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Report to the Ranking Minority Member, Committee on Finance, U.S. Senate

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WELFARE DEPENDENCY

Coordinated Community Efforts Can Better Serve Young At-Risk Teen Girls

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GAO

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Health, Education, and
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The Honorable Daniel Patrick Moynihan
Ranking Minority Member
Committee on Finance
United States Senate

Dear Senator Moynihan:

In recent years, concerns about rising caseloads and long-term dependence on welfare programs, such as Aid to Families with Dependent Children (AFDC), have focused attention on the nation's welfare system. In 1993, AFDC supported almost 5 million low-income families across the United States and was projected to cost over $26 billion in federal and state funds in fiscal year 1995. Increasingly, concerns have centered on the rising number of teenage mothers, and particularly on the high public costs associated with their dependence on programs such as AFDC.

The forces that place a young teen girl at serious risk of long-term welfare receipt begin very early. Recent reports have noted the positive association between growing up in an adverse environment, such as an abusive family or an impoverished neighborhood, and future cognitive, behavioral, and physical functioning.[1] However, the current mix of education, health, and social support programs has been unable to mitigate the effects of multiple family problems and deteriorating neighborhoods on the children being raised in these environments, particularly young teen girls. While many federal, state, and local human service programs target at-risk children and their families, the programs are not configured and services are not delivered in ways that maximize their impact on multiple family problems.

Because of these concerns, you asked us for information about young teen girls who may be at risk for AFDC dependency.[2] Specifically, our focus was the following:

[1]Starting Points: Meeting the Needs of Our Youngest Children (New York: Carnegie Corporation of New York, 1994); and Losing Generations: Adolescents in High Risk Settings, National Research Council (Washington, D.C.: National Academy Press, 1993).

[2]For the purpose of this report, we defined young at-risk teen girls as those who (1) have poor general life circumstances (such as poverty) or exhibit problematic behavior (such as early sexual activity) that is associated with problems such as teen pregnancy or illegal drug use, and (2) generally fall into the age group of 10 to 15 years old.

- describe the health and well-being of young at-risk teen girls and their families, and the condition of the urban neighborhoods where they live;
- obtain the local service providers' perspectives on the needs of these girls, how they are addressing those needs, and what obstacles service providers face in working with the girls, their families, and their communities; and
- describe how the communities where these girls live are responding to the service needs of this group.

To develop this information, we reviewed the relevant literature, contacted experts on services for at-risk adolescents, analyzed data collected by the Bureau of the Census, and conducted site visits in three urban neighborhoods—Ward 7 in Washington, D.C.; Boyle Heights in Los Angeles, California; and West Oakland in Oakland, California. In addition, we visited a community redevelopment project in Detroit, Michigan. (A complete discussion of our methodology and descriptions of the neighborhoods appear in apps. I and II.) We did our work in accordance with generally accepted government auditing standards.

Results in Brief

The forces of poverty—eroding the foundations of individuals, families, and communities—can show some of their most debilitating effects on young at-risk teen girls. Service providers in the neighborhoods we visited characterized many of the 10- to 15-year-old girls they serve as detached and isolated from their families and communities, sexually abused and neglected, and threatened by violence. A combination of poor economic and social conditions—(1) poverty and deteriorating neighborhoods, (2) dysfunctional families, and (3) poor self-image of the young teen girls themselves—has created a population of adolescents with multiple problems who have characteristics, such as early parenthood, associated with long-term public dependency.

Generally, community service providers told us that services for at-risk girls aged 10 to 15 were limited, and the services that were available were often provided after problems reached the crisis stage. The services that did exist in the neighborhoods we visited were not coordinated, and they focused only on the teen and a specific problem, ignoring, for example, the positive influence a parent could have and, conversely, the negative impact of a dysfunctional family. We also found that these girls (1) received a lower level of services than other at-risk groups, (2) were offered few preventive services, and (3) had limited access to the array of health and support services, provided in a safe environment, that experts

agree are needed by young at-risk teen girls. Community service providers told us that the services needed to address sexual abuse and exploitation, psychological and physical neglect, and drug and alcohol dependency were nonexistent, unknown or ignored by those in need, or located far from neighborhoods.

To better serve and reach more area residents, including young girls, some neighborhoods are organizing coalitions, led by local providers, often with assistance from private organizations and public agencies. In some cases, these efforts at integrating services have had a positive effect on neighborhood children. Some providers, often working in middle schools, have expanded their role in the community to better integrate services for at-risk teens and their families. Providers working in these coalitions told us they believed the emergence of neighborhood leadership is critical to the long-term success of the coalitions. New service delivery strategies being tried include identifying and providing multiple preventive services and activities, contacting parents or guardians and encouraging them to become involved in their children's activities, and increasing the community's participation and commitment to the initiative.

Background

There is growing concern among program providers and policymakers that large numbers of our nation's adolescents—particularly young girls between the ages of 10 and 15—are at great risk for a number of problems including pregnancy, alcohol and drug abuse, and school failure. Many of these young teens live in poor neighborhoods.[3] According to the 1992 Current Population Survey (CPS), there were over 7 million girls under 18 years old living in poverty, with over 2.5 million residing in poor neighborhoods. In addition, as many as half of all adolescents aged 10 to 15 are reported to be at moderate or high risk of school failure, early sexual activity, drug and alcohol use, or criminal behavior.[4] Among the most far reaching and costly of all negative outcomes for young at-risk girls is early parenthood. In 1990, about 361,000 babies were born to unmarried teenagers—approximately 9 percent of all births in that year.[5]

[3]A "poverty neighborhood" is defined as a census tract with a poverty rate of 20 percent or more based on the 1980 census.

[4]At-Risk Youth, The Urban Institute Policy and Research Report, Vol. 23, No. 1 (Washington, D.C.: Winter/Spring 1993).

[5]Kids Count Data Book 1993: State Profiles of Child Well-Being (Washington, D.C.: Center for the Study of Social Policy, 1993).

Teen Births Rising and Costly

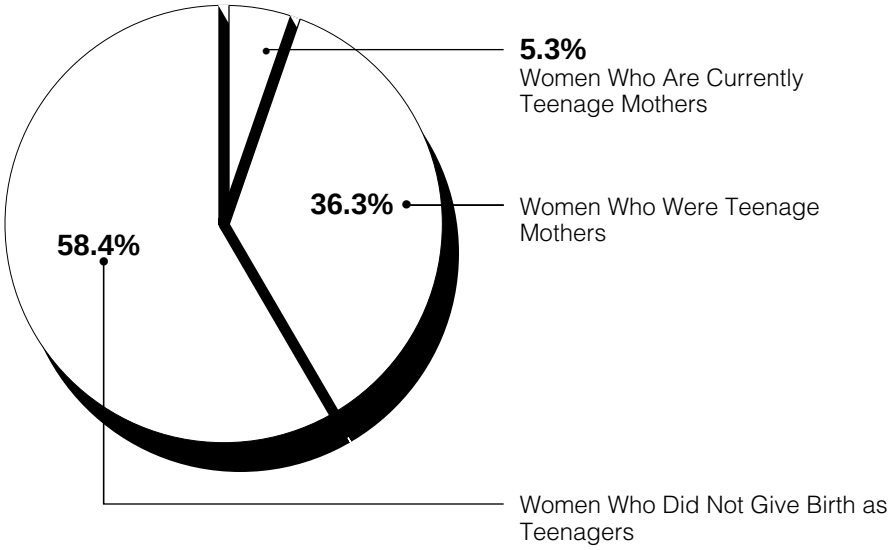
From 1960 to 1992, the birth rate for all teens increased from 15.3 to 44.6 births per thousand. While the number of births to the very young—aged 15 and younger—is not large, this group is experiencing the greatest rate of increased births.[6] Pregnancy rates for all girls under 15 years old rose 4.1 percent in the United States during the period between 1980 and 1988—higher than any other teen age group. In addition, these young mothers often have other characteristics that are associated with long-term welfare dependency and other long-term problems, such as deficient education and employment skills and histories of child abuse and neglect.

The public costs of teen mothers are high. According to the most recent Census data available, nearly one-half of all women receiving AFDC from 1976 to 1992 were or had been teenage mothers (see fig. 1). In addition, these women were more likely to be the least educated and have larger families, thus making them the least likely to leave AFDC and become self-sufficient.[7] The Center for Population Options estimated that in 1992 the federal government spent over $34 billion on AFDC, Medicaid, and Food Stamps to support families begun by teens.

[6]A State-by-State Look at Teenage Childbearing in the U.S. (Flint, MI: Charles Stewart Mott Foundation, 1991).

[7]Families on Welfare: Focus on Teenage Mothers Could Enhance Welfare Reform Efforts (GAO/HEHS-94-112, May 31, 1994).

Figure 1: Proportion of Women Who Gave Birth as Teenagers Is Nearly Half of All Single Women Receiving AFDC



Source: CPS, 1992.

Past Prevention Programs Have Shown Little Success

Generally, teen pregnancy prevention projects have produced less than encouraging results, whether programs were targeted to prevent teens from their first pregnancy or additional pregnancies. For example, the Office of Technology Assessment (OTA) reviewed pregnancy prevention programs that attempted to (1) increase teens' knowledge about reproduction, (2) improve access to contraceptives, or (3) broaden teens' life options. OTA concluded that despite some promising approaches, no evidence existed of significantly reduced pregnancy rates among teen girls when the approaches were applied independently.

Intervening after teens have become sexually active or after they have given birth appears to be too late for positive impacts, regardless of the type of program. For example, a national demonstration project that provided education and employability development as well as other supportive services to teen mothers was unsuccessful at reducing the rate of second pregnancies among teen mothers. The developers of this effort recognized the difficulty of overcoming "serious obstacles to advancement, some psychological in nature, others related to

dysfunctional families, dangerous schools and neighborhoods, and other factors in their social, physical, and economic environments."[8]

Historically, federal initiatives to address the individual problems of youths, their families, and teen pregnancy have generally resulted in "single-problem" programs and reactive, crisis-oriented service strategies by local providers. A Congressional Research Service (CRS) study concluded that some federal programs aimed at reducing the incidence of teen pregnancy disagree on the federal role, resulting in a patchwork of differing goals ranging from promoting abstinence to encouraging the use of pregnancy planning among sexually active teens.[9] Consequently, federal programs often support local projects that target one of these goals at the exclusion of others.

Poor, Dysfunctional Families and Deteriorating Neighborhoods Impact on Young At-Risk Teen Girls

In neighborhoods with high concentrations of poor families, many 10- to 15-year-old girls have multiple problems. The combination of abuse and neglect in young teens' households and dangerous and decaying neighborhoods has increased the numbers of young teen girls with the risk characteristics associated with long-term welfare dependency, education deficits, and early parenthood. These girls are growing up under circumstances that often compromise their health, impair their sense of self, limit their development potential, and generally restrict their chances for independent and productive lives.

Family Abuse and Neglect Leave Young Teen Girls Isolated and Vulnerable

In the neighborhoods we visited, family poverty combined with parental substance abuse and sexual or physical abuse of children makes growing up a significant challenge for many young girls. Many of the girls in these communities lived in households where the income was below the poverty level.[10] In Washington, D.C.'s, Ward 7, for example, according to the 1990 census, 18 percent of the households were considered to be poor.[11] In addition, many of the girls in the communities we visited lived in

[8]New Chance: Interim Findings on a Comprehensive Program for Disadvantaged Young Mothers and Their Children (New York: Manpower Demonstration Research Corporation, Sept. 1994).

[9]Welfare Reform: Adolescent Pregnancy Issues (CRS, 1994).

[10]In 1993, the federal poverty level for a family of three was $11,521.

[11]The city of Washington, D.C., is split into eight political wards.

single-parent households, typically headed by their mothers.[12] These households, as characterized by providers, lacked parental supervision and left young girls isolated from family members as well as from their neighborhoods. The principal of a middle school in West Oakland told us that many of her female students' parents were abusing drugs or alcohol, and crime and violence proliferated in their neighborhoods; one or both parents were often absent; and many of the adults in the homes did not have the skills and abilities to function as parents.

Families living in poverty are stressed and constrained by the normal activities of daily life, which can make parents and children feel hopeless and helpless. In our interviews with service providers and our reviews of recent studies, we found (1) high rates of substance abuse among the parents of young teen girls, (2) widespread physical and sexual abuse of teen girls, and (3) many young girls that were left unattended for long periods of time and who often assumed adult responsibilities in their homes.

Factors associated with family dysfunction, such as substance abuse, were prevalent in all the communities we visited. Nationally, rates of drug and alcohol abuse among women living in poverty and AFDC recipients, for example, have been estimated to range from more than 15 percent to almost 30 percent.[13] Drug and alcohol abuse among parents was seen as a widespread, serious problem by many neighborhood providers, as well as by the young teen girls themselves. For example, in the West Oakland neighborhood we visited, the arrest rate for narcotics was more than double that for all of Oakland. Boyle Heights in Los Angeles registered almost three times the rate of alcohol-related arrests as Los Angeles as a whole between 1991 and 1993. The Ward 7 community was no different. The Director of Recreation for Washington, D.C., said that many of the young girls the Department of Recreation serves witness daily alcohol and drug abuse.

Physical and sexual abuse were also reported by community providers as significant problems. In West Oakland, where the reported number of sexual abuse incidents rose from 49 in 1992 to 91 in 1993, the Adolescent

[12]Nationally, the percentage of children under 18 living with a single parent rose from 12 percent in 1970 to 27 percent in 1993. More notable, however, is that of those children living with one parent, the proportion of those living in a never-married household rose from 24 percent in 1983 to 35 percent in 1993. Marital Status and Living Arrangements, Bureau of the Census, Series P20-478 (Washington, D.C.: Government Printing Office (GPO), Mar. 1993).

[13]Substance Abuse and Women on Welfare, Center on Addiction and Substance Abuse at Columbia (New York: Columbia University, June 1994); and Substance Abuse Among Women and Parents (Washington, D.C.: Department of Health and Human Services, July 1994).

Family Life Director believed that as many as 65 percent of the young girls the office serves have been sexually abused. Some providers reported that young victims of abuse—characteristically passive, lacking self-esteem, and pressured into early sex by extended family members and older men—have few options or role models and often follow what are seen as common practices in their neighborhoods. Providers in residential care facilities for parenting teens reported that most of their clients were victims of abuse. Recent research confirms their observations. Studies reported that as many as 68 percent of teen mothers were sexually abused as children.[14]

According to community providers, young girls are often unsupervised or on their own for extended periods of time and essentially parenting themselves, which isolates them from their families and communities and makes them vulnerable to outside influences. Local providers believed that many of these girls become the functioning adult in the household and assume the responsibility of caring for younger family members.

Neighborhoods Often Dangerous and Decaying

The condition of the neighborhoods where these girls live induces fear and apprehension throughout the community. Their high crime rate, deteriorating infrastructure, and scarcity of commercial ventures threatens neighborhood children and provides them with few positive examples of future livelihoods. The areas we visited also had high numbers of declining public and private residential housing units. Each of these areas started out as a vibrant section of the city, but a variety of socioeconomic factors over time has caused these areas to deteriorate, leaving vacant and dilapidated buildings and reduced community resources. (Fig. 2 contains photographs of the neighborhoods we visited.)

Crime is an important contributor to the destruction of a community. Young teen girls in the neighborhoods we visited feared for their safety and saw few places of refuge. In Boyle Heights, gang violence is a serious problem. Providers told us that the approximately 30 gangs in the area had a membership of about 15,000. In 1993, the police reported 763 gang-related crimes in the Boyle Heights area alone. Service providers told us that the teen girls in the area are at risk of joining gangs—one provider estimated that about 60 percent of the teen girls are already in gang-related

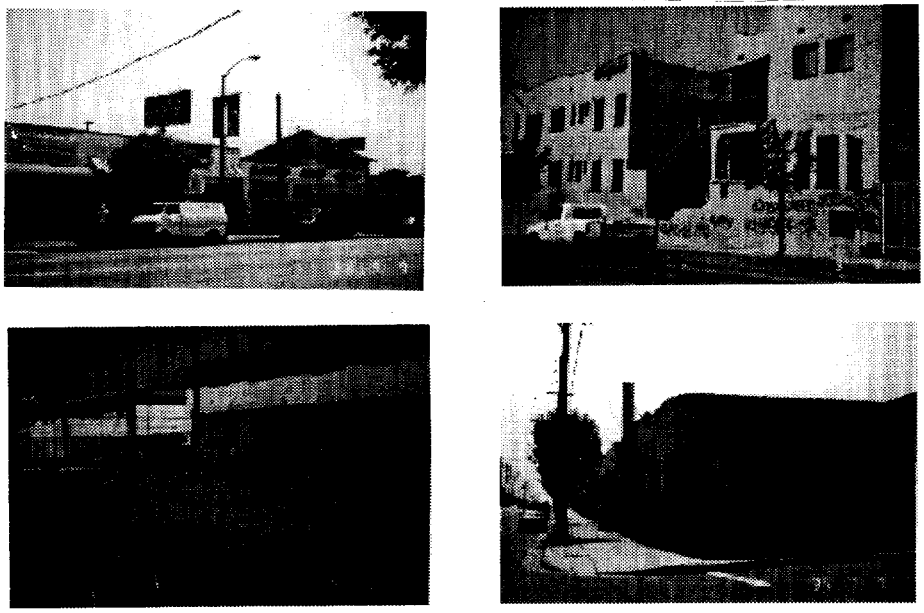
[14]Debra Boyer and David Fine, "Sexual Abuse as a Factor in Adolescent Pregnancy and Child Maltreatment," Family Planning Perspectives, Vol. 24, No. 1 (Jan./Feb. 1992); J. Butler and L. Burton, "Rethinking Teenage Childbearing: Is Sexual Abuse a Missing Link?" Family Relations, Vol. 39, No. 73 (1990); H. Gershenson and others, "The Prevalence of Coercive Sexual Experience Among Teenage Mothers," Journal of Interpersonal Violence, Vol. 4, No. 204 (1989).

activities. Although gang-related crimes were not reported to be high in Washington, D.C., the homicide rate in 1993 for Ward 7 was more than double that for the whole city. The girls we spoke with said that they feared going outside and preferred to stay at home. One girl told us that she feels "paranoid . . . wondering which way the bullet will go."

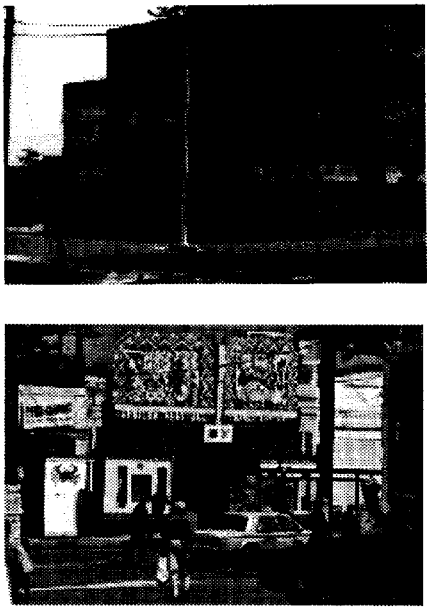
The physical and economic infrastructure of the neighborhoods we visited paralleled the social conditions. The neighborhoods were characterized by high numbers of public housing units—Washington, D.C.'s Ward 7 had the highest concentration of public housing units in the city. This neighborhood once had a solid middle-class residential and small business presence. Today, although the area continues to be residential with over 70,000 residents, 25.8 percent of the households were poor in 1990. In addition, although the area once had a substantial number of small businesses and stores, it now has no restaurants, except for fast-food places, and few opportunities for cultural activities. Boyle Heights, once an affluent suburb, is a mixture of aging commercial and industrial sections and subsidized housing. West Oakland has no drug stores, banks, or major grocery stores to serve its more than 15,000 residents.

Figure 2: Neighborhoods GAO Visited

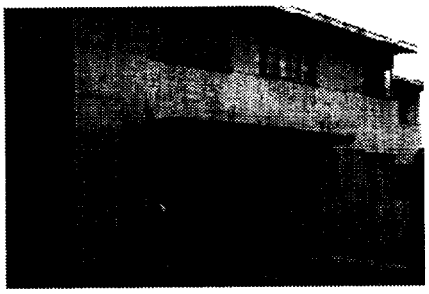
Boyle Heights, Los Angeles, California

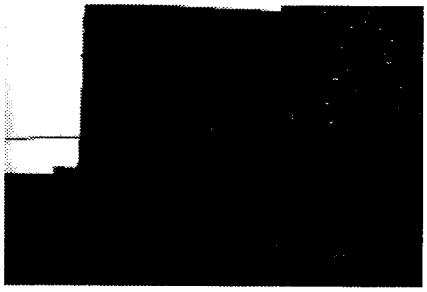


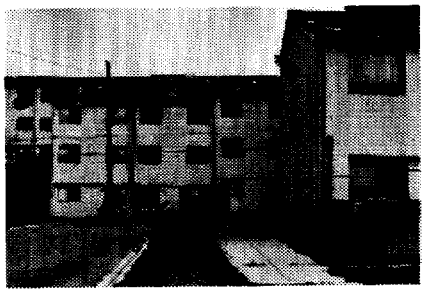
Ward 7, Washington, DC



West Oakland, California







Young Girls in These Neighborhoods Are at Risk for Multiple Problems

The interplay of family poverty—often with parental substance abuse and child neglect and abuse—and neighborhoods with few resources leaves young teen girls at risk for many problems and dangerous behaviors. Research studies and reviews have noted the relationship between adverse living conditions and outcomes that seriously impede teens' growth to self-sufficiency.

Family poverty and parental dysfunction are associated with a number of problems among the children in the household. First, the relationship between teen births and poverty is clear. Nearly half of the AFDC caseload is made up of women who gave birth during their teens, and these women are also less likely to have completed their high school education. Their children are in poorer overall health and can, as a result, suffer developmentally—increasing the likelihood of poor school performance. Parental drug and alcohol abuse has been shown to significantly increase the odds that an adolescent will become a substance abuser. Likewise, research has demonstrated a relationship between a woman's being abused as a child and her becoming a teen mother.

Neighborhoods with high concentrations of poor families generally have poor quality schools that, in addition to family economic stresses, increase the chance that children will fail in school or drop out. Children in poor neighborhoods also run a high risk of becoming both victims and perpetrators of crimes. Compounding the problem, because high numbers of youths and adults in these communities exhibit negative and antisocial behavior, positive community role models are scarce or absent. These distressed communities, with large numbers of children at risk, challenge the limited number of service providers and the poorly coordinated overall system of care.

Complex Needs Rarely Reflected in Services for Young Teen Girls

Communities with high numbers of young at-risk teen girls have had limited success in designing services and approaches that would help the most vulnerable of these young teens. The few services for these girls and their families are typically offered only when problems reach the crisis state. Neighborhood residents see providers and services open and close as funding appears and disappears. Providers believed that the services available generally ignore the positive role a parent can play in a child's development, as well as the negative impact of a dysfunctional family. Services designed to help dysfunctional families, such as mental health and substance abuse treatment, are either in short supply or far from the neighborhoods. Many experts agree that young at-risk teen girls could be

better served if traditional approaches were modified to include early identification and treatment, long-term program commitment, and greater community involvement.

Neighborhood Services Not Designed to Meet Multiple Problems of At-Risk Teens

Many of the providers in the neighborhoods we visited said that supportive services were often provided too late and lacked continuity. Most of the human services available to at-risk teens were crisis-oriented—provided only after a problem had occurred. For example, the schools in all communities we visited had specialized programs for teens who were either pregnant or already parents of very young children. Oakland's school-based Adolescent Family Life Program provided health and supportive services, parent education, job training, and counseling to teen girls under 17 years. However, to be eligible, a girl must be either pregnant or a parent. Providers saw the need for a more continuous approach to avoid early parenthood, such as offering early instruction and counseling or beginning career orientation programs in primary school. Early instruction and counseling is needed, they believed, because of the shortage of positive adult role models and the fact that these girls live in neighborhoods that often condone dependency and submissiveness. In West Oakland, a middle school counselor told us that any positive effects on young girls that a program supplying mental health workers to an elementary school had were eroded when the program was not continued in high school.

In addition, service providers cited a number of critical services needed by young teen girls that were either scarce or nonexistent. These include preventive services, such as strategies to avoid early sexual activity and pregnancy, resist drug use, and avoid gang membership; after-school recreational activities in a safe environment; and ways to identify early signs of school failure. A counselor at the Boyle Heights Boys and Girls Club saw young girls as the "forgotten majority." As their performance in school falters or they leave school because they are pregnant, they are barely missed by the community institutions, unlike the highly visible and sometimes violent young boy. Through our visits to neighborhoods and local inventories of existing services in those neighborhoods, we found few service providers who offered preventive care to young teen girls. For example, in the Boyle Heights neighborhood, we found only one prevention program targeting young girls—Education Now and Babies Later. Safe and secure locations where young girls could find recreational activities before and after school and on weekends were very rare in these communities. Violent gang activity, especially in the Boyle Heights

neighborhood, where there are reportedly 30 separate gangs, creates an environment of fear. Several of the young teens we interviewed said that they felt unsafe walking in their own neighborhood and often were afraid to come out of their home.

Few Services Offered to Dysfunctional Families

In the neighborhoods we visited, the number and scope of mental health services, including substance abuse treatment, supportive services designed to identify potentially abusive parents, and efforts to prevent abuse from occurring, fell far short of addressing the communities' problems. According to providers, community-based treatment and prevention programs geared to dysfunctional families, especially those emphasizing mental health and substance abuse issues, were either not available, in short supply, or located far from the neighborhoods.

Community service providers believe that family dysfunction adversely affects the growth and development of young teen girls and can lead to long-term dependency on public assistance. While providers reported the need for and lack of mental health services for the young girls in their communities, they also said that the parents are, at best, not prepared for their role as a parent and, at worst, need clinical treatment themselves.

Even when the programs exist, providers said that difficulty in getting parents involved in their children's activities is a significant barrier to serving at-risk teen girls. According to providers, parents are often unaware of their children's activities; may condone early sexual activity and childbearing; and give little attention and support to their children. Providers told us that often these characteristics are a function of long-standing and established patterns of parenting in the neighborhood and a general sense of hopelessness in the community. For example, counselors from a West Oakland middle school estimated that "75 percent of the mothers are not there for their children." In this school, children were reluctant to have a day to honor their mothers, and preferred to have their teachers attend. In about half the cases, according to a middle school principal, by the time a young girl reaches middle school, her household has dissolved and she is living with a grandparent.[15]

[15]In 1993, 5 percent of all children were living in a household with grandparents present (3.7 percent of white children, 12.1 percent of black children, and 5.9 percent of Hispanic children). Of the households, 30 percent have only grandparents present—24.9 percent of white households, 38.7 percent of black households, and 22.8 percent of Hispanic households.. See Marital Status and Living Arrangements.

Adolescent Services Can Improve With Changes in Approach and Scope

Research on the problems of adolescents and their service needs has reached a number of conclusions about the best approaches to meeting this population's multiple needs. For example, OTA's study on adolescent health—a comprehensive synthesis of the research findings—notes growing consensus on key components to successful preventive services for teens.[16] Recognizing along with other researchers that many adolescents' needs for health and related services are not being met with mainstream primary care, OTA concluded that school or community-based centers can offer comprehensive and accessible services. Others have joined in reexamining both programmatic and larger system strategies for addressing the problems of at-risk teens generally and teen pregnancy prevention specifically. They concluded that certain programmatic changes, moving toward a more comprehensive approach to care, can lead to greater success.[17] For example, the Urban Institute's review of program practices designed for at-risk adolescents cited the following components for a successful program:

- early identification and intervention;
- long-term and consistent intervention;
- individualized attention, instruction, and counseling;
- emphasis on skills enhancement, life options, and vocational orientation;
- development of multiple channels of influence, including parents, churches, and community organizations; and
- service delivery in a safe physical environment.[18]

Techniques suggested by experts to better integrate community services include collocating multiple service providers, joint planning among providers, and new local-level funding strategies.[19]

"System" changes involve trying new service delivery approaches and attempting to reduce conflicts among programs by removing inconsistencies in program rules and requirements. In our previous work, we found that to accomplish these changes, public and private service

[16]Adolescent Health, Vols. I, II, III, OTA (Washington, D.C.: GPO, 1990).

[17]Risking the Future: Adolescent Sexuality, Pregnancy, and Childbearing, Volume I, National Academy of Sciences, National Research Council Commission on Behavioral and Social Sciences and Education, Committee on Child Development Research and Public Policy, Panel on Adolescent Pregnancy and Childbearing, ed. C.D. Hayes (Washington, D.C.: National Academy Press, 1987); and J. Dryfoos, Adolescents At Risk: Prevalence and Prevention (New York: Oxford University Press, 1990).

[18]Martha R. Burt and Gary Resnick, Youth At Risk: Evaluation Issues (Washington, D.C.: Urban Institute, 1992).

[19]Sharon L. Kagan and Peter R. Neville, Integrating Human Services: Understanding the Past to Shape the Future (New Haven and London: Yale University Press, 1993).

agencies need to reorganize administrative structures around common populations or problems, use more flexible funding approaches, and create coordinated service planning at different levels of government.[20]

New Service Approaches Depend on Increased Community Leadership and Involvement

A community's ability to address the problems of at-risk teen girls depends on more than a collection of programs and service providers. Residents and providers in the neighborhoods we visited are becoming increasingly aware that a coordinated, integrated, and comprehensive network of services is needed to address the problems of teen girls. To do this, neighborhoods may have to overcome deficiencies in their own leadership and organization.

Community service providers in the neighborhoods we visited viewed the emergence of local leadership as an important ingredient in the development of new service strategies. They told us that identifying local leaders to initiate community action, sustain community support, and help residents gain control over their problems is key to the organization of better services for young teen girls as well as adolescents in general. In Ward 7, West Oakland, and Detroit, for example, coalitions and networks of local service providers are being developed to improve the capacity to address community needs and problems. Neighborhood coalitions can take various forms. The neighborhoods we visited showed that these service coalitions can be informal—a network consisting of frequent working relationships among various providers; or they can be a formal, comprehensive planning and implementation effort that incorporates residents, merchants, service providers, and the area's public agencies. Throughout these cooperative efforts, similar themes shape their goals and objectives. Providers believed they have to work collaboratively with local residents and businesses to deal with the needs and problems of not only teen girls but also the families and the communities as a whole. Most importantly, these communities realized that the strategies and solutions to their problems must come from within.

Local providers also found that they have to coordinate community activities with one another as well as with other entities in the community. For example, providers in Detroit's North High School neighborhood saw that they needed to link various activities in order to address the needs and problems facing adolescents, their families, and the surrounding neighborhood. Through a major private philanthropic organization in

[20]See Integrating Human Services: Linking At-Risk Families With Services More Successful Than System Reform Efforts (GAO/HRD-92-108, Sept. 24, 1992).

Michigan, the Kellogg Foundation, a comprehensive 20-year planning and coordination effort was developed jointly by the foundation and local providers and residents. Other efforts are more informal. For example, the Teen Life Choices program in Washington, D.C., established monthly lunch meetings that included many of the youth service providers in the community.[21] These meetings served as a way to get neighborhood providers to better understand each other's services, activities, and program procedures.

Local providers are also leading efforts to build coalitions with area schools as a strategy to deliver coordinated programs to the right age groups. In all the neighborhoods we visited, junior high or middle schools have emerged as major "catchments" for programs serving at-risk teen girls. For example, West Oakland's Lowell Middle School and Washington, D.C.'s Evans Junior High School are working with nonprofit agencies to deliver case management-style programs in the schools to serve their teen populations. Oakland's Lowell Middle School provided on-site case management and support services for students and their families. These services included individual and family counseling, home visits, crisis intervention, and community service referrals. Also, a West Oakland middle school principal is planning a program to include students, parents, and the community at large. The program would operate between 4:00 p.m. and 10:00 p.m. and would provide a fitness lab, computer/job skills training, medical information, mental health services, and parenting courses. Evans Junior High School's Turning Points program provided individual counseling and group activities to students as well as attempted to include parents by developing adult activities and hiring parents as Turning Points staff. [22]

The collaborative school-based efforts we observed in Detroit and West Oakland were achieving positive outcomes. A preliminary evaluation by the University of California of school-based projects in West Oakland identified successes in the start-up of the school-based programs. These programs were seeing positive responses from teachers and school officials as well as increased involvement from teens and their families. West Oakland found that these efforts reduced the number of discipline hearing procedures and the number of suspensions for students in schools receiving the services, when these students were compared with students in schools not receiving the services. In Detroit, the community, along with

[21]Teen Life Choices ceased operation on Octorber 1, 1994, as a result of city budget cuts.

[22]In February 1995, the Turning Points Program at Evans Junior High School and 14 other middle and elementary schools in Washington, D.C., was eliminated as a result of the city's budget cuts.

the Kellogg Foundation and Henry Ford Hospital, created a teen health clinic within Hutchins Middle School. The project reported a reduction in teen pregnancies from 14 in 1991 to 1 in 1993, immunization for all children in the school, and improved standardized achievement test scores over 2 years in both reading and math.

Both the literature and neighborhood providers told us that key to the development of any school-based program is the acceptance and approval of the school's principal.[23] Principals hold significant leverage over school curriculum and physical space. In addition, school principals are well informed about what is going on in school neighborhoods because they participate in various neighborhood activities and coordinating councils. Neighborhood providers and school officials we interviewed agreed that a program's success depends on the principal's acceptance of it. In some cases, programs have to overcome the reluctance of principals and teachers, who may try to "wait out" new initiatives. Providers told us that principals and school staff view new programs as politically motivated, claiming overly optimistic results, or requiring school time and physical space that could crowd out other programs and curricula.

Conclusions

The conditions that surround many young at-risk teen girls, which have replaced the traditional supports provided by functioning families and safe neighborhoods, have created a group of children with few options for future success. These children are among the most vulnerable and least visible residents of our urban areas, and are extremely difficult to serve. Often last in line for services delivered from a taxed and fragmented delivery system, at-risk teen girls—if left unserved—will continue to use scarce public resources and remain waiting to join the rolls of long-term welfare recipients. Individual programs alone, while well-intended and innovative in their approaches, have had little effect on the overwhelming, complex problems of this population. Community-designed and -directed initiatives that coordinate human service programs have shown promise in some urban neighborhoods in attacking the broader influences that place the well-being of these children and their families at risk. These initiatives need to facilitate collaborative planning, problem-solving, and program development at the neighborhood level. The challenge for both policymakers and program officials is to develop and implement national

[23]School-Linked Human Services: A Comprehensive Strategy for Aiding Students at Risk of School Failure (GAO/HRD-94-21, Dec. 30, 1993); and The Future of Children: School-Linked Services, Volume 2, No. 1 (Los Altos, CA: The Center for the Future of Children, David and Lucille Packard Foundation, 1992).

strategies that will support local leadership and at the same time foster cooperative ventures among local service providers.

Because this report focuses on local responses to at-risk teens and their families, we did not obtain agency comments. We did discuss, as a part of our field work, our observations with local providers and program officials.

We are sending copies of this report to relevant congressional committees and other interested parties. Copies will also be made available to others upon request.

This work was done under the direction of David D. Bellis. If you or your staff have any questions concerning this report, please call him on (202) 512-7278 or me on (202) 512-7215. Other major contributors are listed in appendix III.

Sincerely yours,

Jane L. Ross
Director, Income Security Issues

Contents

Figures

Abbreviations

AFDC	Aid to Families with Dependent Children
CPS	Current Population Survey
CRS	Congressional Research Service
OTA	Office of Technology Assessment

Scope and Methodology

To develop the information for this report, we collected and reviewed the literature on adolescent health and service approaches to at-risk teens. In addition, we reviewed studies on teen pregnancy and prevention and analyzed data collected by the Bureau of the Census. We also contacted program officials from federal agencies and representatives from organizations who were familiar with this population and its service needs.

We visited three urban neighborhoods for close review—Ward 7 in Washington, D.C.; Boyle Heights in Los Angeles, California; and West Oakland in Oakland, California—to document the availability of human services for at-risk teen girls; the barriers to serving this population; and how communities are responding to this population's service needs. We selected these neighborhoods because they had (1) high numbers of at-risk teens who had characteristics such as high rates of poverty, teen births, and crime; and had (2) some services for young adolescents. In addition, we visited a community development program in Detroit, Michigan, that was supported by a private foundation. We interviewed local officials, service providers, and young teen girls served by service providers to identify the programs and problems in these neighborhoods. We did our work between September 1993 and December 1994 in accordance with generally accepted government auditing standards.

Profiles of the Three Neighborhoods Reviewed

Boyle Heights, Los Angeles, California

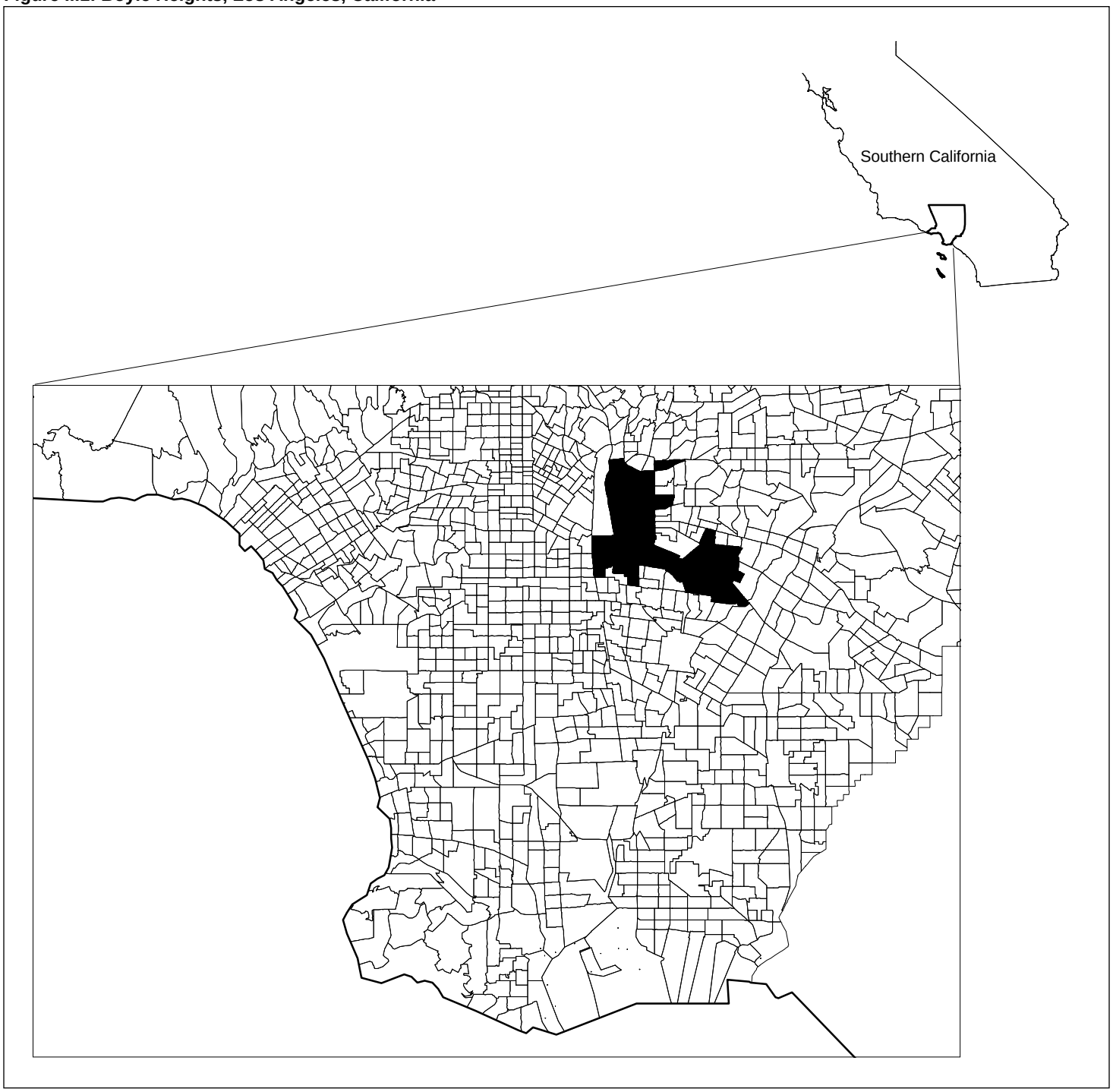
Boyle Heights, located east of downtown Los Angeles, is one of the oldest communities in the city. Since the 1940s, Boyle Heights has been populated by first-, second-, and third-generation families of predominantly Mexican heritage. The community has become an important point of entry for thousands of new immigrants since the 1970s. Boyle Heights has a population of over 94,000, and 94 percent are of Hispanic origin.

The majority of the area's housing was built in the 1920s. Single family houses compose 43 percent of the residential area. Six of the 21 public housing projects in Los Angeles are located in Boyle Heights, which include 2,166 units for about 8,300 residents. Commercial and industrial corridors in the area were developed in the 1920s and 1930s and currently include clothing and fabricated metal production. The predominant retail trade businesses are restaurants, groceries, and clothing stores.

Almost 70 percent of the households are low income, and the area has a poverty rate of about 30 percent, compared with a citywide rate of 19 percent. In 1990, the unemployment rate was almost 14 percent, 8 percent citywide. Approximately 3,000 of the area's 14,500 school-age children are in AFDC households, and the area has the 11th highest number of children receiving free and reduced-price meals in Los Angeles County.

The crime rate in Boyle Heights is higher than in the city as a whole, with homicide at almost twice that of all of Los Angeles; 1991-93 averages were 13 homicides per 10,000 versus 7 per 10,000 for the whole city. Gang violence is a serious problem. Local providers estimate that about 30 gangs operate in the Boyle Heights neighborhood. According to Los Angeles Police Department data, 763 gang-related crimes were committed in the district covering Boyle Heights in 1993.

Figure II.1: Boyle Heights, Los Angeles, California



Contacts Made in Boyle Heights Neighborhood

Aliso Pico Multipurpose Center
Barrio Action Group
Booth Memorial Center (residential care for pregnant teens)
Boyle Heights Continuation High School
Catholic Charities Brown House
City of Los Angeles, Department of City Planning
City of Los Angeles, Housing Authority
County of Los Angeles, Adolescent Family Life Program
County of Los Angeles, Department of Children's Services
County of Los Angeles, Department of Health Services
County of Los Angeles, Division of Alternative Education
Eastside Revitalization, Community Redevelopment Agency
El Centro (mental health services)
Hollenbeck Junior High School
Hollenbeck Youth Center
Latino Family Preservation Project
Los Angeles Department of Public Social Service, GAIN Division
Los Angeles Police Department
Los Angeles Unified School District
Ramona Gardens Community Service Center
Ramona Junior High School
Ramona High School
Roosevelt High School
Salesian Boys and Girls Club
St. Anne's Maternity Home
United Way
Variety Boys and Girls Club

West Oakland, Oakland, California

Over the past 40 years, West Oakland has declined from a vibrant working-class community to a decaying neighborhood. Neighborhood conditions began to deteriorate after World War II, when houses built for wartime workers were torn down as defense-related jobs dwindled. Also, large public construction projects, such as the Cypress Freeway, a Bay Area Rapid Transit station, and a main postal facility, displaced families, destroyed homes, and separated commercial activity from the neighborhood. Since the 1970s, the neighborhood has been unable to regain the local businesses it once had—the neighborhood has no drug stores, banks, or major grocery stores.

West Oakland has 12 public housing projects and one of the city's highest concentrations of Section 8 housing assistance recipients. In addition, 39 percent of all housing units in West Oakland are assisted housing, in contrast to 10 percent for the entire city of Oakland.

West Oakland has poverty and unemployment rates that far exceed those of Oakland as a whole. About 34 percent of West Oakland residents live in poverty, almost double the city average of 19 percent. Moreover, more than half (55 percent) of the youths living in West Oakland are poor, compared with 30 percent citywide.

West Oakland is a dangerous neighborhood. West Oakland's crime rates exceed those in the rest of the city, with a homicide rate that is more than double the citywide average, and rape and burglary rates that are almost 150 percent higher.

Figure II.2: West Oakland, Oakland, California

Contacts Made in West Oakland Neighborhood

Adolescent Family Life Program
Alameda County Housing Authority
Alameda County Welfare Department
Bananas (teen parent services)
Big Brothers and Big Sisters
Carter Middle School
Catholic Charities
Child Health and Disability Prevention
Child Protective Services (foster care)
Children's Hospital
Comprehensive Teenage Pregnancy and Parenting Program
Court Appointed Special Advocate
Dream West (education program)
East Bay Omega Club
East Bay Perinatal Council, Adolescent Family Life Program
Education Now, Babies Later
Emergency Services Network
Florence Crittenton Services
George Schnotlan Youth and Family Center
Girls Incorporated (community organization/center)
Gladman Memorial Hospital
Hillcare Health Services
Imani House (community organization/center)
Lowell Middle School
Marcus A. Foster Educational Institute
McClymonds High School
Mental Health Services for Children and Youth
National Runaway Switchboard
Pregnancy Crisis Center
Oakland Birth to Schools
Oakland Housing Authority
Oakland Office of Health and Human Services
Oakland Parent Child Center
Oakland Parks and Recreation
Oakland Unified School District (Comprehensive Health and Safety Program)
Teen Counseling Helpline
Thurgood Marshall Family Resource Center
United Way
Urban Strategies Council (community organization/center)
We Speak
West Oakland Health Center (teen clinic)

West Oakland Mental Health Center
Youth Crisis Runaway Hotline

Ward 7, Washington, D.C.

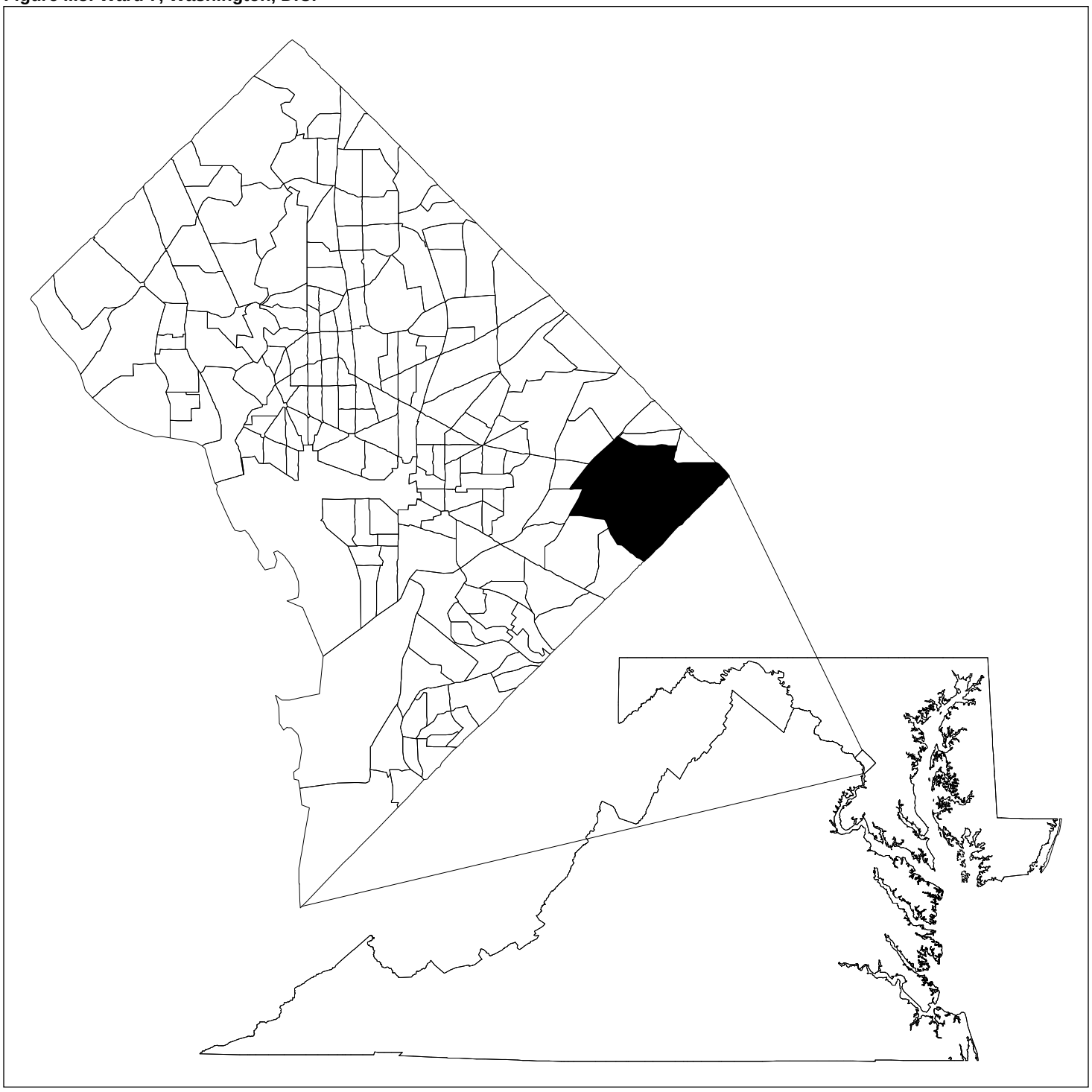
Ward 7 is the easternmost ward in Washington, D.C., and it is physically separated from the central and western sections of the city by the Anacostia River. Although it was never among the wealthiest of the District's communities, Ward 7 once had a solid base of middle-class families, as well as a substantial number of small businesses and retail establishments. However, the out-migration of many middle-income families and businesses, which began in the 1970s, has helped to destabilize the ward.

Ward 7 has the highest concentration of public housing stock in the city, one-third of the city's total stock—or about 2,880 units. In 1990, Ward 7 had a population of about 73,000, as compared with over 86,000 in 1980. The neighborhood in Ward 7 we visited had about 43,000 residents. Over 25 percent of the Ward's residents live in poverty. In contrast, about 17 percent of the total Washington, D.C., population lives in poverty. Forty-six percent of the neighborhood's 32,473 adult residents (16 and older) were either not in the labor force or not employed.

Nearly 5,300 families, or 67 percent of the Ward's families with children, were headed by a single parent. Further, 26 percent of its population was under 18 years of age in 1990. About 20 percent of all births in the neighborhood were to females under age 20.

In 1993, the Ward 7 neighborhood accounted for 64, or about 14 percent, of the city's 453 homicides and 11 percent of the reported rapes that occurred in the city.

Figure II.3: Ward 7, Washington, D.C.



Contacts Made in Ward 7

African Heritage Dancers and Drummers
Ballou High School (Project We Care)
Best Friends (mentoring program)
Center for Law and Social Policy
Center for Substance Abuse Prevention
Center for Youth Services
Children's Trust Neighborhood Initiative (case management and social support)
Columbia Hospital Teen Center
Community Health Care, Inc.
D.C. Bureau of Training and Employment, JOBS Program
D.C. Department of Child Protective Services
D.C. Department of Recreation
D.C. Department of Human Services, Office of Maternal and Child Health
D.C. Healthy Start
D.C. Mayor's Youth Initiative
East Capitol Dwellings
East of the River Health Clinic
Edward Mazique Parent/Child Center
Greater Washington Boys and Girls Club—Jelleff House (residential program)
Greater Washington Urban League
James Bell and Associates
Kenilworth-Parkside Recreation Center
Marshall Heights Community Development Organization
Metropolitan Police Boys and Girls Clubs
People's House (hotline and referral service)
Planned Parenthood of the Metropolitan Washington Area
Richardson Elementary School
Roving Leaders Program (counseling and referral service)
Sasha Bruce Youthwork
SYNERGY (adolescent health community coalition)
Teen Life Choices
Turning Points Program at Evans Junior High School
United Black Fund
U.S. Department of Justice, Office of Juvenile Justice Programs

GAO Contact and Staff Acknowledgments

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David Bellis, Project Manager, (202) 512-7278

Acknowledgments

The following individuals also made important contributions to this report: Valerie Rogers, Evaluator; John Vocino, Senior Evaluator; Lisa Shibata, Evaluator; Pamela Brown, Evaluator; and Margie Shields, Senior Evaluator.

Related GAO Products

Community Development: Comprehensive Approaches Address Multiple Needs but Are Challenging to Implement (GAO/RCED/HEHS-95-69, Feb. 8, 1995).

Families on Welfare: Teenage Mothers Least Likely to Become Self-Sufficient (GAO/HEHS-94-115, May 31, 1994).

Families on Welfare: Focus on Teenage Mothers Could Enhance Welfare Reform Efforts (GAO/HEHS-94-112, May 31, 1994).

Foster Care: Parental Drug Abuse Has Alarming Impact on Young Children (GAO/HEHS-94-89, Apr. 4, 1994).

Residential Care: Some High-Risk Youth Benefit, But More Study Needed (GAO/HEHS-94-56, Jan. 28, 1994).

School-Linked Human Services: A Comprehensive Strategy for Aiding Students at Risk of School Failure (GAO/HRD-94-21, Dec. 30, 1993).

Integrating Human Services: Linking At-Risk Families With Services More Successful Than System Reform Efforts (GAO/HRD-92-108, Sept. 24, 1992).

Child Abuse: Prevention Programs Need Greater Emphasis (GAO/HRD-92-99, Aug. 3, 1992).

Public And Assisted Housing: Linking Housing and Supportive Services to Promote Self-Sufficiency (GAO/RCED-92-142BR, Apr. 1, 1992).

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