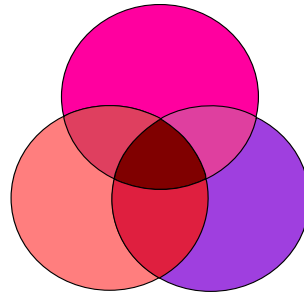


Youth Violence Prevention in Metropolitan Richmond
A Report to



By
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...There are just so many systemic problems out there that enable crime to continue in a cycle...until we begin to put emphasis, along with resources, on developing more partners to address those issues...we're going to keep seeing these vicious cycles that we're not going to arrest our way out of.

~Richmond Police Chief Rodney Moore
(Nolan, June 13, 2006)

 ***Systems trump programs...***

~Patrick McCarthy, Annie E. Casey Foundation, 2002

Executive Summary

Purpose. The Jenkins Foundation is committed to using its resources to assist in meeting community needs. This report was prepared to provide information that can be used by the Foundation to plan action and guide future decision-making related to youth violence prevention.

Methods. The report is based on background research conducted during a five (5) month period—March to July 2006. That research included review of numerous studies and other documents, an Internet search, and interviews in person and by telephone with 70 individuals. These key informants were affiliated with 42 public and private nonprofit organizations. Also, it involved attendance at presentations invited by the Jenkins Foundation Board to provide information in certain areas, including juvenile justice and City of Richmond initiatives.

Overview. The report attempts to describe the context of the youth violence problem in Metropolitan Richmond in 2006. It considers the continuum of services for children and their families from birth to late adolescence, across all major domains of influence. Findings of recent needs assessments at the state, regional and local levels are presented, including information about program resources. Major issues and needs were identified by key informants, some of whom also recommended additional materials or drafted specific suggestions for review.

Major Themes. The report's major themes can be summarized as follows:

- Issues related to youth violence are primarily systems-level
- Planning and evaluation systems are critical components of any solution
- Engagement of all key stakeholders is an essential process
- A full-continuum of multi-contextual services is required
- Interventions that have scientific evidence of effectiveness are available
- Family-focused services are best provided in neighborhoods
- Agency networks and community-based coalitions can multiply resources and impact.

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*The main goal of the future is to stop violence.
The world is addicted to it.*

~Bill Cosby

Defining the Problem

The prevalence of violence is a major gauge of the health of any community, state or nation. In fact, it is one of 10 *leading health indicators* used to measure the nation's progress toward its health-related goals and objectives [Department of Health & Human Services (DHHS), 2006]. For our young people, interpersonal violence is a leading cause of injury and death, with homicide and suicide the second and third leading causes of death among 15-24 year olds. Homicide is *the* leading cause of death for African-American males in that age group [Centers for Disease Control & Prevention (CDC), 2006].

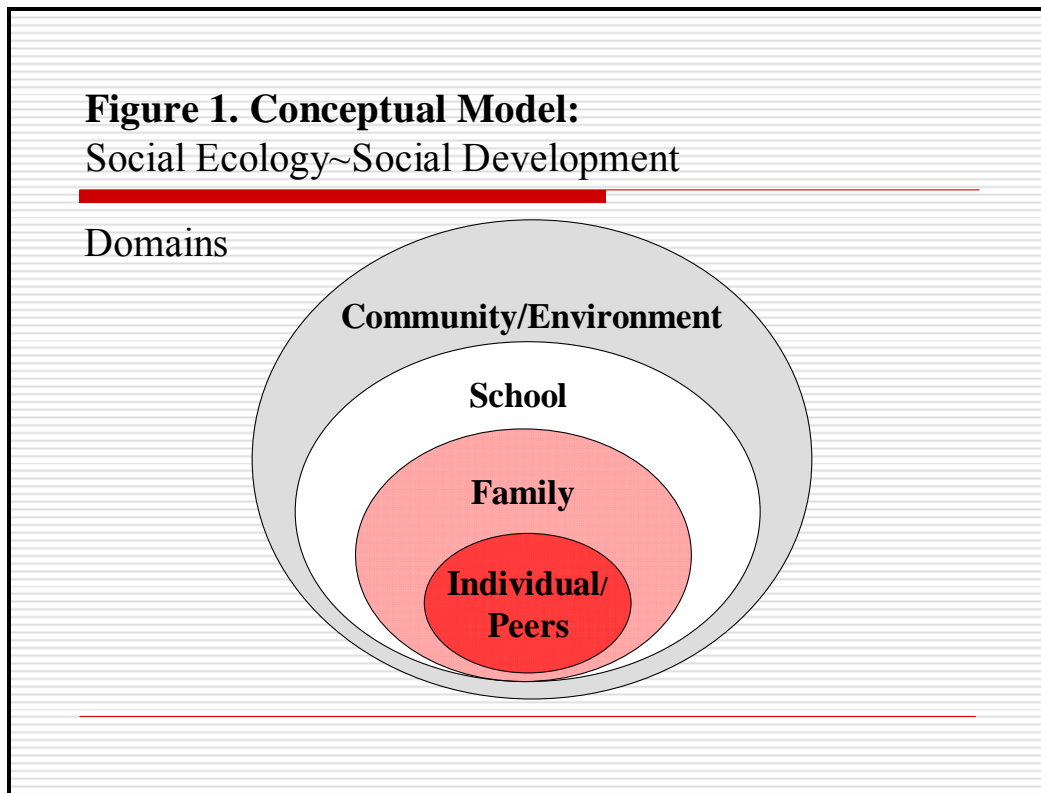
Several key indicators of violent behavior—arrest records, victimization data and hospital emergency room records—have shown downward trends since 1993 (DHHS, 2001). Recent reports, however, are cautionary. Preliminary statistics for 2005 indicate that the rate of violent crime increased for the first time since 2001; and, the overall rate of increase (2.5%) is the largest annual rise since 1991 (Federal Bureau of Investigation, 2006). Locally, the City of Richmond gained the distinction of having Virginia's highest rates of murder, robbery, aggravated assault and forcible rape in 2005 (Blakley, 2006).

While these data are troubling, they are the proverbial *tip of the iceberg*. Violence is much wider spread than crime data indicate. Confidential reports by youth themselves, a fourth key indicator of violence, demonstrate the magnitude of the problem. For every youth arrested in any given year, as many as 10 others may be involved in some form of violent behavior (DHHS, 2001). Additionally, the CDC's *Youth Risk Behavior Surveillance System* reported that 36% of high school students surveyed in 2005 reported that they had been in a physical fight in the past

year (Eaton; Kann; Kinchen; Ross; Hawkins; Harris; Lowry; McManus; Chyen; Shanklin; Lim; Gunbaum & Wechsler, 2006).

Organizing Framework

Before effective programs to prevent youth violence can be developed, an understanding of the factors and circumstances that may be related to violence is needed. There is a growing body of research that considers children’s personal characteristics and how these characteristics interact over time with the social environments in which they live. This conceptual approach integrates theories of child development related to social learning, social control, and ecological (or bioecological) theory, which suggests that behavior is affected by complex social interactions across overlapping systems or spheres (see Figure 1 below). The major domains (or systems) of influence are individual and peers, family, school, and community [National Youth Violence Prevention Resource Center (NYVPR), 2001].



Research has shown that certain conditions in children's environments, as well as their own personality and physiologic traits (constitutional factors), may be **risk factors** for problem behaviors that include violence, substance abuse, delinquency, school drop-out, teen pregnancy, and some mental health disorders [Hawkins, Catalano & Miller, 1992; Social Development Research Group (SDRG), 2006]. Risk factors may be attitudes, beliefs, situations or actions that put someone or some group at risk. While these factors cannot predict whether a particular individual will develop problem behavior, they can assist in predicting which *groups of individuals* will develop problems (DHHS, 2001)

Then what explains why some children with similar risk factors have different experiences and outcomes? Research suggests that this may be explained by certain **protective factors** and processes that buffer the effects of the risk factors, with the potential of reducing problem behaviors. Protective factors (also called *assets*) may be attitudes, beliefs, situations or actions that build *resilience* in individuals, groups, organizations, or communities (Atkinson & Ashton, 2002). Some sources, including the U.S. Surgeon General's *Report on Youth Violence* (DHHS, 2001) call these *proposed* protective factors, because there is less scientific evidence of their effects.

Most experts agree that the number of risk and protective factors to which children are exposed affects their eventual outcomes. That there is a cumulative effect, with more risk factors increasing the likelihood of problems and more protective factors reducing that likelihood (Wasserman, Keenan, Tremblay, Cole, Herrenkohl, Loeber & Petechuk, 2003). This *risk and protective factors framework* is well-known and is endorsed by the federal Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Prevention (CSAP) (See Table 1 for Risk & Protective Factors).

Table 1. Risk & Protective Factors Related to Youth Violence
(Atkinson & Ashton, 2002; DHHS, 2001; NCMHPYVP, 2004; SDRG, 2006)

Domains	Risk Factors*	Possible Protective Factors**
Individual & Peer	Being male Aggressive behavior (males) Early use of tobacco, alcohol or other drugs Early & persistent antisocial behavior Antisocial or delinquent peers Gang membership Weak social ties to conventional peers Certain constitutional factors Favorable attitudes toward the problem behavior Alienation, isolation, lack of social bonding Exposure to media violence	Intolerant attitudes toward deviant behavior High IQ (buffers antisocial behavior) Positive social orientation (buffers antisocial) Social & emotional competence Problem-solving abilities Sense of autonomy, purpose & future Positive relationships with family, other adults Bonding with societal values & institutions Friends who engage in conventional behavior
Family	Antisocial parents Low socioeconomic status Family conflict Family management problems Family history of the problem behavior Favorable parental attitudes toward the problem behavior Separation from parents	Healthy beliefs & clear standards & expectations Positive bonding among family members Emotionally supportive, warm parenting Orderly/structured parent-child relationships Parental involvement in homework & school-related activities
School	Low/lack of commitment to school Academic failure (late elementary school) Inconsistent expectations Lack of emotional or social support for students Violence in school Availability of tobacco, alcohol & drugs Availability of weapons	Commitment to school Clear standards & rules for appropriate behavior High expectations for students Opportunities to participate in after-school activities & other prosocial involvement Recognition/rewards for prosocial involvement
Community	Low neighborhood attachment Community disorganization Limited economic opportunity; economic & social deprivation Availability of tobacco, alcohol & drugs Availability of firearms Community laws & norms favorable toward substance use, firearms & crime Pervasive media violence	High expectations for youth Opportunities for prosocial activities Rewards for prosocial activities Norms & laws unfavorable to substance use Limited access to tobacco, alcohol/other drugs Limited access to firearms

Key: *Not all risk factors are equally predictive; those with greatest predictive ability are in **bold**.
 There is less research evidence in support of protective factors; strongest evidence in **bold.

Developmental Perspective

Certain risk and protective factors are more significant at different stages in a child's development. During childhood, the strongest **risk factors** are *individual or family* attributes or

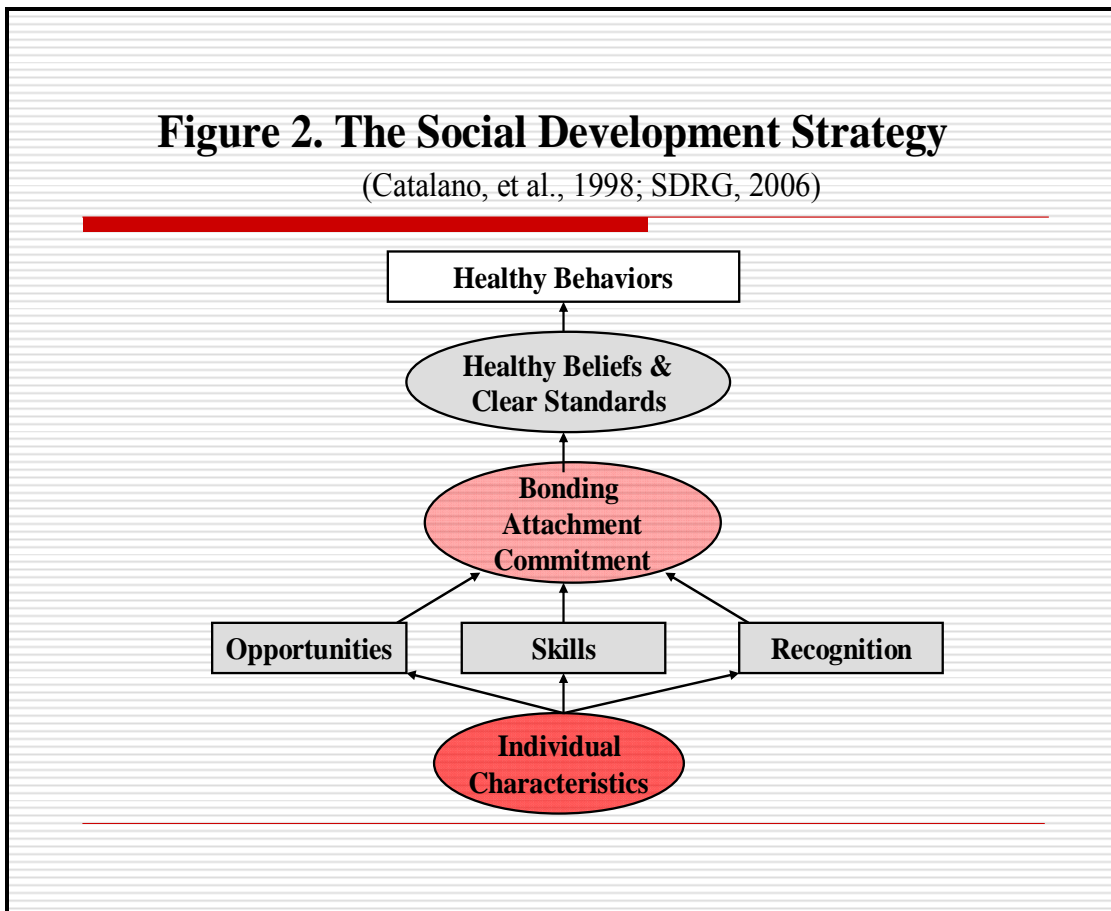
conditions, including being male, serious criminal behavior, substance use, physical aggression, low family socioeconomic status, and antisocial parents. For adolescents, the strongest risk factors are primarily *peer-related*. They include weak ties to conventional peers, ties to antisocial or delinquent peers, belonging to a gang, and involvement in other criminal acts (Atkinson & Ashton, 2002; DHHS, 2001).

The developmental perspective looks at a range of risks over time, from prenatal factors to those that influence the persistence of problem behaviors into adulthood. Two general ages of onset for violent behavior have been identified: (1) *early onset*, before puberty (ages 6-11); and, (2) *late onset*, after puberty (ages 12-14). There are stronger links between childhood factors and persistent involvement in violent behavior for the early-onset group (DHHS, 2001).

Some authorities believe that *early antisocial behavior* in the child may be the best predictor of later problems, with *early aggression* the most significant social behavior in predicting serious problems before age 13 (Wasserman et al., 2003). Furthermore, that inadequate parenting practices are among the most powerful predictors of early antisocial behavior in children (Hawkins, Herrenkohl, Farrington, Brewer, Catalano, Harachi & Cothorn, 2000). Because young offenders are more likely to continue involvement in crime, it's particularly disturbing to note that the number of child delinquents (ages 7-12) handled in juvenile courts has increased 33% over the past decade (Loeber, Farrington & Petechuk, 2003).

For **protective factors**, buffering effects *against violence* have been shown for those individuals with intolerant attitudes toward deviance and commitment to school; and, against *antisocial behavior* for children with high IQs and positive social orientations (DHHS, 2001). Proponents of a *positive youth development* or social development strategy emphasize two protective factors: bonding to prosocial (sharing, caring, cooperation) family, school and peers,

and clear standards or norms for behavior. They also describe processes that encourage these factors, including: (1) opportunities for involvement in productive prosocial roles; (2) the skills to be successfully involved in these roles; and, (3) consistent systems of recognition and reinforcement for prosocial involvement (Catalano, Berglund, Ryan, Lonczak & Hawkins, 1998; SDRG, 2006) (see Figure 2 below).



Designing Interventions

A public health approach to this problem necessarily attempts to prevent its occurrence and seeks treatment when it does occur. To prevent problems, you must address known risk factors; and to design effective interventions, you must also address known protective factors that may build resilience against those risks.

Some of the principles of effective program design include (Atkinson & Ashton, 2002):

- Know which risk factors the program will address and how the program activities will reduce the risk factors; enhance protective factors while reducing risk;
- Address risk factors at the appropriate developmental stage and as early as possible;
- Focus on the risk factors most prevalent in a particular group of children or community;
- Target programs to children and youth exposed to multiple risk factors;
- Deliver programs to reach the community's diverse racial and cultural groups; and,
- Collaborate with others to address risk factors across multiple social domains.

According to Greenwood (2006), prevention strategies will ultimately be more effective if the emphasis is on changing antisocial behavior (aggression, repeated lying, criminal acts, irresponsible behavior, disregard for others). In terms of reducing *social and economic costs*, programs that target the highest risk groups have demonstrated the greatest benefit. And, while there are many effective programs that can be used in schools and other group settings, some evidence suggests that family-based interventions are the most *cost effective* way to work with at-risk and acting-out youth (Greenwood, 2006). Prevention programming, however, should not focus on a particular age group, circumstance, or type of intervention. Instead, there needs to be a full continuum of programs and services, beginning before the child is born, with pregnant teens and women, and ending with those older adolescents involved in the criminal justice system.

Determining Effectiveness

What can we say about programs designed to reduce youth violence and its related problems? Many programs have been evaluated through scientific research and shown to be effective in producing the intended results. These *best practice* programs (also called evidence-based, science-based, or research-based) are typically classified according to the strength and consistency of the evidence, for example, as *promising*, *proven*, or *model*. It can be confusing, however, because there are numerous groups reviewing the evidence for programs, setting varying criteria, and using different rating categories. Furthermore, some reviewers include only

those interventions specific to violence prevention while others (because of related risk factors) also include programs that target substance abuse and delinquency.

The Surgeon General's *Report on Youth Violence* (DHHS, 2001) critically reviewed programs, naming seven (7) as models and 20 as promising. The report further subdivides the model and promising programs by effects as either violence prevention (Level 1) or risk prevention (Level 2) programs. The Center for the Study and Prevention of Youth Violence (CSPYV, no date) at the University of Colorado is another major review organization. The *Blueprints for Violence Prevention Initiative* there also has a very high standard for program review: Of 600 programs reviewed, 11 were considered models and 17 as promising programs (Appendix C lists all of these programs, p. 41).

In addition, the Center analyzed classifications by 12 other reviewers (federal agencies, private organizations and individual researchers) that had collectively examined 361 programs. *Blueprints'* matrix of programs (2005) highlights the differences across reviewer ratings. For example, two school/group programs that had their origins in Richmond (*Al's Pals: Kids Making Healthy Choices* and *Responding in Peaceful and Positive Ways*), were both rated by three federal agencies as: **model** programs by the Center for Substance Abuse Prevention; **promising** programs by the Department of Education (Safe Schools initiative); and, **exemplary** programs by the Office of Juvenile Justice and Delinquency Prevention (Title V, related to innovative programming in elementary and secondary education).

The caveat here: Organizations trying to determine which *best practice* program to use for a particular purpose, setting, and target population need to evaluate each possible intervention carefully. That evaluation will determine for whom and what purpose the intervention was originally designed, and whether there is evidence that it produces the intended effects. Once that

is understood and an intervention has been selected, the challenge of implementing the program begins: Achieving intended outcomes requires both effective intervention *and* effective implementation.

It is sometimes assumed that because a *best practice* program or intervention is being used, the results are guaranteed. To the contrary, many programs fail because the organization either does not have the capacity to implement the intervention as intended (that is, with *fidelity* to the original design) or other circumstances in the setting prevent it (Fixsen, Naoom, Blase, Friedman & Wallace, 2005). For example, let's say you have a model program to be implemented in an after-school program. In the first instance (inadequate capacity), perhaps there are not enough staff to implement the program correctly. Or, in the second instance (situational or systems failure), you may have a program director who routinely reassigns staff to other duties. To determine whether a program is effective, therefore, both a *process evaluation* that examines implementation and an *outcomes evaluation* that analyzes results are needed.

Assessing Need

A major issue in determining community needs is the availability of recent data. Unfortunately, Virginia is one of only seven (7) states that does not participate in the CDC's *Youth Risk Behavior Surveillance System*. Several factors, however, mitigate this problem in the short term: The Center for Substance Abuse Prevention (CSAP) at SAMHSA initiated a national effort to conduct prevention needs assessments in the 1990s; and, these data are required for state or local mental health agencies and for schools in applying for certain federal grant funds. In addition, public mental health agencies are mandated to create community coalitions for planning purposes related to prevention activities. While the primary focus of these efforts is substance abuse prevention, it is also relevant for related issues such as violence prevention.

State-Level Data. The Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (VDMHMRSAS), through a contract with the Center for Substance Abuse Prevention, conducted a *Statewide Prevention Needs Assessment*. That assessment involved three studies: (1) the *Virginia Community Youth Survey: 2000* (CSR, 2001); (2) an *Archival Social Indicator Study* (CSR, 2002a); and, (3) a *Community Resource Assessment: 2002* (CSR, 2002b).

The *Virginia Community Youth Survey* (CSR, 2001) was designed to measure substance use and antisocial behaviors based on 25 risk factors and 10 protective factors. The survey was administered in the fall of 2000 to a sample of public school youth in 8th, 10th and 12th grades across the state. Among the findings were: (1) alcohol is the most commonly used substance (37% of 10th graders; 52% of 12th graders reported recent use); (2) tobacco is the second most commonly used substance; and, (3) middle school students are using inhalants more frequently than high school students. In terms of risk profiles, those varied considerably across Health Planning Regions (HPR) and will be discussed in the section related to regional data.

A follow-up statewide youth survey was conducted for state department of mental health in 2003 (Moore, Glaze, Honnold, Ellis & Rives, 2004). Its findings demonstrate relative stability in substance use (2000-2003), antisocial behaviors, risk factors, and protective factors. The greatest changes were related to protective factors in the school domain, with increases in opportunities and rewards for prosocial involvement. The Eastern region of the state (HRP V) had the highest scores for risk factors and antisocial behaviors, and lowest for protective factors.

Note: The *Virginia Community Youth Survey* and other surveys mentioned in this needs assessment section are based on two national survey instruments, *Monitoring the Future (MTF)* and the *Communities that Care^R Youth Survey*. The *MTF* survey, conducted annually by the

University of Michigan and funded by the National Institute on Drug Abuse, provides prevalence information on substance use for a representative sample of 8th, 10th and 12th graders (Johnston, O'Malley, Bachman & Schulenberg, 2006). The *Communities That Care^R (CtC) Youth Survey* is one of the tools in the *CtC Community Planning System*. It is available from the Center for Substance Abuse Prevention at SAMHSA, developed from research by Hawkins, Catalano and others at the University of Washington's Social Development Research Group. The *CtC Survey* includes substance use items, as well as scales constructed to measure risk and protective factors [National Clearinghouse for Alcohol & Drug Information (NCADI), 2006].

As part of Virginia's *Archival Social Indicator Study (CSR, 2002a)*, in 1998 VDMHMRSAS began the development of an archival (meaning those previously collected by other public agencies) indicators database, including statewide as well as data by HPR and locality. These 42 indicators were collected to measure nine (9) risk factors related to substance use and five (5) outcomes of adolescent problem behaviors across individual, family, school, and community domains. At the state level, most indicators were stable or declined from previous rates. Two *exceptions* were an increase in alcohol sales between 1996 and 2000, and an increase in the number of single parent households between 1990 and 2000 (CSR, 2002a).

The third component of the statewide needs assessment was the *Community Resource Assessment (CSR, 2002b)*, whose purpose was to look at prevention programs available that targeted risk factors and other behaviors related to substance use. This involved two phases and 376 survey respondents, who represented state and local public agencies, nonprofit organizations, and colleges and universities. Among the major statewide findings were:

1. The most common services provided by local programs (by >50%):
 - a. *For individuals*: (1) life/social skills training; (2) mentoring; and, (3) community service (volunteer/service-learning); least common was: teen drop-in centers;

- b. *For families:* (1) parenting/family management; (2) family support (family planning, home visiting, etc.); and, (3) prenatal & infancy services;
 - c. *For schools:* <50% provided any service to schools; organizational change through school-community partnerships or management teams was typical for those who did;
 - d. *For communities:* (1) information dissemination; (2) media campaigns; and, (3) community development/capacity building.
2. The most common youth populations served were: (a) economically disadvantaged; (b) “other” youth; and, (c) at-risk of dropping out of school; least common was: homeless/runaway youth;
 3. The most commonly perceived *major* program barriers were: (a) insufficient staff; (b) lack of transportation; and, (c) staff turnover; *minor-to-moderate* barriers were: (a) lack of public awareness; and, (b) participant drop-out.
 4. The most commonly perceived prevention needs were: (a) substance abuse prevention; (b) teen pregnancy prevention; and, (c) family management/parenting skills.

Those surveyed were also asked about program evaluation. Most indicated that in-house (82%) process or outcomes evaluations were done, although 13% reported no evaluations. Data from these needs assessment studies were expected to be used for prevention planning purposes at the HPR and locality levels, as well as statewide.

Regional-Level Data. The *Virginia Community Youth Survey* (CSR, 2001) provided data by Health Planning Region (HPR), Community Service Board area, and by rural/urban location. HPR IV includes Metropolitan Richmond, the Tri-Cities area, and also parts of Southside as far away as South Boston. Of particular note were the results for *middle school* (8th graders) students on eight (8) **antisocial behaviors**: HPR IV was considerably higher than the state as well as Regions I, II and III on each of the behaviors. For example, 23% of students had attacked someone with the intent of seriously harming them (vs. 15% state); and 32% had been suspended from school (vs. 15% state). These high ratings on antisocial behaviors were not maintained for HPR IV high school students. Several explanations for this were offered,

including the possibility that that by 9th or certainly 12th grade, many students involved in these kinds of behaviors would no longer be attending school.

In the *Archival Social Indicator Study*, several measures for HPR IV were above the state average and higher than other regions. These included substance use, violent and non-violent crime, and adolescent sexual behaviors. In addition, standardized social indicator risk profiles showed higher than average rates for certain risk factors (CSR, 2002a), and there was no appreciable change in a 2004 update (VDMHMRSAS). Those risk factors were:

- For *individuals/peers*: early initiation of problem behavior;
- For *families*: family conflict; family management problems;
- For *schools*: low commitment to school; and,
- For *communities*: low neighborhood attachment; extreme economic/social deprivation; and, availability of drugs.

The third component of the statewide needs assessment, the *Community Resource Assessment* (CSR, 2002b), also provided HPR IV specific data. Major findings included:

1. The services most commonly provided by local programs were the same as those reported statewide (see pages 12 & 13) for individuals, families, and communities. The services provided for schools were different, in that classroom organization, management and instruction was an additional area of focus (second to organizational change through community-school partnerships or management teams).
2. The youth populations most commonly served were the same as those statewide, but with higher proportions serving youth who were economically disadvantaged or at-risk of dropping out of school (both 52% of programs).
3. The program barriers most commonly reported were the same as those statewide, for *major* barriers (insufficient staff; lack of transportation), as well as for *minor-to-moderate* barriers: lack of public awareness (70%); participant drop-out (63%); and, lack of community interest (59%).
4. The perceptions of the most common prevention needs were similar to those statewide, but with greater agreement among respondents and the addition of violence prevention: (1) substance abuse prevention (63%); (2) teen pregnancy prevention (42%); (3) violence prevention (21%); and, (4) family management/parenting (20%).

Consistent with statewide findings, most agencies conducted in-house (82%) process or outcome evaluations, with fewer agencies (7%) reporting no evaluations.

Locality-Specific Data. Archival social indicators are available for all jurisdictions in the Metropolitan Richmond area from the VDMHMRSAS (2004) database. When 2003 data for the City of Richmond are compared to statewide rates and to the counties of Chesterfield, Hanover, and Henrico, a number of indicators are higher for Richmond (see Table 2, p.16). There are, however, several indicators with rates that are not appreciably different than the state rate, and other rates that are lower for Richmond (see Table 3, p.16).

Those rates in **bold-type** in Table 3 are considerably higher than the state rate. As indicated in this table, certain rates for non-violent crimes and substance use are actually higher in Chesterfield, Hanover and Henrico Counties than in the City of Richmond. (The **unusually low rate** for alcohol arrests in Richmond was not explained, but has been unusually low since 2000.) There has been a downward trend in these rates since 1999, for Virginia, Richmond, and Henrico County. For Chesterfield and Hanover Counties, however, there has been an upward trend in rates for violent crimes and drug arrests, as well as certain non-violent crimes.

Community Coalitions. As mentioned previously, public mental health agencies have a mandate to develop community coalitions for prevention planning purposes, so organized groups of public and private nonprofit agencies are meeting regularly. In the four largest Metropolitan Richmond jurisdictions, those coalitions are: the *Friends of Prevention* in Richmond; *SAFE* (Substance Abuse Free Environment) in Chesterfield County; *I CARE* (Increased Community Awareness Requires Everyone) in Hanover County; and, *Healthy Families/Healthy Youth* in Henrico County. These coalitions have been important in developing local information, as well as in organizing community-wide initiatives.

**Table 2. Selected Archival Social Indicators for City of Richmond & Virginia, 2003
(VDMHMRSAS, 2004)**

Indicators by Domain	Richmond	Virginia
Community: Extreme Economic & Social Deprivation		
▪ Average monthly rate of Food Stamp recipients per 1,000 population	157.53	59.58
▪ Rate of participants in the federal TANF (temporary assistance for needy families) program per 1,000 population (ages 0-17)	163.28	39.45
▪ Percentage of labor force not employed	6.54	4.07
▪ Percentage of students enrolled in public schools (K-12) whose FRLP (free & reduced lunch program) applications have been approved	72.14	30.61
Community: Low Neighborhood Attachment		
▪ Rate of admissions to state prisons per 100,00 population	235.20	149.34
Community: Transition & Mobility		
▪ Number of new residents who moved into area minus number of residents who moved out per 1,000 population	-14.66	7.56
School: Low Commitment to School		
▪ Percentage of students (grades 7-12) who drop out of school in a single year	12.05	2.12
Individual/Problem Behavior: Adolescent Sexual Behavior		
▪ Rate of live births to adolescent females (age 10-17) per 1,000 adolescent females	18.92	6.75
▪ Rate of pregnancies to adolescent females (age 10-17) per 1,000 adolescent females	37.63	10.68
Individual/Problem Behavior: Violent Crime		
▪ Rate of homicide victims per 100,000 population	21.05	3.61

**Table 3. Selected Archival Social Indicators for Metropolitan Richmond, 2003
(VDMHMRSAS, 2004)**

Indicators by Domain	VA	Richmond	Chesterfield	Henrico	Hanover
Individual/Problem Behavior: Non-Violent Crime					
▪ Rate of juvenile (age 10-17) arrests for curfew violations, vandalism & disorderly conduct per 100,000 juveniles	559.02	587.79	2038.56	681.38	324.81
▪ Rate of juvenile (age 10-17) arrests for property crimes per 100,000 juveniles	733.58	712.96	2448.43	1531.57	974.43
Individual/Problem Behavior: Violent Crime					
▪ Rate of juvenile (age 10-17) arrests for violent crimes (murder, aggravated assault, robbery, rape) per 100,000 juveniles	132.89	266.68	358.64	156.53	116.60
Individual/Problem Behavior: Substance Use					
▪ Rate of juvenile (age 10-17) arrests for alcohol violations per 100,000 juveniles	233.59	43.54	431.44	325.34	149.91
▪ Rate of juvenile (age 10-17) arrests for drug violations per 100,000 juveniles	333.08	424.51	887.15	601.58	866.16

For example, through the efforts of the *Friends of Prevention*, additional information is available for **Richmond** from a *City of Richmond Prevention Needs Assessment* (Belgrave, Bennett, Alleyne, Grange, Hedgepeth, Stowe, Williamson, Edwards & Everette, 2004). That assessment looked at archival social indicators, and collected additional information from a youth summit and seven (7) focus groups. The report provides an in-depth description and discussion of many social indicators (those highlighted in Tables 2 & 3 and others). The focus groups, which included youth and a variety of community organizations, were organized by the domain in which services were provided and by age group of the youth population served. Among the study's identified *needs and recommendations* were (Belgrave et al., 2004):

- Additional out-of-school-time programs and structured activities that are free or low-cost;
- Additional youth employment opportunities;
- Involvement of youth in program planning and development;
- Increased public and provider awareness of services available;
- Improved access to programs through better transportation systems;
- Higher levels of community interest and involvement;
- Increased collaboration among agencies; and,
- An inventory of programs and funding sources for use by service providers.

The community coalition in **Chesterfield County**, SAFE, sponsored a prevention needs assessment survey in 2005, reviewed archival data, interviewed more than 100 key informants, and conducted a resources assessment (J. Carter, personal communication, 7/11/06). Updated information from the archival data included a 55% increase in the number of violations of school drug policies over the past three years; an increase in juvenile drug arrests of about 5% between 2003 and 2005, and alcohol violations up 35% over the same period (SAFE, 2006a). The needs assessment survey was conducted in the fall of 2005, with 2,501 public school students in grades 8, 10 and 12 (Bach Harrison, no date). Survey results were compared against a national norm, and indicated:

- Alcohol was the most commonly used drug, with less frequent use than the norm;

- The most important risk factor was *favorable parental attitudes toward antisocial behavior* across all grade levels and was above the norm; and,
- The most important protective factors were, above the norm: *opportunities for prosocial involvement*, across all grade levels and domains; and below the norm: *rewards for prosocial involvement*, particularly for 8th graders and in school and community domains.

In the report, *total risk* was calculated as the percentage of 8th graders with eight (8) or more risk factors or 10th and 12th graders with nine (9) or more risk factors. Those results were 40% for 8th graders, and 43% for 10th and 12th graders. *Total protection* was calculated as the percentage at all grade levels with six (6) or more protective factors, which was 73% for 8th & 10th graders, and 76% for 12th graders.

The Chesterfield County survey data were also combined with similar surveys conducted in **Hanover County and Henrico County** public schools (Rothenback Research & Consulting, 2006). (A similar survey for the City of Richmond is expected to be conducted in the fall of 2006.) These surveys and their review and analysis were sponsored in part through funding obtained by the *Regional Drug-Free Alliance*, a coalition in the Richmond area representing more than 100 individuals and organizations (M. Earley, personal communication, 7/24/06). A total of 6,980 public school students in grades 12, 10, 8 and 6 (Henrico only) completed the surveys. Alcohol was the most common substance used, and the highest rates for eight (8) antisocial behaviors were: attacking someone with the intent to harm (15%), and getting suspended from school (11%).

In the study report, results for 21 risk factor scales and 10 protective factor scales are discussed in-depth and compared with national norms (*CtC Youth Survey*). The highest risk factors were family conflict (54); lack of commitment to school (54); and, favorable attitudes toward antisocial behavior (52)—all above the normative average of 50. The lowest risk factors (which can be built on as strengths) were early initiation of drug use (40); laws and norms

favorable to drug use (40); and, low perceived risk of drug use (42). For protective factors, the highest were social skills (56); belief in a moral order (56); and, religiosity (55). The lowest protective factors were opportunities for prosocial involvement at school (49), and family rewards for prosocial involvement (50).

What can we say about the Richmond Metropolitan area based on these recent assessments? First, substance use and antisocial behaviors are significant problems in all jurisdictions, with a perceived need for greater prevention programming for substance abuse, teen pregnancy, violence prevention, and family management. Across the domains of influence, there were more limited services targeted to schools and the community at large. Among the important risk factors were family conflict and favorable parental attitudes toward antisocial behavior, low commitment to school, low neighborhood attachment, social/economic deprivation, and availability of drugs. Significant program barriers included insufficient program staff, staff retention, and lack of transportation for clients.

Program Resources

To better understand current and developing program resources in Metropolitan Richmond, various documents were reviewed and interviews with key individuals were conducted. The interviews involved 70 *key informants*, representing 42 public agencies, private nonprofit organizations, and universities, and took place by phone or in-person between March 1 and July 30, 2006. Interview content focused on the organization's programming, perceived needs in the community related to violence prevention, and suggestions for change assuming funding were available (see Appendix B for organizational affiliations listing).

An original intention of this study was to provide an inventory of organizations and programs in the Richmond area providing services related to youth violence. It became apparent, however, that such an inventory would not be particularly useful unless some determination of program effectiveness could be made. That is, unless there was some method of rating or

classifying programs against certain criteria for inclusion or exclusion, it would be a list with limited utility for the Jenkins Foundation and others interested in targeting funding to those organizations with the greatest capacity to make a significant impact on community indicators.

It was not possible to make such a determination for several reasons. A major reason was the diverse purposes, target populations, and types of organizations involved (from early childhood home visitation to programs ordered for delinquent youth). Another was the fact that there is no basic or minimum standard (eg, licensure) or recognition of achievement (eg, accreditation) for many if not most programs or organizations. And, it was beyond the scope of this study to review evaluation data from local programs.

Best Practices. In relation to *best practices*, a number of organization's programs have been developed in-house, although they may use an approach or principles consistent with national evidence-based practice. That is not to say that there are no nationally-recognized programs in Richmond. In fact, there are a variety of these programs. Some are discrete curricula, others are particular methods with specific components, and still others are *whole organization* approaches.

In preschool and school settings, these include *Al's Pals*; *Responding in Positive and Peaceful Ways (RIPP)*; *Olweus Bullying Prevention Program*; and *Life Skills Training*, among others. In the community, there are on-site (school-based) and community-based programs that provide structured *mentoring*, such as *Big Brothers*, *Big Sisters*, and others that provide parenting programs, such as *Families That Care: Guiding Good Choices* (formerly called *Preparing for the Drug-Free Years*). Also, for older youth adjudicated by the juvenile justice system, there are at least three model programs in use by court-ordered counselors: *Functional Family Therapy (FFT)*; *Multisystemic Therapy (MST)*; and, *Multidimensional Treatment Foster Care (MTFC)*.

There are other after-school programs and organizations using a *positive youth development* approach, whose components may not be well-defined enough to reach the level of an evidence-based rating. However, at least one of these organizations—*Boys and Girls Clubs*—has national evaluations that consistently demonstrate intended outcomes (Greenwood, 2006). Because no evaluation data for local programs were reviewed for this report, it is not known whether those organizations using the previously named or other *best practice* programs have effectively implemented their programs and produced the desired outcomes. Program evaluation is an area deserving further study.

Program Expansions. Many youth-serving organizations are involved in program expansions, including the following (which is not meant to be a comprehensive listing):

- *Big Brothers, Big Sisters* (www.bigbrobigsis.com), which has site-based mentoring programs in three (3) elementary schools—Chimborazo, Dumbarton and Ginter Park—as well as in Hopewell and Petersburg, will add two (2) new elementary schools—Blackwell and Fairfield Court—this fall. This will require many more adult volunteers, as there is currently a waiting list of over 150 children in need of mentors (S. Milliken, personal communication, 7/6/06).
- *Communities in Schools at Family Lifeline* (www.family-lifeline.org) has added middle and high schools to their traditional focus on elementary schools and will expand from 19 to 24 sites this fall (B. Frierson, personal communication, 6/28/06).
- *Team Up Richmond* (www.teamuprichmond.org) has had after-school programs in nine (9) Richmond middle schools, then added two (2) elementary school-based programs and an after-summer school pilot program. This fall, they will expand into five (5) comprehensive high schools and 15 elementary schools, with before and after-school programming (I. Reaves, personal communication, 3/21/06).
- *William Byrd Community House* (www.wbch.org) is expanding their after-school programming from Oregon Hill to a middle school in Fulton (R. Gordon, personal communication, 5/8/06).

New Initiatives. A number of community-based organizations and public agencies are developing or have developed new programs and collaborative initiatives over the past few years. Among those mentioned by key informants were:

- *Friends Association for Children* (www.friendsassn.org) has several new programs. One is an intensive, year-long program for teens (13-18) that uses the Ansell-Casey Life Skills curriculum and includes weekly individual and group counseling. Another is being developed in conjunction with the Robins Foundation-funded *Partnership for Families Northside*, with whom Friends is a collaborating organization (see <http://kidsreadytolearn.org>). This is a new six (6) month leadership program for parents with children under age five, and will be held in a Northside Richmond location (K. Legato, personal communication, 5/1/06).
- *William Byrd Community House* is developing a teen drop-in center (for ages 14-24) in Highland Park, modeled on Denver's successful urban youth program, *The Spot* (R.Gordon, personal communication, 5/8/06; see www.thespot.org).
- *Greater Richmond SCAN (Stop Child Abuse Now; www.grscan.com)* is in the process of restructuring its public education program. The new program, called *FAM*, will include several components (parent support groups, parent training sessions, speaker's bureau). This program is to be launched in conjunction with a media campaign focused on normalizing the process of parents seeking help, and building awareness of available services (A. Davis, personal communication, 7/3/06).
- *United Way Services' (UWS) Success by Six, Youth Matters, and Voices for Virginia's Children* have been sponsoring the *Greater Richmond Early Child Development Coalition* (ECDC) since 2001, bringing together more than 165 members who provide services to families with young children. (Note: Success by Six and Youth Matters merged this summer and are housed at UWS.) Among those members are 52 child care programs that have been focusing on quality improvements and working toward national accreditation. In December 2004, UWS became the convener of the *Partnership for Out of School Time (POST)*, a coalition of more than 20 members. The goal of *POST* is to improve the quality and accessibility of out of school time programming for children, youth, and their families (H. Turbyne-Pollard, personal communication, 6/30/06; www.yourunitedway.org).
- The *Regional Drug-Free Alliance* (www.drugfreealliance.org) is a coalition of over 100 individuals and organizations in the Richmond area. In 2006 this group obtained funding to review and analyze youth survey data from Chesterfield, Hanover and Henrico Counties (public distribution of that report is expected in September 2006). The Alliance expects to provide partial support for a similar survey in Richmond this fall. The group also provides training for a best-practices parenting program called *Families That Care: Guiding Good Choices*, and they are currently working on the development of a social marketing campaign (M. Earley, personal communication, 7/24/06).
- *Evening Reporting Centers* have been implemented in Petersburg (2003) and Hopewell (2005) for youthful offenders, as part of the Annie E. Casey Foundation's alternatives to detention project. The centers provide court-ordered after-school supervision and activities (tutoring, recreation, food, transportation) for boys and girls. The programs are funded by justice system grants, appear to be well-received by youth and juvenile justice personnel, and are a cost-effective alternative to detention (eg, in Hopewell, savings of \$170/day compared to detention). In Hopewell, the program is for boys only and is contracted out to the Boys &

Girls Club (J. Weigel, personal communication, 6/12/06); in Petersburg, both boys and girls are included and the program is contracted out to several organizations for particular components (M. Hardy, personal communication, 6/14/06). Several juvenile justice system informants in the City of Richmond (also a Casey Foundation site) have indicated an interest in this model, and are exploring it as a possibility for youth needing probation supervision (K. O'Donnell & S. Garrison, personal communications, 4/4/06).

- The *Clark-Hill Institute for Positive Youth Development* at Virginia Commonwealth University (VCU) has been designated by the Centers for Disease Control and Prevention as one of eight national Academic Centers of Excellence on Youth Violence Prevention. The Institute was created in 2006 with the merger of the former VCU Center for Promotion of Positive Youth Development and VCU Center for the Study and Prevention of Youth Violence. Faculty and staff are involved in a number of projects, with a focus on the City of Richmond and Richmond Public Schools (K. Allison & A. Meyer, personal communications, 6/20/06; R. Cohen, personal communication, 3/22/06). Among those projects is a recently completed Latino needs assessment (R. Corona, personal communication, 7/9/06). (The institute's website is under construction.)
- *Vision 2020* is an ambitious plan by Richmond's Mayor and Human Services Committee to improve conditions in critical areas of need. These include: early child care and parent education, child and adolescent health, school success, and at-risk males; also, seniors and disabled persons, and homelessness (see www.ci.richmond.va.us/citizen/city_gov/mayor). The City hopes that partners from the business and philanthropic communities will come forward to invest in this effort. The major strategic initiatives related to youth and families, briefly stated, are:
 - A citywide *early childhood initiative* for families with children ages 0-6 years, which will include (among other things) an expansion of home visiting services (through community partners, including *CHIP of Greater Richmond* and *Healthy Families*) and improved access to parent education resources and to quality child care. It is modeled, in part, on Hampton's (see www.hampton.va.us/healthyfamilies) successful *Healthy Families Partnership*.
 - A citywide *teen pregnancy prevention initiative* that includes implementation of the Casey Foundation's *Plain Talk* program, a community and neighborhood-based strategy to reduce adolescent risk-taking behavior (see www.aecf.org/publications/plaintalk). In addition, the feasibility of establishing school-based health clinics will be explored.
 - For school success, *comprehensive out of school time programming* is planned, linking the school day and after-school programs and increasing the availability of such programs.
 - For at-risk males, an *intervention and support program* is planned that will provide mentors, job training, employment opportunities, and other services.

Pilot/Exploratory Projects. There are also several programs being piloted or about to be piloted in Richmond, and others that are in exploratory phases, according to key informants:

- *Virginia's Office of the Attorney General* initiated *GRIP* (Gang Reduction and Intervention Program) through a \$2.5 million federal grant from the Office of Juvenile Justice and Delinquency Prevention. This four year (2004-2007) project, *one of four pilot programs* across the country, focuses on 10-24 year olds and is targeted at parts of southside Richmond (police beats 212 and 213). It involves 40 programs provided by a variety of public and private nonprofit agencies, 25% of which are faith-based. A One Stop Resource Center at Southside Plaza opened in July, housing service providers, public agencies, and local businesses. A sustainability plan is being developed in anticipation of the phasing out of federal funding in summer 2007 (E. Welch & M. Fero, personal communications, 3/27/06; see www.vaag.com).
- The *National Center for Neighborhood Enterprise* (see www.ncne.com) in Washington, DC has a school-based program, the *Violence Free Zone*, that is intended to reduce disruptive or violent incidents, truancy and suspensions, and increase attendance. It is being implemented in 24 schools in five (5) cities, and is expected to be *piloted at Richmond's* Chandler Middle School during the 2006-2007 school year. Dr. Morris Henderson of 31st Street Baptist Church will be the local coordinator of the project (L. Everette, personal communication, 7/10/06).
- The *Virginia Mentoring Partnership (VMP)* (www.mentoring.org/virginia) has proposed development of a technical assistance toolkit, which would be part of a two-year *Comprehensive Mentoring Achievement Plan*. VMP would partner with area public schools and direct-service mentoring groups to enhance existing school-based mentoring initiatives and provide support for the creation of new initiatives. VMP will seek funding for the project (J. Smith-Slaybaugh, personal communication, 6/28/06).
- *Voices for Virginia's Children* (www.vakids.org) has proposed an educational program for mental health professionals and other providers of services to young children. The project would provide six (6) days of training related to children's social and emotional development over a 12 month period; and, would be taught by a *Zero to Three* certified trainer (see www.zerotothree.org). A similar program was completed in Roanoke. Voices is currently seeking funding to implement the project (S. Johnson, personal communication, 7/10/06).
- The *Tariq Khamisa Foundation (TKF)* in San Diego, California was founded by Azim Khamisa following the 1995 shooting death of his 20 year old son, Tariq, by a 14 year old gang member. The foundation has developed a school-based *Violence Impact Forum* and other programs emphasizing restorative justice (Mr. Khamisa believes that "forgiveness is the only way to stop the cycle of violence"). These programs are being implemented in localities across the country. Mr. Khamisa visited Richmond several times in 2006 and made presentations at public and private events; however, it is not known whether anything will develop as a result of these initial meetings (see www.tkf.org).

Major Themes

In Metropolitan Richmond, youth violence and its related problem behaviors are getting increasing attention across all domains, sectors, and jurisdictions; and, there seems to be a growing willingness to work together on solutions. A number of *themes* emerged from this study, including:

- ◆ The *issues and problems are systems-level*—in families, schools, neighborhoods, organizations, and communities. Solutions will also need to be systems-level—they cannot be addressed by individual programs, agencies or organizations, whether public or private.
- ◆ *Planning and evaluation systems* are critical components of this effort; and, reliable ongoing data sources are needed. Planning should be regional, comprehensive, and collaborative. Evaluation should include both process *and* outcomes assessment; and, indicators should be reported at the neighborhood and community-level as well as the program-level. Annual *community report cards* could indicate the cooperative efforts made and results achieved.
- ◆ *Engagement of key stakeholders* is essential to this process. Parents and youth must be empowered to assist in creating solutions, along with leaders from business, faith, philanthropic, nonprofit and government sectors. Rather than believing that it is someone else's problem, it must become *everyone's* child, family, neighborhood, school, and community that need attention.
- ◆ The *overall strategy* should include a full-continuum of services (all ages and stages of development) and be multi-contextual (all domains of influence). Interventions should be thoughtfully and deliberately selected, based on scientific evidence of effectiveness. Services should be coordinated across agencies working in networks and community-based coalitions. Services provided should be family-focused and neighborhood-based.

Identified Needs

The issues and needs specified by key informants, and those that became apparent from a review of regional information, can be organized into several categories. These include: organization and infrastructure; community values and norms; public schools, juvenile justice; service providers; and, programs and services (see Table 4, page 27 for a summary).

Organization & Infrastructure. As mentioned previously, there is a general consensus that regional as well as city/county-wide *planning* are needed. While the City of Richmond's *Mayor's Vision 2020* was developed through the cooperative efforts of selected stakeholders, several key informants suggested the need for another, more inclusive and perhaps broader planning process. One such method is the *whole community* approach of the *Communities That Care^R Planning System* (Hawkins & Catalano, 2005), which is being used by a number of communities across the country. Originally developed for substance abuse prevention planning by the University of Washington's Social Development Research Group, this model and its related materials have been purchased by SAMHSA and are available online (<http://ncadi.samhsa.gov/features/cte>). Its five-stage planning process includes selection of *best practice* interventions, as well as the creation of a *Community Action Plan* (CAP).

To plan effectively, *reliable data sources* are needed on an ongoing basis. At the state level, consideration should be given to participation in the CDC's *Youth Risk Behavior Surveillance System* (YRBSS), which monitors six categories of priority health-risk behaviors. This includes an annual national school-based survey by CDC, and state and local surveys conducted by state health and education agencies (Eaton et al., 2006). Participation requires an agreement between CDC and Virginia's Department of Education (VDOE), which we can hope will be forthcoming with the recent appointment of Dr. Billy Canady to head VDOE. At the regional and local levels,

Table 4. Summary of Major Needs Identified by Key Informants

A. Organization & Infrastructure

- Regional cooperation & planning
- City/county-wide strategic prevention planning
- Reliable and ongoing sources of data (eg, *Youth Behavior Risk Surveillance System*)
- Outcome indicators focused at neighborhood and community-levels
- Funding service capacity rather than specific programs
- Access to public transportation

B. Community Values & Norms

- More effective use of media for social marketing messages
- Recognition & empowerment of parent-caregivers
- Reduce exposure to media violence
- Greater community awareness and involvement in issues & solutions
- Engage leaders in business, faith & philanthropic communities
- Limit availability of tobacco, alcohol, other drugs & firearms

C. Public Schools

- Cooperation & partnership between parents & schools
- Educational advocacy (children know rules, parents know rights)
- Review of suspensions & expulsions & alternative education options
- Increased use & effective implementation of model interventions (eg, *Al's Pals*; *RIPP*)

D. Juvenile Justice

- Family-focused, systems approaches (eg, mediation, family courts, drug courts)
- Alternatives to detention & traditional supervision (eg, Evening Reporting Centers)
- Expedite treatment service referrals to community providers from court services units
- Additional services & programs for high-risk teens

E. Service Providers

- Organizational networks or coalitions for information & resource sharing
- Coordination of services & case management across agencies & jurisdictions
- Attract & retain qualified staff; provide staff development & training
- Agency recognition/accreditation where appropriate

F. Programs & Services

- Link hospitals & physician offices to other agencies
- Increase affordable, high quality child care
- Expand service hours & locations
- Establish neighborhood-based family resource centers
- Increase low or no-cost programs & structured activities
- Develop teen programming that increases participation & keeps them engaged
- Provide additional services for teen parents & other high-risk teens
- Increase job & life skills training for teens & adults
- Expand employment opportunities for teens & adults
- Require state & federal screening of all volunteers working with children

recent data collection efforts have been organized and funded through the efforts of the Regional Drug-Free Alliance, a nonprofit organization, in cooperation with community coalitions. To many observers, it seems reasonable that state and local governments provide this funding.

Evaluation is a necessary component of planning, for monitoring and improvement of programs and to determine effects. *All* organizations should be evaluating their program implementation processes *and* their client-focused outcomes. In addition, where services are provided by networks of organizations targeting particular geographic areas, ***neighborhood and community-level outcome indicators*** should be possible and are desirable. Planning and evaluation require time and money. Organizations should budget for these administrative processes and they should be recognized and funded as a necessary expense.

Another major issue for both public and private nonprofit agencies is the ***manner in which programs are funded***. As one key informant commented, because many organizations are dependent on grant support and most funders prefer or require service-specific proposals, it necessarily keeps the focus short-term and the effects program-level. An alternative, which could allow both longer-term planning and neighborhood or community-level effects, might be for funders to evaluate agencies according to their capacity and provide multi-year financial support for those known to be efficient and effective. With relief from some funding pressure, staff would be better able to develop innovative approaches and collaborate with other organizations.

Finally, lack of access to ***public transportation*** is a major dilemma for many clients and citizens. Without reliable transportation, clients are often unable to obtain services, participate in community events, or seek employment. A regional transportation system is needed to address this issue, which is particularly problematic in the counties surrounding Richmond.

Community Values & Norms. There were a variety of needs and issues identified that

relate to community values and norms. These include the need to use all media more effectively for *prosocial and social marketing purposes*, particularly related to messages about the importance and influence of parents (eg, the *Power of Know*). There is also a need to *reduce exposure to media violence* by monitoring children’s viewing and listening habits, and by using our individual and collective influence to change programming on local television and radio stations.

Greater *community awareness* of the issues *and involvement* in designing the solutions is another need; with *engagement of leaders* from business, faith, and philanthropic sectors, as well as ordinary citizens. For example, individuals or groups of individuals can respond to the increasing demand for mentors, particularly in neighborhoods where there is significant poverty and crime. Greater involvement is also needed by parents and youth themselves, with incentives, recognition and rewards for participation.

It should be understood, fundamentally, that all children and youth in the community are at risk. To reduce that risk, parents and other adults need to make it clear that *access to tobacco, alcohol and other drugs, and firearms* is strictly prohibited. Policies and laws need to be enacted that enforce these norms and make it difficult to obtain either substances or weapons—at home, at school, and in the community at large.

Public Schools. Several key informants described issues and needs related to the public schools. *Cooperation and partnership* between schools and parents was identified as a significant need by some, with *educational advocacy* for children and parents also an issue. This advocacy would ensure that children know the rules and parents know their rights in relation to school system policies and state and federal laws.

The growing number of *school suspensions and expulsions*, in the Richmond area and across the state, is a major concern. In fact, at its November 2005 meeting, the Virginia Commission on Youth (2006) approved a study to determine whether there is a problem related to this increase in public school expulsions. An advisory group has been formed, which will explore this issue and, if a problem is found, make recommendations to address it. The study will also review school districts' use of *alternative education options*. There are multiple issues here, and a few of the questions include: Are the problems primarily related to children's behavior? Are teaching and classroom management techniques developmentally appropriate? Are children with *Individualized Education Plans* (IEPs) being suspended or expelled for behaviors identified in those plans as related to their special needs? For children with long-term suspensions or expulsions, what alternative education resources are available, where are they located, and who will pay for them?

These issues will be magnified by the possible influx of thousands of additional preschool-aged children into the public schools. A recent national study (Gilliam, 2005) indicated that *preschoolers are expelled* at more than three times the rate for K-12 students. The typical preschooler expelled is a 4 year old African-American male—*does the cycle begin here?* The rate of expulsion (10.25 per 1,000 children) and percent of teachers expelling (12%) was higher for the *Virginia Preschool Initiative* than the national averages (6.67 per 1,000 and 10%, respectively).

With the establishment of the *Early Childhood Foundation* and the launch of *Start Strong* in Virginia, there's a new emphasis on making public preschool programs for four year olds available (see www.smartbeginnings.org). Do we have enough teachers prepared to teach these preschoolers? One key informant suggested that there needs to be more widespread *use of model*

programs, such as *Al's Pals*, that show young children how to make healthy choices as well as reinforce children's normal social and emotional development with teachers.

Juvenile Justice. Several key informants discussed issues related to children and families already involved in the juvenile justice system. They emphasized the need for *family-centered systems* with a less punitive and more prevention and treatment-oriented approach. This approach, which needs public support to be widely accepted, includes mediation, family courts, and drug courts. *Alternatives to traditional detention* and supervised probation for youth are also consistent with this orientation. Among these alternatives are the previously mentioned *Evening Reporting Centers* (see p. 22), which have been successfully implemented in Hopewell and Petersburg. This model is under consideration in Richmond as an alternative to traditional supervised probation.

Another issue mentioned by key informants was the need to *expedite treatment service referrals* from court services to community treatment providers. The sometimes lengthy lag between the court order and the initiation of treatment (because of court service unit caseloads and agency waiting lists) provides too much opportunity for youth to re-offend. Additionally, several individuals suggested the need for more services targeted at the *high-risk population of youth* who have already become involved in the criminal justice system.

Service Providers. Several informants indicated that there is a need for *more organizational networks or coalitions* of service providers, for information and resource sharing, as well as to provide more comprehensive services. The *Greater Richmond Early Childhood Development Coalition* and the *Partnership for Families Northside* (see p. 22) were named as possible models for this. Also mentioned was the need for *coordination and case management* across agencies (public and private) and jurisdictions.

Attracting and retaining *qualified staff* remains a major barrier to the implementation of many programs. In addition, staff development and training are areas in need of attention and funding, particularly for those providing services to children and families with complex social and emotional situations (which is almost everyone). Furthermore, agencies should be encouraged to work toward *national recognition through accreditation* of their programs, where that is available and appropriate.

Programs & Services. There was not a general sense among key informants that there are major gaps in the continuum of services. Rather, they indicated that there may be a need for expansion to meet demand or further refinement to attract and retain participants in certain service areas. The following suggestions were made:

- Link *hospitals and physician offices* to other community agencies providing services for families with young children (eg, *Hampton's Health Families Partnership*);
- Increase the availability of *affordable, high quality child care*; and, expand child care hours (up to 24 hours) to accommodate parent work schedules;
- Provide services at times (evenings and weekends) and locations that are *convenient for working parents*;
- Establish *neighborhood-based family resource centers* to provide information, services, and safe places;
- Increase the number of *low or no-cost programs and structured activities* for children and youth (after school, summers and holidays);
- Develop *programming for teens* that increases participation rates and engages them;
- Provide *additional services for teen parents and other high-risk teens* (such as those leaving the foster care system at 18, or those involved with juvenile justice);

- Increase *job and life skills training* programs for teens and for adults;
- Expand *employment opportunities* for teens and for adults; and,
- Require (legislate) *screening of all volunteers working with children*, such as mentors and tutors, through state and federal background checks.

Strategic Planning

The Jenkins Foundation is committed to using its resources to assist in meeting community needs. This report was prepared, therefore, to provide information that can be used by the Foundation to plan action and guide future decision-making. The report attempts to describe the context of the youth violence issue in Metropolitan Richmond in 2006. It reviews the continuum of services for children and their families from birth to late adolescence, across all major domains of influence. Findings of recent needs assessments at the state, regional and local levels are presented, including information about program resources. Themes related to major issues and needs were identified by key informants, some of whom also recommended additional materials or drafted specific suggestions for review.

Major thematic principles to guide decision-making can be summarized as follows: (1) Issues related to youth violence are primarily systems-level problems; (2) planning and evaluation systems are critical components of the solution; (3) engagement of all key stakeholders is an essential process; (4) a full-continuum of multi-contextual services is required; (5) interventions that have scientific evidence of effectiveness are available; (6) family-focused services are best provided in neighborhood settings; and, (7) networks of agencies and community-based coalitions can multiply resources and impact.

*Barbara H. Dunn
August 2006*

Appendix A. References & Resources

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Note: Entries in **bold** are major resource references & websites

Appendix B.
Key Informants' Organizational Affiliations
(42 organizations & 70 individuals)

GRANTEES: *Note:* Number of individuals per organization in parentheses

Big Brothers, Big Sisters (1)
Boys & Girls Club (1)
Chesterfield CASA (1)
Children's Health Involving Parents (CHIP) of Greater Richmond (1)
Family Lifeline: Communities in Schools & Healthy Families (3)
Friends Association for Children (3)
Greater Richmond (SCAN) Stop Child Abuse Now (1)
Hanover Safe Place (1)
Henrico CASA (1)
Memorial Child Guidance Clinic (3)
Neighborhood Resource Center (1)
Richmond CASA (1)
Sacred Heart Center (1)
St. Joseph's Villa (10)
Team-Up Richmond (1)
United Way Services (1)
Virginia Mentoring Partnership (1)
William Byrd Community House (1)
YMCA (1)
YWCA (2)

OTHERS:

Attorney General's Office: (GRIP) Gang Reduction & Intervention Program (2)
Chesterfield County: Juvenile Services (2)
Chesterfield County Schools (2)
CHIP of Virginia (1)
Faith Leaders Initiative (1)
Hanover County Mental Health (1)
Healthy Families Partnership, Hampton (1)
Henrico County Mental Health (1)
Hopewell District Court Services (1)
Medical Home Plus (1)
Petersburg Juvenile Community Crime Control Program (1)
Regional Drug Free Alliance (1)
Richmond Behavioral Health Authority & Friends of Prevention (1)
Richmond City (3)
Richmond Juvenile & Domestic Relations Court (2)
Richmond Public Schools (1)
Robins Foundation (2)
University of Richmond/Connect Richmond (1)
Virginia Department of Health (2)
Virginia Commonwealth University (VCU) (6)
Voices for Virginia's Children (1)
Wingspan/Al's Pals (1)

Appendix C.
Model & Promising Programs: Surgeon General & Blueprints
(Center for the Study of Youth Violence & Prevention)

(Note: bolded programs are named in both reports; program name variations are per reports)

A. Surgeon General's Report (DHHS, 2001)

(see www.surgeongeneral.gov/library/youthviolence)

1. Model Programs (7):

Level 1 (Violence Prevention)

Functional Family Therapy (FFT)

Multisystemic Therapy (MST)

Multidimensional Treatment Foster Care (MTFC)

Prenatal and Infancy Home Visitation by Nurses

Seattle Social Development Project

Level 2 (Risk Prevention)

Life Skills Training (LST)

Midwestern Prevention Project (MPP)

2. Promising Programs (20):

Level 1 (Violence Prevention)

Intensive Protective Supervision Project

Perry Preschool Program

Montreal Longitudinal Study/Preventive Treatment Program

School Transitional Environmental Program (STEP)

Striving Together to Achieve Rewarding Tomorrows (CASASTART)

Syracuse Family Development Research Program

Level 2 (Risk Prevention)

Bullying Prevention Program (Owelyus)

Families and Schools Together

Good Behavior Game

I Can Problem Solve

Iowa Strengthening Families Program

Linking the Interests of Families and Teachers (LIFT)

Parent Child Development Center Programs

Parent-Child Interaction Training

Preparing for the Drug-Free Years (Guiding Good Choices)

Preventive Intervention

Promoting Alternative Thinking Strategies (PATHS)

The Incredible Years Series

The Quantum Opportunities Program

Yale Child Welfare Project

Appendix C.
Model & Promising Programs: Surgeon General & Blueprints
(Center for the Study of Youth Violence & Prevention)

(Note: bolded programs are named in both reports; program name variations are per reports)

B. Blueprints for Violence Prevention (CSYVP, no date)

(see www.colorado.edu/cspv/blueprints)

1. Model Programs (11):

Big Brothers Big Sisters of America (BBBS)

Functional Family Therapy (FFT)

Life Skills Training (LST)

Midwestern Prevention Project (MPP)

Multidimensional Treatment Foster Care (MTFC)

Multisystemic Therapy (MST)

Olweus Bullying Prevention Program (BPP)

Project Towards No Drug Abuse (Project TND)

Promoting Alternative THinking Strategies (PATHS)

The Incredible Years: Parent, Teacher and Child Training Series (IYS)

2. Promising Programs (17):

ATLAS (Athletes Training and Learning to Avoid Steroids)

BASICS (Brief Alcohol and Intervention of College Students)

Behavioral Monitoring and Reinforcement Program

Brief Strategic Family Therapy (BSFT)

CASASTART (Striving Together to Achieve Rewarding Tomorrows)

FAST Track

Good Behavior Game (GBG)

Guiding Good Choices (GGC) (formerly Preparing for the Drug-Free Years)

I Can Problem Solve (ICPS)

Linking the Interests of Families and Teachers (LIFT)

Perry Preschool Project

Preventive Treatment Program (PTP)

Project ALERT (Adolescent Learning Experiences in Resistance Training)

Project Northland

School Transitional Environmental Program (STEP)

Seattle Social Development Project (SSDP)

Strengthening Families Program For Parents and Youth 10-14

Appendix D. List of Abbreviations

Federal Agencies/Departments & Centers

CDC—Centers for Disease Control & Prevention

CSAP—Center for Substance Abuse Prevention at SAMHSA

DHHS—Department of Health & Human Services

NCMHPVP—National Center for Mental Health Promotion & Violence Prevention at SAMHSA

NCADI—National Clearinghouse for Alcohol & Drug Information

NYVPR—National Youth Violence Prevention Resource Center at CDC

SAMHSA—Substance Abuse and Mental Health Services Administration

State Agencies

VDOE— Virginia Department of Education

VDMHMRSAS—Virginia Department of Mental Health, Mental Retardation & Substance Abuse Services

University-Affiliated Organizations

CSPYV—Center for the Study and Prevention of Youth Violence, University of Colorado

SDRG—Social Development Research Group, University of Washington

Other

CtC—Communities That Care^R; SAMHSA/CSAP's planning system & youth survey

I CARE—Increased Community Awareness Requires Everyone; Hanover County coalition

MTF—Monitoring the Future; University of Michigan's national youth survey

SAFE—Substance Abuse Free Environment; Chesterfield County community coalition

YRBSS—Youth Risk Behavior Surveillance System; CDC's national youth risk surveys