Richmond's Response to Students at Risk

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Troubled youth referred to the Comprehensive Interagency Diagnostic and Prescriptive Center have a "last chance" to improve their prospects for a successful future.

A June graduation in Richmond, Virginia, provided tangible evidence for several city agencies, the school system, and the staff of the Comprehensive Interagency Diagnostic and Prescriptive Center that their concept produces results. The concept is a cooperative approach to serving troubled youth, which involves the pooling of staff and resources from five contributing agencies to provide comprehensive diagnostic assessments and treatment planning services within a nine-week period. The "evidence" was the triumphant graduation of 19-year-old Everette Wayne Seymore, who was referred to the center three years ago because he was unable to attend regular school.

Everette entered the center in January 1982 after a very bad semester of high school. He already had repeated the 9th grade and was continuing to have academic difficulties. He had been hospitalized twice for a psychotic reaction to drugs— specifically, a marijuana cigarette that contained PCP ("angel dust"). Chronic absences from school, continuing unpredictable hallucinations, and his own personal con-

Photographs by Ben Schultz

fusion seemed to point in the direction of escalating academic failure. Sandra Mitchell, director of the center, recalls, "He was a child at a pivotal point in his life, a child who with a nudge could have gone either way."[1] Fortunately, Everette was the beneficiary of not merely a nudge, but a coordinated effort to shore up the positive forces in his life. The center provided intensive remedial work in language arts and later arranged a transfer to give him a fresh start in a new school. The center's small classes and individualized instruction established strong, supportive relationships, which eventually helped Everette overcome his painful shyness. Everette credits the center with turning his life around. "Those people helped me to see the light. If it wasn't for them, I'd probably still be in the same situation. . . ."[2]

Not all cases handled at the Diagnostic and Prescriptive Center end so positively. Eighteen-year-old William (a pseudonym), who was enrolled the same year as Everette, is now hospitalized for psychiatric problems. The center did, however, correctly identify the seriousness of William's emotional problems, which were rooted in a destructive relationship with his mother and made normal functioning in school impossible. At the time of his referral, he had a history of academic failure, absenteeism, and depression. Previous attempts at special placement and counseling had been thwarted by his mother's refusal to accept services. The collaborative efforts of several agencies, coordinated by the center to implement and monitor treatment, brought about the mother's cooperation. William was placed in a special education program, and later, when psychiatric treatment became necessary, the center was instrumental in arranging the hospitalization, which offers his best hope for adjustment in the future.

Our national concern for the quality of public education focuses essentially on strengthening school curriculums, raising academic standards, and promoting academic achievement. School systems are judged on the basis of their standardized achievement test scores and the percentage of students who go on to higher education. This emphasis, while admirable, may blur the fact that educating children successfully is much more than an academic enterprise. Sociological changes of the past few decades have placed enormous burdens on school systems to foster growth and development that is not strictly cognitive. When successful academic and social development does not occur, the causes of failure are usually complex. Failures inevitably show up in school settings, however, and thus the temptation arises to hold school systems responsible for solutions and to regard the remedies as academic. The magnitude of the problem, though, often goes beyond a school system's capacity to respond by itself.

Responding to Community Needs

The Comprehensive Interagency Diagnostic and Prescriptive Center was created out of a need to coordinate services for high-risk youth. A task force convened by the Youth Services Commission reviewed the fragmented manner in which human service agencies were responding to troubled children. Too often, limited resources were being used to repeat diagnostic procedures for the exclusive use of a single agency. When children and families were being served by several agencies, there was no mechanism for communication among them. In June 1980, after months of discussion and planning by the task force, a new agency was established, which pulled together resources and staff from existing agencies to coordinate services within the community.

This remarkable feat, accomplished through the negotiation of "Memoranda of Understanding" with the various agencies, brought together under one roof social workers employed by the Department of Public Welfare; an occupational therapist and an educational diagnostician from the Department of Mental Health and Mental Retardation; and teachers, aides, and a program director from the Richmond Public School System. A major component at the time the center was established was the Youth Development Program, funded by a federal grant from the Division of Justice and Crime Prevention and supervised by the Youth Services Commission. The center was housed in a partially vacant school building and administered through the school system.

Over the past five years, staff and funding have changed: the grant expired, the staff cutbacks occurred. Having endorsed the concept of interagency cooperation, the Richmond

Turning Lives Around

One student wrote, "Since I have been here, I have been feeling good about myself." He summed up the essence of the struggle and the way success will be won.

Other young people describe the impact of the program in somewhat different terms. "I know this center can change some parts of your life; it gives you room to think, and the teachers give you good advice about things."

Students see the center as a place apart: "The center is something special to me; it is an opportunity that I will never get again if I decide to pass it up." And a place where one can change direction: "The reason why I like the center so much is because the people there really try to understand you. And they go out of their way to help you get somewhere in life."

Everette Seymore put it directly: "I told them [the center staff] I was going to make them proud of me—I was going to graduate."

Some old problems resurfaced in Everette's case, but, supported by his mother, his counselors, and follow-up contacts from the Diagnostic and Prescriptive Center, he reasserted his self-confidence and accomplished his goal.

City Council first allocated funds to ensure the center's survival, added parttime services of a physician and two public health nurses during the fourth year, and recently incorporated the center as a division with the city's Department of Human Development Services.

Through all of these changes, the initial concept of coordination and collaboration has persisted. Today, financially stable and stronger than ever, the Diagnostic and Prescriptive Center is sustained through contributions of staff and resources from Richmond Public Schools, the City Council, the Department of Mental Health and Mental Retardation, the Department of Public Welfare, and the Department of Public Health. The Juvenile and Domestic Relations Court and the Youth Services Commission support the center through representation on its advisory board, and the Capital Area Agency for Aging provides foster grandparents for two of the center's clinical classrooms.

A New Model for Diagnosis and Prescription

The goal of the center is to complete a comprehensive diagnostic evaluation and treatment plan that will serve the needs of all sponsoring agencies. The center gathers information, completes a diagnosis, recommends treatment, and then coordinates and monitors its implementation. Students between the ages of 5 and 17 are served if they have been involved with several agencies; if they have a history of school absences, grade retentions, or chronic unresolved developmental problems; or if there is a need to define serious problems in family-child relationships. The center completes within nine weeks a comprehensive assessment (medical, social, psychological, and educational) of a child's strengths and weaknesses and provides for psychiatric evaluation as well, if needed. Selected outside assessments, such as audiological, neurological, or optometric examinations, may be obtained while students are in fulltime attendance.

Undergirding the center's program is the notion that studying and working with troubled students in a classroom environment will enable evaluation specialists to obtain a realistic view of each child's functioning. Therefore, clinical classrooms are an important component in the center's operation. Teachers are able to use the services of the social workers, psychologist, educational diagnostician, occupational therapist, and physician as on-site consultants to question patterns of behavior. Specialists such as the psychologist or psychiatrist consult with teachers and social workers to validate observations.

Most students served by the center have experienced academic failure and suffer from low self-esteem. A major emphasis of the program, therefore, is building self-confidence and expanding a child's willingness to become engaged academically and behave in socially appropriate ways. While staff members openly accept students, they do not accept negative behavior and seek to assist students with more appropriate responses through a behavioral management system.

When their stay at the center is over, students return to their home schools, and center staff members take responsibility for monitoring treatment. A social worker actively supervises each case, and an educational diagnostician works with regular classroom teachers to interpret and implement instructional recommendations. The average case is monitored from 6 to 12 months, though the center's involvement with some youth may go on for more than a year and may require 20 to 40 follow-up contacts with service agencies and families.

Each year, approximately 165 high-risk students with academic, emotional, behavioral, and family problems are referred to the center. Planning treatment strategies is easiest for elementary-age students. Adjustments in home and school environments produce remarkable improvements in their behavior and academic achievement. However, over half of the referred students are adolescents, functioning on the 6th to the 9th grade levels. For many of them, the center may be a last chance. To drop out of school, to become dependent on drugs and alcohol, to be chronically unemployable, to be incarcerated—such risks are imminently real for these troubled young people, many of whom have been dealt an unfair share of life's advantages. Working with them can be exhausting, frustrating, heart wrenching, but also stimulating, creative, and fulfilling. Solutions are not easy because ultimate success will be determined at some point in the future. But the agencies and staff involved in the center are convinced that their best hope of making a difference in these children's lives lies in coordination of resources and cooperative intervention.□

1. "Graduate Puts Demons Behind Him," *Richmond News Leader*, 18 June 1985, p. 4.

2. Ibid.

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