3,077

3. Referring to Question #2, of the children who are in your custody without adoptive rights, how many will

Probably return to their parents at some time in the future◆.....2,538
Probably not return to their own parents before emancipated◆.....6,010

4. Referring to Question #3, of the children who will probably not return to their parents, how many have

Had regular contacts (personal visits, letter, phone) with either biological parent in the last year◆.....1,783
Had at least one contact (personal visits, letter, phone) with either biological parent in the last year◆.....1,896
Had no contacts whatsoever (visit, letter, phone) with either biological parent in the last year◆.....2,891
Received financial support (excluding VA, social security benefits, etc.) from their parents on a regular basis◆.....739
Received financial suport from their parents on an occasional basis◆.....684
Received no financial support from their parents◆.....5,040
Had only one foster care placement◆.....3,221
Had 2 or 3 foster care placements◆.....2,539
Had 4 or more foster care placements◆.....977

5. How many children in your caseload, who are now in your custody without adoptive rights, has the agency attempted to get adoptive rights for in the past?....410

Give below the number for whom you failed due to: (More than one reason may apply in some cases.)

Court unwilling to terminate parental rights because of contact within previous year.....48
Court unwilling to terminate parental rights because of contact at some time prior to the previous year.....26
Court unwilling to terminate parental rights because of financial support payment.....5
Court unwilling to terminate rights of an incarcerated parent.....7
Court unwilling to terminate rights of a parent in a mental institution.....4
Agency or court unable to locate parent.....112
Parent(s), who had not had recent contact, renewing interest and blocking adoptive plans when court proceedings were initiated.....75

Parent(s) blocking agency's attempt to get adoptive rights through the use of legal representation, although unable to demonstrate an ability to provide for the child.....70
Agency unable to secure adequate legal representation.....38
Roadblocks in legal or investigative procedures.....84
Other (please specify).....186

6. How many children in your caseload has the agency not attempted to free for adoption, anticipating failure due to one of the reasons listed below?.....2,596

Give below the number for whom you anticipate failure to obtain adoptive rights due to: (More than one reason may apply in some cases.

Court unwilling to terminate parental rights because of contact within previous year.....2,152

Court unwilling to terminate parental rights because of contact at some time prior to previous year.....690
Court unwilling to terminate parental rights because of financial support payment.....63
Court unwilling to terminate rights of an incarcerated parent.....53
Court unwilling to terminate rights of a parent in a mental institution.....75
Agency or court unable to locate parents.....229
Parent(s), who had not had recent contact, renewing interest and blocking adoptive plans when court proceedings were initiated.....203
Parent(s) blocking agency's attempt to get adoptive rights through the use of legal representation, although unable to demonstrate an ability to provide for the child.....229
Agency unable to secure adequate legal representation.....55
Roadblocks in legal or investigative procedures.....150
Other (please specify).....507

7. How many other children in your caseload has the agency not attempted to free for adoption because (More than one reason may apply in some cases.)

Agency felt no appropriate home could be found due to child's age, race, handicap, or membership in a sibling group.....2,696
Agency lacked staff to handle the case.....213

Agency philosophy does not encourage releasing children for adoption.....78
Social worker reluctant to risk court returning child to suitable parent(s).....177
Social worker reluctant to testify due to lack of confidence and fear of cross-examination.....50
Child has no desire for adoption.....1,035
Child living with relative.....480
Child has close contact with parent(s).....1,422
Child has attachment to foster parents.....1,184
Other (please specify).....364

8. Of the children who have been committed or entrusted to your custody with the right to make an adoptive placement, how many were in agency custody without adoptive rights

0 to 6 months before parental rights were terminated◆.....637
6 months to 1 year before parental rights were terminated◆.....219
1 year to 2 years before parental rights were terminated◆.....290
2 years to 5 years before parental rights were terminated◆.....277
5 years or more before parental rights were terminated◆.....78

9. Of the children who have been committed or entrusted to your custody with the right to make an adoptive placement, how many are

Currently in an adoptive placement◆.....593
In foster care following the breakdown of their initial adoptive placement◆.....112
In foster care following the breakdown of two or more adoptive placements◆.....28
Still in foster care, never having had an adoptive placement
0 to 6 months after parental rights were terminated◆.....81
6 months to 1 year after parental rights were terminated◆.....158
1 year or more after parental rights were terminated◆.....734

10. Referring to Question #9, how many children are still in foster care, never having had an adoptive placement, because

No suitable home can be found due to child's age, race, handicap, or membership in a sibling group◆.....661
Child resists placement◆.....132
Agency lacks staff to work on case◆.....55
Agency prefers not to break up long-term, secure foster placement and foster parents are unwilling to adopt◆.....272
Long-term foster parents feel financially unable to adopt child, but are not eligible for subsidized adoption◆.....99
Other (please specify).....245

11. How many children on your foster care caseload currently reside

In an adoptive home◆.....683
In a foster home◆.....7,776
In a group home◆.....692
In a residential treatment center for emotional or behavioral problems◆.....546
In a residential treatment center for medical problems◆.....54
In a residential treatment center for retarded children◆.....128
In a mental hospital◆.....12
In an independent living arrangement◆.....284
Other (please specify)◆.....295
In Virginia◆.....9,120
Outside Virginia◆.....483

12. Would you favor mandatory review of all foster care and ADC/FC cases every six months for the first year and then annually

By the courts◆
Yes.....194
No.....150
By the agency accountable to a uniform monitoring system◆
Yes.....358
No.....52
Not at all◆.....32

13. Would it be helpful to you and to your court if the legal guidelines regarding psychological abandonment and/or emotional neglect were clarified?

Yes.....62
No.....23

14. What would your feelings be if there were a mandated registration with AREVA/ARENA of all children who are free for adoption who have not been placed with a view toward adoption through the efforts of the local department within 3 months following termination of parental rights?

Positive.....402
Negative.....91

FOOTNOTES

1. Commonwealth of Virginia, Department of Welfare, Public Welfare Statistics, June, 1975, pp. 10, 18.

2. Ibid.

3. Information supplied by Betty Lee, Foster Care Consultant, Department of Welfare. The figures include the federal funds expended under ADC-FC, but do not include the local share of regular foster care—about $6 million.

4. Public Welfare Statistics, p. 19.

5. Ibid., p. 1.

6. Commonwealth of Virginia, First Report of the Virginia Commission on the Status of Women (Richmond: Department of Purchases and Supply, 1971), p. 61.

7. United States, Bureau of the Census, 1970 Census of Population - Detailed Characteristics - Virginia, Table 158.

8. Information supplied by Betty Lewis, Virginia Department of Welfare.

9. See Elizabeth Waldman and Robert Whitmore, "Children of Working Mothers, March 1973," Monthly Labor Review, May 1974, pp. 56-57.

10. Report of the Child Care Advisory Council to the Fairfax County Board of Supervisors, April, 21, 1975, pp. 4, 29.

11. John Ciero, Valerie Emerson, et al., "A Study of the Need for Additional Licensed Day Care Facilities in the City of Richmond, Virginia," (unpublished Master's Thesis, School of Social Work, Virginia Commonwealth University, 1972), p. 85.

12. Information supplied by Linda Bayless, Virginia Department of Welfare.

13. 45 CFR 71.17.

14. §§ 63.1-248.1 through 63.1-248.17 of the Code of Virginia.

15. William L. Lukhard, Commissioner of Welfare, to Senator Paul W. Manns, October 9, 1975.

16. Commonwealth of Virginia, Board of Education, Report on Public Education in Virginia, 1974-1975, p. 6.

17. Ibid.

18. Commonwealth of Virginia, Annual Report of the Superintendent of Public Instruction of the Commonwealth of Virginia, School Year 1974-1975 , In press. (Hereafter referred to as Report of the Superintendent .)

19. Code of Virginia, § 22-10.7(b).

20. Dr. Mack I. Shanholtz to Richard W. Hall-Sizemore, staff of Committee, September 17, 1974.

21. See memorandum from Dr. Mack Shanholtz to regional and local health directors, May 20, 1975.

22. Information supplied by Paul Mergler, Administrative Supervisor, Division of Medical and Hospital Services, Virginia Department of Health.

23. Shanholtz to Hall-Sizemore.

24. Ibid.

25. Mental Retardation Clinic Services Report—Submitted by Bureau of Child Health to Department of Health, Education and Welfare for year ending June 30, 1975.

26. Mergler.

27. Commonwealth of Virginia, Department of Health, Virginia State Plan - Title V. Program of Projects (Draft) (Hereinafter referred to as State Plan), p. 14.

28. Ibid. , p. 36-37.

29. Ibid. , p. 33.

30. Dr. Patricia Hunt, Director, Bureau of Child Health, to Richard W. Hall-Sizemore, April 22, 1975.

31. State Plan , pp. 44-45.

32. Ibid. , pp. 45-46.

33. Mergler.

34. Information supplied by officials of the Medical Assistance Program, Virginia Department of Health. Compare this to the group aged 65 and over. They constituted only 17% of the entire eligibles for the year 1973-1974, yet received 39% of the payments. All percentages derived from data furnished by the Department of Health.

35. 42 USCA § 1396d(a)(4)(B).

36. EPSDT Phase II Evaluation and Impact Study , (San Antonio, Texas: Regional Health Services Research Institute, undated), p. 9.

37. Memorandum from Dr. F. C. Hays, Director, Virginia Medical Assistance Program, to Deputy Directors of Local Health Services, local health directors and local welfare directors, August 18, 1975.

38. Donald M. Beagle, Information Officer, Immunization Activities, Virginia Department of Health, to Richard W. Hall-Sizemore, March 19, 1975.

39. United States, DHEW Publication No. (HSM) 72-8134, p. 11.

40. Report of the Superintendent .

41. 7 CFR 225.1.

42. Public Welfare Statistics , p. 23.

43. See minutes for October 24, 1975, meeting of the Virginia Advisory Legislative Council's Committee to Study Public Welfare.

44. Merril S. Read, Malnutrition and Learning (Washington, D. C.: National Institute of Child Health and Human Development, National Institute of Health, 1969).

45. Ibid.

46. State Plan , pp. 26-27.

47. Dr. Patricia Hunt, Director, Bureau of Child Health, to Richard W. Hall-Sizemore, November 7, 1974.

48. "The Cost of Maintenance and Curative Care in Virginia as Compared with Prevention," Paper prepared by the Bureau of Child Health, October, 1973.

49. Ibid.

50. 42 USCA § 706(e).

51. Shanholtz to Hall-Sizemore.

52. "Interim Report—Child Mental Health Study Group," (Virginia Department of Mental Health and Mental Retardation, December 17, 1975), pp. 9-10.

53. Ibid. , p. 21.

54. Ibid. , p. 27.

55. Larkin B. Baggett, Fiscal Administrative Services Director, Department of Mental Health and Mental Retardation, to Richard W. Hall-Sizemore, May 28, 1974.

56. Information supplied by John W. Daniels, Jr., Regional Coordinator, PACE Project, Appalachian Regional Commission.