DEPOSITORY COPY
DO NOT REMOVE

COMMISSION ON CHILDREN'S SERVICES
PUBLIC HEARING ON SERVICES
TO BLACK AND HISPANIC CHILDREN

MONDAY, SEPTEMBER 21, 1981

ATTORNEY GENERAL'S LIBRARY
NOV 30 1981

STATEHOUSE LIBRARY
ARCHIVES ROOM
STATE STREET
TRENTON, NEW JERSEY
9:00 a.m.

B E F O R E:

YOLANDA AGUILAR deNEELY, Vice-Chairperson of the Commission on Children's Services
SANDY LARSON, Director of Commission on Children's Services
CAROL KASABACH, Associate Director of Commission on Children's Services
JOHN S. MILLER, JR., Member of Commission of Children's Services
THOMAS H. CASEY, Member of Commission of Children's Services
GERALD THIERS, Member of Commission of Children's Services
JERRY JOHNSTON, Representing William Merritt
CIRO SCALERA, Representing Linda Wood
MARIA RIVERA, Community OutReach Specialist
ROBERT NICHOLAS, Department of Human Services.

REPORTED BY:

JANE LORFING, C.S.R.

SILVER, RENZI & GEIST REPORTING SERVICE
CERTIFIED SHORTHAND REPORTERS
824 WEST STATE STREET
TRENTON, NEW JERSEY 08618
(609) 989-9191
800 792-8880 (N.J. ONLY)

in Washington this weekend, it's not just occurring in New Jersey, it's occurring all over this country. And that's the sad part. The social service unit of the Camden County Welfare Board is an excellent unit. So is other agencies that are in that county. I think we have an excellent social service system in our county. People who are not, they pit us against each other and I feel very bad about that because the people they can hurt are the very people that are here today and with that in mind, I certainly am going to make sure that less and less were pitting against one another occurs and that we more and more become more imaginative about how we can address the problems of low-income, especially minority communities, black, Hispanic, and other under-funded groups get addressed because we have done it in the past and we can do it again.

Our next speaker is Stephen Eisdorfer, who is with the Division of Public Interest Advocacy with the Department of the Public Advocate.

MR. EISDORFER: My name is Stave Eisdorfer. I'm appearing on behalf of the Department of the Public Advocate and I would like to thank you for holding this hearing and

1 inviting us to participate. We are agenda-less.
2 Verice Mason was to represent the Department.
3 Unfortunately, she had a medical emergency and was
4 unable to make it this morning, so I am appearing
5 in her place. If I stumble around a little bit,
6 I hope you will excuse me, since I'm improvising
7 a little bit from the materials that she developed.
8 You have before you a document
9 prepared by the Department of the Public Advocate.
10 I don't intend to read that document, but I hope
11 you will do so. What I propose to do is just
12 present some highlights from that document.
13 What we have sought to do is to
14 explore a little bit the inequities in receipt of
15 services by minority children. And we have focused
16 in four specific areas, in health, education,
17 employment and child placement services. And
18 there is a pattern that runs throughout all of
19 these areas and the pattern is that minority
20 children experience a three-fold burden. First
21 of all, the burden of discrimination, the second
22 burden is the burden of poverty, the third is the
23 particular topography in New Jersey that results
24 in New Jersey cities where minorities disproportion-
25 ately live, being depressed, decaying, and having

1 the greatest burden of problems and the poorest
2 quality social services. So for example, if the
3 area of health, and health is,good health is a
4 prerequisite to all of the other good things in
5 life, we see inequities in the quality of health
6 that begins before birth and runs throughout the
7 child's lifetime. Mothers of--pregnant mothers are--
8 minority pregnant mothers are twice as likely not
9 to have received prenatal care. Black infants
10 have twice as high a death rate as White infants
11 in New Jersey. Black infants are twice as likely
12 as to be low-weight infants which leads to a whole
13 variety of later-life medical problems. Minority
14 children/teenagers are 25 percent more likely to
15 die from illness.
16 Now, certainly some of this problem
17 is simply lack of access to medical care. Minority
18 children are only half as likely to have a regular
19 source of medical care. They are five times as
20 likely to rely on hospital emergency rooms or
21 outpatient clinics. They are three times as likely
22 as white children to receive mental health care in
23 residential institutions rather than in the
24 community. They are twice as likely not to--take
25 that back, white children are two and a half times

1 as often to have dental visits. The area of
2 health, there is something we can do about it
3 because there is a Federally-funded program that
4 has not yet been cut by the Reagan budget cuts,
5 specifically directed at this issue. We in New
6 Jersey just haven't done much with it, early
7 diagnostic screening and testing program. In New
8 Jersey our program is fragmented, lacks outreach
9 and follow-up, just doesn't do the job. The first
10 recommendation we would make here is that New
11 Jersey coordinate and unify its program, that it
12 tie its program into community-based providers
13 and to the public schools so all children who
14 are eligible are reached.
15 In the area of health, minority
16 children have a particular set of problems, one
17 of which is lead paint poisoning. Research
18 demonstrates even low levels of contact with lead
19 paint and not really eating it which is what
20 everybody talks about, simply being in rooms with
21 that paint have long-term consequences. While
22 we have a lead paint poisoning program, it has not
23 been focused on units that now have children
24 living in them. At the area of health, I direct
25 your attention to the area of education. It is a

1 Governmental function that touches most children
2 in the State of New Jersey. And it's a Governmental
3 function that has a powerful determining affect
4 on what happens to them as adults. And in
5 examining this we think there are three areas in
6 education where inequity clearly just leaps out.
7 One is in the area of school discipline and if you
8 will look in the report, you'll see a whole page-
9 long table of inequity rates of school discipline,
10 but let me just summarize the most dramatic
11 situation.

12 A Black child is twice as likely
13 to be suspended from school as a White child in
14 Ocean, Monmouth, and Salem, Gloucester Counties.
15 In Ocean County, a Black child is three times more
16 likely to be suspended from school. We think this
17 is a clear area where the State Department of
18 Education has to use its powers to monitor and
19 enforce equal treatment.

20 A second area is the area of
21 special education. We have a pattern of disbray
22 of evaluations and disbray placement of minority
23 children and in special education. Although the
24 overall rates of handicapped are approximately the
25 same, Black children are four times as likely as

White children to be classified as educably, mentally retarded. One of our more stigmatizing handicaps. When you look at the less-stigmatizing handicaps, White children are much more likely to be classified as perceptually impaired and 12 times as likely to be classified communications impaired. We have a statewide pattern of Blacks being classified in more-stigmatizing categories and Whites being classified in less-stigmatizing categories.

Now, there are a number of things to be done to deal with that. The first is to eliminate the present provisions of the school funding system that encourage over-classification and unnecessarily stigmatizing categories. The second thing is elimination of excessive and illegal reliance on IQ tests as an exclusive device for categorizing children as educable-mentally retarded and third is a vigorous state monitoring by the Department of Education to spot these areas of disparate treatment and to intervene just to stop them.

Now, the third area is the area of unemployment. And we hear about these things on a national basis, but it's worth keeping in

1 mind what unemployment means in New Jersey. The
2 most recent figures we have which are from the
3 second quarter of 1981, minority children between
4 the ages of 16 and 19 have an unemployment rate
5 of almost 41 percent. This compared as to the
6 already over-high unemployment rate of White youth
7 of 23 percent. So minority children are almost
8 twice as likely to be unemployed as Whites.
9 A recent study by the Vice-President's
10 Taskforce on Unemployment indicate there are four
11 factors that lead--that are indicators of high
12 unemployment. Being in any one of these categories
13 decreases your chance of getting a job and that is,
14 being a woman, being a dropout, being a member of
15 a minority group, coming from a poor family. And
16 this taskforce analyzing its figures, concluded
17 if you are a member of any two of these categories,
18 you had overwhelming barriers. If you are young
19 and looking for a job.
20 There are things that can be done
21 about this. One thing is simply job information.
22 Our present system of disseminating job information
23 through guidance counselors, employment services,
24 simply aren't reaching out to minority youth. We
25 need a system that makes more direct links between

the young and between private enterprise where the jobs are. The second area is the area of job training and here it's important to keep in mind two facts, the more important kinds of training people receive for jobs are, is training they receive on-the-job. And the second fact is that Federal economic projections indicate that virtually a hundred percent of all new jobs created in 1980 will be created in the private sector. What this means is that our job training has to not merely involve vocational schools and the like, but must involve private enterprise, must involve business and unions and the proper role of the Government is to bring business, unions and youth together to make those linkages and if need be, to fund training programs run through unions and businesses.

Now, a final area and I've saved it for last because it's really symptomatic of all the other problems I have described to you, is in the area of juvenile justice and child treatment placement and protective services.

We have a pattern that runs through this area. It is a pattern of disproportionate involvement of minorities in the juvenile justice system and disparate treatment once they get there.

1 Approximately 14 percent of the population, school-
2 age population, is made up of Blacks. They are
3 involved in 37 percent of the arrests for serious
4 offenses, but 58 percent of the population, juvenile
5 correctional facilities. That is to say, if you
6 are Black and you are arrested for a serious
7 offense, you are far more likely to go away to
8 jail than if you are White.
9 Now, to widen out the picture, it's
10 not unfair to say that we have two separate
11 unequal systems. For treatment of minorities when
12 it comes to institutionalization; they run in
13 parallel. We have a system of locked facilities
14 for minorities and non-secure facilities for Whites.
15 Of our institutionalized population, I should not
16 use the term institutionalized, group-care
17 facilities for children, 43 percent of that
18 population is minority. But 56 percent of the
19 population in state institutions is minority.
20 On the other hand, the more
21 treatment-oriented, less punitive, less likely to
22 be jail like private treatment facilities, only
23 37 percent of that population is minority.
24 In short, if you are a minority
25 child, you are more likely to go to a state

1 institution and looks like an institution and acts
2 like an institution.
3 If you are White, you are more
4 likely to find yourself in a private treatment
5 fa .ity. And even within the state institutions,
6 if you are Black, you are more likely to be in a
7 correctional facility. If you are White, you are
8 more likely to end up in a psychiatric facility.
9 What can be done about this? One solution is
10 simply going back to everything I've said. This
11 problem is symptomatic of the unequal education,
12 ealth, housing, jobs. And in part it can't be
13 solved without solving those problems but at the
14 same time we need to closely scrutinize all the
15 decisions to determine whether we are introducing
16 racial stereotyping and subtle forms of
17 discrimination. And we need more Black casework
18 staff to identify and to avoid these subtle forms
19 of discrimination.
20 Now, I would like to say to you
21 that I see solutions coming from the Federal
22 Government on the horizon, but it's not so. The
23 final word I have to say to you is we are going
24 to have to deal with these problems ourselves
25 because what's happening at the Federal level is

1 going to disproportionately impact on minority
2 children. Cut in daycare and funding for education,
3 in funding for social services, in funding for
4 health services, are all going to aggravate the
5 problems I have described to you. But there are
6 things we can do, I've listed you some already.
7 If you read the written testimony, more are listed.
8 There are things we can do in New Jersey and I
9 think we must do. I would be happy to answer any
10 questions if you have questions.
11 MS. deNEELY: Mr. Casey?
12 MR. CASEY: Steve, you indicated
13 there should be more Black casework staff?
14 MR. EISDORFER: I don't have that,
15 but I can get it for you. I'd be happy to do so.
16 MR. WILLIAMS: In mentioning Black
17 casework staff, is there any suggestion that that
18 staff be specialized or used exclusively for Black
19 clients?
20 MR. EISDORFER: No, sir. The
21 disparities we are describing are systemic in
22 character. They run through the whole decision-
23 making process and it is important that that staff
24 be distributed and deal with everybody because
25 that's the only way you eliminate the kinds of

1 systemic disparities.

2 MS. deNEELY: Steve, you alluded

3 to the fact there was testimony in here about the

4 foster parent or the foster child?

5 MR. EISDORFER: I haven't alluded

6 to it, but there is.

7 MS. deNEELY: There is?

8 MR. EISDORFER: Yes.

9 MS. deNEELY: Would you like to

10 make some comments in regard to that? We can

11 read, I'm sure.

12 MR. EISDORFER: In honesty, I

13 wouldn't. Mrs. Mason was better prepared to do

14 that than I. I don't think that I can do better

15 than you can reading it.

16 MS. deNEELY: Okay. I didn't

17 want to put you on the spot. It's probably

18 excellent in here and I know it is, and we'll read

19 it. I was just referring to some testimony we

20 received earlier this morning that probably you

21 will put some meat in in terms of statistics and

22 all, that probably there is a correlation between

23 some front line testimony as well as analysis by

24 the Department of the Public Advocate. We'll have

25 to see.

1 MR. EISDORFER: I think you will
2 find some useful things there. I wish I could
3 pull them all out off the cuff, but I won't be
4 able to.
5 MS. deNEELY: Thank you very much
6 for presenting this report and your testimony.
7 We'll be reviewing that very carefully.
8 The next person to testify today
9 will be Beverly Gilbert, with the New Jersey
10 Coalition for Battered Women.
11 MS. GILBERT: Thank you. I feel
12 somewhat at a loss after trying to follow that act.
13 I do represent the New Jersey Coalition for
14 Battered Women. Because battered women's programs
15 have only been in existence at the most four, four
16 and a half years, I don't have the kinds of
17 statistics that the gentleman before me presented,
18 but I would like to talk to you for just a couple
19 minutes about the children whom we see in our
20 shelter, 1.8 for every woman who comes to our
21 shelter. So almost twice as many children we
22 serve even though our prime directive is adult
23 oriented and I'd like to talk just for a couple
24 minutes about the needs of those children and
25 what's happening to them at this point in time.

DEPOSITORY COPY
DO NOT REMOVE

ATTORNEY GENERAL'S LIBRARY
NOV 30 1981

TESTIMONY OF THE DEPARTMENT OF THE PUBLIC ADVOCATE BEFORE THE COMMISSION ON CHILDREN'S SERVICES

Presented by:

Verice Mason,
Assistant Deputy Public Advocate
September 21, 1981

Participating in the
preparation of the testimony:

Steven Blader
Stephen Eisdorfer
Verice Mason
Marguerite Rosenthal
Edward Tetelman

Introduction

This written testimony is presented by the Department of the Public Advocate to the Commission on Children's Services in response to the Commission's concern that community and advocacy organizations address the issue of services for minority children in New Jersey.

This testimony addresses four specific areas: health, education, protective and treatment services, and employment. In these areas the public data demonstrates clear inequalities in the provision of essential services and clear failures to address the important distinctive needs of minority children.

The picture this data presents is a discouraging one. And, as the final section indicates, the federal budget cuts for fiscal year 1982 will almost certainly darken it still further.

Nonetheless, there are solutions. Throughout this testimony, we make recommendation which we urge the Commission to consider and adopt.

Health Care

Access to health care services has increased for the poor and minorities in the last twenty years with the establishment of medicaid and medicare. However a substantial gap continues to exist between whites and nonwhites. These differences are particularly visible in the delivery and availability of health care services to children. Indeed, the lack of services has resulted in more illness, more disability, and poorer school performance for nonwhite children. Additionally, the health care services that are available to nonwhite children tend to be more institutional and less mainstream than those available to white children. This results in decreased quality and continuity of care. These facts and results have been documented by national and state studies which highlight the impact of the gap in health care services between whites and nonwhites.

Childbirth and Pregnancy

Infant and fetal death rates for nonwhites are at least double those for whites. In 1979, infant deaths for nonwhites were 22.4 per 1000 live births (p.th.l.b.) as compared to 10.4 p.th.l.b. for whites; neonatal deaths were 15.0 p.th.l.b. for nonwhites and 7.7 p.th.l.b. for whites; fetal deaths were 15.9 p.th.l.b. for nonwhites and 7.8 p.th.l.b. for whites; and perinatal deaths were 30.4 p.th.l.b. for nonwhites and 15.4

p.th.l.b. for whites. Of special interest was a drop in white fetal deaths from 8.5 p.th.l.b. in 1978 to 7.8 in 1979, while nonwhite deaths in this category rose .02.*

Low birth weight is a major factor in overall survival, future health and development of children. New Jersey figures from 1975-77 show that the rate of births of babies weighing under 2,500 grams for blacks was 13.6 per 100 live births as compared to 6.2 per 100 live births for whites.** One of the major reasons for the substantial differences between white and nonwhite rates of infant and perinatal death and low birth weight is the lack of or delay in obtaining prenatal care by nonwhite women. The U.S. Department of Health and Human Services reports that 1.1% of whites and 2.9% of blacks receive no prenatal care at all, and that black women obtain prenatal care later in their pregnancies than do white women. Moreover, nonwhite women are five times more likely to die of complications in childbirth than are white women.

<u>The Lack of Access to Health Services and its Result</u>

Low income children, who are disproportionately minority,*** have no regular source of primary care. Indeed, statistics demonstrate that nonwhite children are twice as

---

* New Jersey Department of Health: Health Statistics 1979.

** Department of Health & Human Services, Health, United States: 1980

*** Nonwhites are approximately 18% of New Jersey's population. However they make up a disporportionate percentage of the (continued on next page)

likely as white children, even in lower income groups, to have no regular source of medical care. In addition they are five times more likely than white children to use hospital outpatient clinics and emergency rooms.* Regardless of family income, white children see physicians in their offices more often than nonwhite children do.**

One out of every three low income children under age 17 (18 million children) has never seen a dentist. Nonwhite children visit a dentist once for every two and a half times that white children do.***

Nonwhite children also are not as likely as white children in the same age groups to be immunized for major childhood diseases such as polio, diphtheria, measles, rubella, and mumps. The lack of immunization and access to health care services, as well as poorer nutrition, has resulted in higher morbidity and mortality for nonwhite children than for white children. For example, in 1974, nonwhite children were found to have tuberculosis at a rate more than five times that

---

low income population. The New Jersey Division of Public Welfare reported in 1977 that 78.6% of the Aid to Families with Dependent Children Program population were nonwhite and in 1980 there were 209,908 whites as compared to 331,421 nonwhites on medicaid.

* DHEW, Health, U.S. 1976-77, Table 57.

** CBO Health Differentials between White and Nonwhite Americans (1977) p. 12.

*** Portrait of Inequality: Black and White Children in America, Children's Defense Fund, 1980, p. 102.

of white children.* Nonwhite children and teenagers die from illnesses at rates 25% higher than those of white children and teenagers. The following statistics affirm these rates:

Death for all causes per 100,000 persons **

Age	under 1	1-4	5-9	10-14
white male	1,429.7	69.7	38.4	42.5
black male	3,038.7	113.6	53.6	55.7
white female	1,094.8	55.0	25.6	25.0
black female	2,509.6	91.0	35.6	28.3

Diseases of the heart per 100,000 persons

Age	under 1	1-24
white male	24.0	1.7
black male	43.8	3.9
white female	16.2	1.2
black female	37.7	3.1

These figures also prove to be higher for blacks than for whites when examining the major causes of death for ages 1-14:

Major Causes of Death 1976 per 100,000 persons

	Accidents	Motor Vehicles	Birth Defects	Influenza & Pneumonia	Homicide
white	9.8	8.8	3.7	1.5	1.0
black	15.1	10.0	4.2	2.9	3.3

---

* Preliminary Report: U.S. Immunization Survey, 1978. (Atlanta G.A.: Public Health Service, 1980) Tables 10,11,12,13,14.

** DHS, Health, United States, 1980.

Mental Health Services

Nonwhite children are treated for mental health problems at higher rates than are white children. However, white children are more likely to be seen as outpatients while a substantially higher percentage of nonwhite children are institutionalized:*

Service & Admission to State & County Mental Hospitals: 1975

	white male	nonwhite male	white female	nonwhite female
Inpatient				
under 18	39.3	103.1	23.6	52.2
18-24	343.9	892.1	129.4	241.8
Outpatient				
under 18	620.7	947.3	385.4	480.4
18-24	798.3	881.3	965.5	699.0

At least one author has offered an explanation for this situation. Dr. Richard Shapiro has described the tendency of community mental health professionals to misdiagnose blacks' conditions and to classify blacks in groups with worse prognoses.**

Public Health Screening

Two major public health problems that affect low income and minority children are lead poisoning and sickle cell anemia.

Lead poisoning usually occurs when infants and young children eat lead-based paint (pica) or when lead is ingested

---

* President's Commission on Mental Health, Task Force Panel Reports. Submitted to the President's Commission on Mental Health, Vol. III Appendix (Washington, D.C. 1978) unnumbered tables on pgs. 832 and 833.

** Richard Shapiro, "Discrimination and Community Mental Health: Challenging Institutional Racism," Civil Rights Digest, 8:192-23 Fall, 1975.

through contact with environmental conditions such as a near-by battery smelter or heavily-traveled highway. Serious lead poisoning can result in brain damage, damage to the nervous system, mental retardation and death. However, recent studies have demonstrated that even low levels of lead in children have contributed significantly to psychological problems and poor school performance and behavior, e.g. hyperactivity, lack of concentration, etc.* The lead screening programs in New Jersey in 1979 tested 14,564 children of whom 3,051 had significantly high lead levels and of whom 1,103 were at very high risk. During that year, the cities with the largest number of high risk children were Newark, East Orange, Paterson, Elizabeth, Camden, and Plainfield, all cities with substantial, if not predominant, low-income and minority populations.

Sickle cell anemia is almost exclusively a black condition. The New Jersey Department of Health estimates that 93,000 persons are sickle cell carriers. Sickle cell anemia is characterized by arthritic manifestations, shortness of breath, acute attacks of pain, circulation problems, and a lack of usual energy. The result of this condition in an active state will limit a child's ability to perform and fulfill his potential.

---

* Needleman, Herbert, "Deficits in Psychologic and Classroom Performance of Children with Elevated Dentine Lead Levels," 300 N. Eng. J. of Med. 689 (March, 1979). Needleman, Herbert, "Exposure to Lead: Sources and Effects," 297 New England Journal of Medicine No. 17 (October, 1977).

It is clear from the foregoing that minority children have less access to health care services, receive lesser quality and continuity of services, and pay a dear price in higher morbidity and mortality for these circumstances. Moreover, this present situation is expected to worsen under the federal budget cuts which directly effect those programs, such as community health centers, family planning, etc., that serve the low-income and minority population. The result of these cutbacks will be a further increase in mortality and morbidity.

Recommendations

(1) The Early Periodic Screening Diagnosis and Treatment (EPSDT) program offers a comprehensive mechanism to deliver health care services to children through medicaid. Unfortunately, this program has often been fragmented, lacking in outreach and follow up, and has been less than fully effective. We suggest that EPSDT be used as a cornerstone upon which to build a more comprehensive health care delivery system for children and that the following be incorporated into EPSDT to make the program more effective:

(a) The EPDST program, in cooperation with the Department of Health, the New Jersey Medical Society, the New Jersey Hospital Association, the Public Advocate, and others, should develop a program to provide comprehensive EPSDT through the supervision of single providers. This case management

system would allow a child's medical and evaluation records to be kept in one place and would assure that continuity, comprehensive screening, assessment, diagnosis, and follow up care or treatment would be accomplished quickly and efficiently. An additional benefit of such a system would be the availability of specific data on the health problems of children in particular groups or in specific geographic areas. This information then could be compiled and analyzed by the Department of Health and would serve as a basis for developing needed services or preventive strategies.

(2) Outreach for the EPSDT and other screening programs, such as those for lead poisoning, should be conducted wherever possible, through community-based organizations which serve or are made up of low-income persons. These organizations, especially if they are EPSDT providers, should be reasonably reimbursed for their efforts. Outreach conducted in this fashion has proved extremely effective in getting medicaid families to participate in such programs and to understand what the programs are designed to do.

(3) Developmental assessments through EPSDT, community mental health centers, etc., should be done comprehensively using various modalities and tests. No standardized tests should be used unless the tests are standardized to norms for age, sex, race, and socioeconomic status of the

assessed population, are demonstrated valid and reliable, and are stated in language appropriate to the child. Any test used should be established in conjunction with professional and consumer groups.

(4) The EPSDT program, in cooperation with the Department of Health, community mental health programs, developmental disability advocacy groups, and others, should develop community-based programs to meet the needs of mentally ill and developmentally disabled children.

(5) The EPSDT program and other health care providers should encourage and support the development and use of community-based providers who operate with physician extenders to conduct EPSDT and to deliver health care services, especially in areas where there is a shortage of primary health care services.

(6) The Division of Medical Assistance and Health Services (Medicaid program) and the Department of Health must develop a better system of reporting specific health care data. Individual providers who supervise or manage child care must be able to report any problems discovered, diagnoses, treatments, and resolutions to a central information system.

(7) In areas where physicians and other medical personnel are either unavailable or do not serve the indigent and low income community, school health programs should contract with Medicaid to do assessments, diagnoses and proper referrals of children with uncovered physical and mental conditions under

the EPSDT program. If EPSDT is operated in this fashion then school health personnel must be obligated to manage individual cases.

(8) The Lead Poisoning program's abatement system must set priorities to remove lead paint from houses and apartments where children presently reside.

(9) The Department of Health should permit pre-natal clinics to receive reimbursement for sickle cell anemia tests from the crippled children's program. It should obtain appropriate data from those clinics.

(10) The Physician-Dentist Loan Redemption Program should be increased to place more physicians and dentists in medically underserved areas.

(11) The College of Medicine and Dentistry of New Jersey should continue its strong affirmative action program in medicine and dentistry and should increase its efforts to graduate and interest more students in family practice and primary care.

(12) The Department of Health should require hospitals as a condition of licensure to pass staff bylaws requiring physicians on staff to accept and treat their fair share of medicaid and indigent patients on a regular basis.

(13) The Department of Health should enforce its regulation requiring hospitals to have outpatient clinic services with appropriate hours to meet community needs.

(14) Head Start and daycare programs should coordinate with parents and health care providers to help children obtain basic health care services such as immunization and EPSDT.

(15) The school health programs, especially in urban areas, should conduct blood lead tests as part of their yearly examinations.

Public Elementary and Secondary Education

No government function more directly affects children than the public education system. No governmental function has more impact on the future well being of society as a whole and various groups within society. Patterns of unequal treatment of minorities in the public education system are therefore matters of the greatest public importance.

School discipline

An important area of unequal treatment is school discipline. Data collected by the federal government and analyzed by the Children's Defense Fund indicates that minority children are more frequently suspended or expelled, more likely to be suspended repeatedly, and suspended for longer periods of time than white children. New Jersey does not collect data that permits full analysis of the problem, but as the accompanying chart indicates, a significantly greater proportion of minority children than white children were suspended at least once in 1979-80. In counties such as Ocean, Monmouth, Gloucester, and Salem a minority child was twice as likely as a white child to be suspended at least once. And in Cape May County, a minority child was almost three times as likely as a white child to have been suspended at least once.

Sound educational arguments can be made that suspension is rarely an appropriate or educationally productive means of

COMPARATIVE RATES OF SCHOOL DISCIPLINE 1979-80

TY	% MINORITY ENROLLMENT	% PUPILS SUSPENDED AT LEAST ONCE IN 1979-80 WHO WERE MINORITY	% WHITES SUSPENDED AT LEAST ONCE IN 1979-80	% MINORITIES SUSPENDED AT LEAST ONCE IN 1979-80
ntic	34.1	45.1	6.7	10.5
en	10.8	15.7	4.6	7.0
ington	19.7	21.6	7.7	8.5
en	28.3	30.1	8.4	9.2
May	12.3	28.5	3.6	24.4
erland	38.0	5.2	11.1	16.1
x	59.3	6.4	4.7	5.7
cester	12.8	22.9	9.8	19.8
on	60.3	40.8	5.7	2.6
erdon	1.7	2.7	4.7	7.4
er	34.6	44.3	9.6	14.4
llesex	16.9	23.9	7.3	11.2
outh	15.9	27.2	7.5	14.8
is	6.6	5.8	5.1	4.4
an	7.8	14.5	6.5	13.1
saic	40.4	46.3	7.1	9.0
em	23.5	37.3	11.1	21.6
erset	9.6	64.5	5.1	11.0
sex	1.6	.7	6.2	2.7
on	35.7	49.7	9.3	13.2
ren	2.6	3.3	5.4	6.9
AL STATE	26.7	32.4	6.7	8.8

Source: N.J. Dept. of Education, Vital Educational Statistics 1979-80, v. 1, pp. 16, 17, 21 (1980)

dealing with misbehavior in the schools.* In many instances it is simply a device to avoid dealing with more fundamental educational problems. The fact that it is utilized in so plainly discriminatory a fashion throughout the State makes its use all the more questionable.

At present, the data available on this issue is inadequate. The State routinely collects data by race only on suspensions and not on expulsions or other forms of school discipline. A first essential step is to require school districts to maintain a log of all suspensions, expulsions, disciplinary transfers, and disciplinary exclusions from school activities which indicates the reason for the action, the age, sex, and race of the child, the procedural safeguards provided, and the nature and extend of the sanction. A statistical compilation from these logs should be made annually. Second, the State Department of Education should adopt affirmative policies of close monitoring of districts which display patterns of racially disparate student discipline, of utilization of the full range of state powers to correct this form of discrimination, and of prompt intervention in egregious individual cases.

Evaluation and Classification of Handicapped Children

A second area of unequal treatment of minorities is in the placement of children in programs outside the regular school program. Recently gathered statewide statistics demonstrate

---

* See, Children's Defense Fund, Suspensions: Are They Helping Children? (1974).

that blacks are overrepresented among children classified as educable mentally retarded, socially maladjusted, and emotionally disturbed and are underrepresented among children classified as communication impaired and learning disabled (perceptually impaired). A black child is more than four times as likely as a white child to be classified educable mentally retarded and two-and-a-half times as likely to be classified emotionally disturbed. On the other hand a white child is twelve times as likely to be classified communication impaired.

In some individual districts, these disparities are even greater. In Atlantic City 1.1 percent of all white children are classified EMR, but 2.7 percent of all black children are so classified; in Bridgeton, 1.5 percent of all white children are classified EMR compared to 5 percent of all black children; and in Elizabeth, .6 percent of white children and 2.3 percent of all black children are classified EMR.

Both under and overrepresentations are important. Blacks are somewhat more likely than whites or Hispanics to be characterized as educationally handicapped. This characterization is socially stigmatizing. It also reduces teacher expectations and aspirations and provides excuses for school ineffectiveness. The characterization may trigger needed special programs and services, but it also may lead to placement of the student in dead end programs outside the educational mainstream.

PERCENTAGE OF CHILDREN IN RACIAL OR ETHNIC GROUP CLASSIFIED AS HANDICAPPED IN N.J.

NDICAP	WHITE	BLACK	HISPANIC
L HANDICAPS	10.4	12.5	10.1
UCABLE MENTALLY RETARDED	.47	1.91	1.42
CIALLY MALADJUSTED	.08	.19	.17
OTIONALLY DISTURBED	.67	1.64	.84
MMUNICATIONS IMPAIRED	.25	.02	.15
RCEPTUALLY IMPAIRED	2.85	2.30	1.38

URCE: Manni, Winikur, & Keller, A Report on the Status of Minority Group Representation in Special Education Programs in the State of New Jersey, p. 10 (1980).

Even more important, black children are more likely than whites to be identified as having the particular types of handicaps that are regarded as highly stigmatizing and requiring self-contained programs, e.g., mental retardation and emotional disturbance, and less likely than whites to be identified as having the particular types of handicaps that are regarded as relatively non-stigmatizing and suitable for partial integration into the educational mainstream, e.g., communication impairment and perceptual impairment.

This problem clearly stems in part from excessive reliance on IQ testing. Review of records of selected school districts by the Department of the Public Advocate indicates that the practice of relying exclusively on IQ tests in classifying children as educable mentally retarded is widespread. There is good reason to believe that overreliance on IQ testing leads to overcharacterization of blacks as mentally retarded. This practice not only represents unsound educational practice and is discriminatory in effect, but is also violative of both New Jersey and federal laws. N.J.A.C. 6:28-1.6(c); 20 U.S.C. § 1412(5)(C); 45 C.F.R. § 300.532.

Part of the problem also arises from the history of special education. Between 1910 and 1970, the thrust of reform in education of the handicapped was toward expansion of special, self-contained classes. New Jersey's urban districts, which were in the national forefront of educational innovation,

actively sought to establish self-contained special education classes and to place children who were having difficulities in such classes. After 1970, the thrust of reform has been to find less stigmatizing and isolating ways of providing special services to children, but New Jersey's urban areas, no longer in the forefront of reform, have rigidly retained the older model. As a result, it is children in the predominantly white suburban districts who are more likely to have less stigmatizing labels and less isolating programs. Until 1978, for example, Paterson had no perceptually impaired program and therefore classified no child as perceptually impaired.

Several steps are essential to make a real dent in this _de facto_ racial discrimination.

First, an effort must be made to minimize the fiscal and bureaucratic pressures to overclassify, especially in urban districts. These pressures are powerful and probably cannot be wholly eliminated. One significant step, however, would be to eliminate the present categorical program aid formula, which bases state school aid for education of the handicapped on the classification categories rather than on the cost of services actually provided. This formula creates a clear fiscal incentive for school districts to prefer more stigmatizing classifications over less stigmatizing ones. A return to some form of reimbursement for services rendered, would have some beneficial impact.

Second, standards for classifying children as handicapped should be made more restrictive, more explicit, and more uniform. The categories of handicapped in which black children are markedly under or overrepresented largely suffer from being "soft" and dependent on ad hoc, ill-defined, subjective criteria, or, in the case of mental retardation, inappropriate criteria. This makes it very difficult to extirpate racial stereotypes and to monitor misclassification. It also makes it easy for beleaguered school districts to "blame the victim" by attributing systemic educational deficiencies to the incidence of handicap.

Third, the category of "socially maladjusted" should be abolished. It serves no useful educational function except to permit dumping children with behavioral problems out of the system.

Fourth, steps need to be taken to limit use of standardized test instruments to their proper functions. It is neither legal nor professionally sound to base classification as mentally retarded solely on IQ tests nor is it legal or professionally sound to base classification as perceptually impaired solely on any one of the various standardized instruments developed for that purpose (most of which have been validated against subtests of the Weschler or Stanford-Binet IQ Tests).

Finally, a more rigorous program of state monitoring and enforcement is needed. Data on the racial distribution of

children by handicap classification and by program type should be collected regularly from all districts. Significant racial disparities should trigger automatic State review of local practices and State intervention to ensure implementation of corrective measures.

School Finance

Both the Joint Committee on Public Schools of the Legislature and the State Department of Education* now agree that the system by which New Jersey pays for public education is riddled by serious inequities. The State's method of school finance creates grave and systematic disparities in expenditures for education between affluent communities and poor ones, between urban communities and suburban ones. Dividing school districts into seven groups based on local district wealth, school districts in group 1 (the most affluent) and 2 spent $2,671 per pupil and $2,531 per pupil respectively on public education in 1979-80. School districts in groups 6 and 7 (the least affluent) spent $2,083 and $2,166, respectively. The gap between the average expenditures per pupil of districts in group 1 and group 7 was $505.

---

* Joint Committee on the Public Schools, School Budgets and Property Taxes in 1978 (April 1979); N.J. State Board of Education, The Four-Year Assessment of the Public School Education Act of 1975 (March 1980). See generally, Goertz, Money and Education: How Far Have We Come? -Financing New Jersey Education in 1979? (March 1979); Goertz, Where Did the Four Million Dollars Go? The Impact of the New Jersey Public School Education of 1975 (March 1978); Rubin, An Evaluation of the Fiscal Impact of New Jersey's Public School Act of 1975 on the State's Low and Moderate Wealth and Urban School Districts (June 1978).

This disparity in expenditures means that New Jersey's poorest communities cannot afford to provide quality public education for their children. This fact is reflected in disparaties in quality of programs and facilities, e.g., staff/pupil ratios, classroom teacher/pupil ratios, specialist/pupil ratios, and condition of school buildings. While the relationship of expenditures to educational outcomes is very complex, children in the poorest school districts consistently have the lowest scores in standardized tests and, in particular, have the highest rates of failure to master minimum basic academic skills as measured by New Jersey Minimum Basic Skills Test.

These inequities disproportionately affect minority children. In 1979-80, 69.3 percent of all black public school children were enrolled in districts in the two lowest wealth groups. The systematic inequities built into New Jersey's method of public school finance operate to seletively injure minority children. Thus Camden, with $23,759 in taxable property behind each pupil and a school enrollment that is 91.4 percent minority, spent $2,009 per pupil on education, while Ocean City, with $552,000 in taxable property behind each pupil, spent $2,748 per pupil. East Orange, with $35,170 in taxable property behind each pupil and a school enrollment that is 99.4 percent minority, spent $1,996 per pupil in 1979-80, while Livingston, with $154,000 in taxable property behind each child, spent $2,600 per puril. Plainfield, with $53,842 in taxable property behind

each child and a school enrollment that is 93.8 percent minority, spent $2,225 per pupil, while Princeton, with $262,658 in taxable property behind each pupil, spent $3,070 per pupil in 1979-80.

The principal source of funds for public education is local revenue raised by taxation of real property. Poor communities with less taxable property cannot raise as much money for education as their richer neighbors. Local property tax revenues are supplemented by various types of state aid. "Equalization aid," N.J.S.A. 18A:7A-19, is intended to equalize school districts' revenue raising capacity. Although it does so to some extent, it does not do so sufficiently to place all districts on an even fiscal footing. The reasons for this are several and complex. Three significant points, however, do stand out. First, the equalization effects of the statute apply merely to resources potentially available to district and not to the actual level of expenditures. Although equalization aid has been of some limited benefit in easing the burden on taxpayers in poor districts, it does not necessarily have any impact on the schools or school children.

Second, equalization aid for low expenditure districts is based on the previous year's budget. Any increase in local expenditures over the previous year's budget must, in effect, be financed wholly through local property tax revenues. This makes it very difficult for low-expenditure, high-tax-rate districts to increase their school budgets, especially in times of high inflation.

Finally, the statutory formula does not compensate or account in any degree for the problem of "municipal over-burden," i.e., the fact that in urban areas the school must compete with other expensive municipal services for limited (and often decreasing) local property tax revenues.

It is feasible to formulate school finance plans that retain the concepts of local control and of sharing the cost of public education between the State and local communities but that effectively equalize expenditure levels and eliminate the selective impact of existing inequities upon minority children. The New Jersey Legislature, however, has not yet done so.

Children in Placement in New Jersey

Minority children constitute a disproportionate segment of the clientele served by many public services including public assistance, public health programs, nutritional services, and child welfare services, including protective services. Minority children, in particular, form a major proportion of those children who are placed out of their homes under a variety of auspices. Whether one examines foster care placements, remands to correctional institutions, "temporary" stays in county-run detention or shelter care facilities, or admissions to facilities for the treatment of behavioral problems, one finds that black and Hispanic children comprise a far greater percentage of the population of these facilities than would be expected from a normal population distribution by ethnicity in this state. Thus, for example, while minority children are approximately 14 percent of school-aged children in New Jersey, they represent 52 percent of Division of Youth and Family Services out-of-home placements (excluding placements with relatives) and an even more remarkable 70 percent of the juvenile training school population.*

---

*New Jersey Department of Education, Public School Racial/Ethnic Data, 1979-80; New Jersey Department of Human Services, Division of Youth and Family Services. Office of Management Information Systems, "Summary of Children in Placement by Ethnic Group," August 7, 1981; New Jersey Department of Corrections, Division of Policy and Planning, Bureau of Correctional Information Systems, "Inmates in Correctional Institutions on June 27, 1981 by Ethnic Identification."

There are a variety of possible explanations for these disparities. On the one hand, the programs may simply be compensating for strains which are a concomitant of the economic and social discrimination that affect the lives of most minority citizens of this state.* On the other hand, there may be aspects of these service systems which are themselves discriminatory and lead to differential treatment of minority youth. More than likely, a combination of factors is responsible for the findings, detailed below, which indicate a concentration of black and Hispanic children in more restrictive, more stigmatizing, and more institutional out-of-home settings than those in which most white children are placed.

To begin with the most restrictive form of institutionalization, incarceration, an examination of data pertaining to black youngsters indicates that overall arrests for black youths, who are 18 percent of the school-aged population, account for 24 percent of the total arrests of youth but a higher 37 percent of the "more serious," Part I offenses (including murder, manslaughter, forcible rape, and especially, robbery, aggravated assault, burglary, larceny-theft, and motor vehicle theft).**

---

* Ample and convincing research has shown that economic stress and material deprivation are very closely associated with child abuse and neglect, conditions which disproportionately affect the minority groups of this state. For instance 60-80 percent of children going into foster care are members of families who have received public assistance. See Bernard Horowitz and Isabel Wolock, "Material Deprivation, Child Maltreatment, and Agency Intervention Among Poor Families," In Leroy Pelton, ed., <u>The Social Context of Child Abuse and Neglect,</u> Human Sciences Press, 1981.

** 1979 Uniform Crime Reports, New Jersey, p. 61. These reports do not count Hispanic as a minority population, and therefore this comparison is for blacks only.

While arrests for serious offenses are not necessarily followed by conviction and incarceration, there should be a logical connection between the percentage of arrests for serious offenses and incarceration. However, black children make up 58 percent of the juvenile correctional population, a figure far higher than the 37 percent figure (arrests) cited above. While arrest data for Hispanic children are not available, statistics show that this group comprises approximately 7 percent of the school population, but a slightly higher 10 percent of the training school population. Conversely, white children who are 73 percent of the state's total (school-age population), account for only 28 percent of the training school population. Of the female youth in correctional settings, only 12 percent are white.* These disparities indicate that the juvenile justice system may be operating in a manner which allows for very unequal treatment of children who enter into it, with minority children standing a much greater chance than white children of receiving restrictive, correctional punishments. Clearly, New Jersey needs to know what factors influence these discrepancies including whether the police, court intake officers, probation personnel, and the courts are influenced by race in the decisions they make with regard to treatment and placement.

Differential treatment according to race also characterizes other public agencies responsible for the care

---

* See note **, pg. 26.

of children. Most startling is the finding that the state's Division of Youth and Family Services, which is responsible for the provision of a wide array of prevention and treatment programs for children (many of whom are referred from the courts as delinquents or juveniles in need of supervision), also appears to be providing for its minority and white children generally in different settings. DYFS may provide directly for the care of children in its own facilities or, through subsidies, in foster boarding homes, or it may refer children to other state-run programs or purchase care in privately operated treatment programs.

Concentrating for the moment on group care facilities, that is, treatment and institutional settings which care for eight or more children using employed staff, and which include public and private facilities for the treatment of emotionally disturbed and mentally retarded children, and group homes, residential treatment facilities, and public training schools, it is found that minority children are much more likely to be placed in state-run facilities while white children are much more likely to be placed in privately operated residential treatment programs: 44 percent of DYFS wards who are nonwhite are in state-run programs while only 34 percent of whites are in these programs. Within state-run programs there are also remarkable differences: minority children are concentrated in state-run correctional facilities while whites are much more likely than blacks to be in therupeutically aimed, psychiatric programs.

The following table, extrapolated from the DYFS "Summary of Children in Placement by Ethnic Group" for August 7, 1981, will better illustrate this point:

PROGRAM TYPE	NON-WHITE		WHITE		TOTAL**
	No.	% *	No.	%	
I. State-Run Programs					
State Inst. Delinq.	215	61	136	39	352
State Inst. E.D. (Psych)	42	45	51	55	93
State Inst. M.R.	12	33	24	66	36
State Inst. DYFS	87	55	70	45	157
Sub-Total	356	56	281	44	638
II. Privately Operated Programs					
Group Home	110	53	98	47	209
Inst. School	135	42	181	57	318
Inst. Drug Rehab.	3	18	14	82	17
Inst. Other***	80	44	102	56	182
Private Inst. E.D.	18	41	26	59	44
Private M.R.	7	64	4	36	11
Inst. Out of State	92	22	331	78	424
Teaching Parent	11	34	21	66	32
Sub-Total	456	37	777	63	1237
TOTAL	812	43	1058	57	1870

*Read across

** Total may differ slightly if placements included Asian or American Indians not included in this chart.

*** Not explained.

Forty-three percent of the placements in congregate care are of minority youth, 44% of whom are in state-run programs; on the other hand, 73% of white youths are placed in private programs. Of great concern is the fact that in the major purchased treatment programs--institutional schools, other institutions, private facilities for the emotionally disturbed, including out-of-state institutions--so little of the care provided goes to minority youth. Only 325 placements of nonwhite children (34%) have been made in these facilities. Since these disparities cannot be explained by chance, questions must be raised as to why this pattern exists.

Without knowing the variety of other factors which influence placement choices and decisions, including age of the children, behavioral histories, sex, prior placement history and so forth, a precise conclusion about why these different placement patterns occur is not possible. But these data raise questions about the ways in which caseworkers make referral decisions, the acceptance preferences of private institutions, and, indeed, the treatment foci of private programs who hold contracts with the state agency. These findings echo the earlier findings of the Association for Children of New Jersey that, with reference to shelter and secure detention care, "two parallel systems have been established in New Jersey--locked facilities for nonwhite youths and non-secure settings for white youths" and similarly indicate the need for a close examination of

exactly why these placement disparities occur.*

Turning briefly to available information about foster care placements, 56% of the 5,708 boarding foster care placements are of black children, another 7% are of Hispanic children, and another 4% are composed of Asian, American Indian or other minority children, making minority placements 67% of all foster care placements (3,348 children). This percentage has increased slightly (although the numbers have remained fairly stable) from the 64% of foster care placements one year ago.** More information is again needed to understand this phenomenon, although it would appear that, in the absence of sufficient family support services, this high rate is related to economic and situational stresses among minority families, and this pattern is doomed to worsen with impending budget cuts. Examination of decision-making with regard to subtle racial influences is an indicated need for DYFS; however, there may be need as well to increase the numbers of minority casework staff within the agency in order to eliminate racial biases.

Similar findings with regard to race characterize the Johnstone Training School, the one state-run mental retardation facility geared specifically for the "training" of educable mentally retarded children, where children are largely

---

* Association for Children of New Jersey, Beneath the Labels: Children in Detention and Shelter Care, 1981.

** DYFS placement material for August 7, 1981 cited above and similar information for June, 1980 supplied by DYFS, Office of Management Information Systems.

referred by schools and the courts. Johnstone has a resident population which is 48% minority (33% black, 11% Hispanic and 4% other)*, compared again to the 14% of school-aged children who are black or Hispanic. Again, this disparity of percentages of residents by race is a much higher figure than can be explained by chance. These findings indicate, once more, a pattern of differential referral for institutional care of minority children whose needs might better be met in less restrictive community programs.

Except for data supplied by DYFS for children in its system who are in drug treatment programs (see table above), it is not known what percentage of youth in drug addiction or alcohol abuse services are minorities, although both state departments involved have identified increased services to blacks and Hispanics as well as minority-sponsored programs as among their programmatic priorities.** While sensitivity to these issues is laudable, there are indications that these needs have been recognized for some time with little corrective action taken, while funding for programs whose utility is uncertain and in which minorities may not feel comfortable has been allowed to continue.

There is little evidence, indeed, to show that residential care of the various kinds discussed here is successful

---

* New Jersey Department of Human Services, Division of Mental Retardation, "Individual Data Base," June 31, 1980.

**See New Jersey Departments of Health and Human Services, 1982-1984 New Jersey Behavioral Health Service Plan, Parts IV and V.

in meeting its goals of providing care, treatment, education, and resocialization of children who have a variety of problems.* At best, such care provides children who have inadequate familial care with a humane and comfortable living alternative. At worst, it cannot be punitive and damaging to its residents. From the evidence provided above, it seems clear that minority children are being consigned to living arrangements other than home in disproportionate numbers.

Ultimately, the solution to these problems would appear to lie in remedies suggested elsewhere in this presentation: better and more meaningful educational programs, jobs (for youths and their parents), adequate income supports and supplements, better housing and so forth. Because our current, inadequate programs in these areas are threatened with drastic reductions, it is imperative that attention be focussed on evaluating those programs that do work and that renewed attention be paid to the needs of minority youth who are at high risk of placement. It is important, also, that administrative practices of public agencies be scrutinized to assure that subtle discriminatory practices do not take place and to eliminate any that do.

---

* See, James Robison and Gerald Smith, "The Effectiveness of Correctional Programs, <u>Crime and Delinquency</u>, Vol. 17, 1971; Anthony N. Maluccio and Wilma D. Marlow, "Residential Treatment of Emotionally Disturbed Children: A Review of the Literature," <u>Social Service Review</u>, June, 1972; and James K. Whittaker, "The Changing Character of Residential Care," <u>Social Service Review</u>, March, 1978.

Minority Youth Unemployment

There are nearly 44 million Americans aged 14-44 of whom 24 million are in the critical 16-21 age span, the period of transition from school to work. Figures published by the Bureau of Labor Statistics for the first quarter of 1980 show that the national unemployment rate for white youth aged 16-19 years was 13.9%, but for minority youth the average was 35.2%. Most importantly, these figures, as contrasted to first quarter 1979 figures of 13.7% and 33.1% respectively, demonstrate that the number of minorities unemployed is rising at a faster rate than that for white unemployed. Nationally, it appears that black teenagers are unemployed at rates nearly three times as high as the rate for white teenagers.

What is the situation in New Jersey? The Bureau of Labor Statistics reports that for the second quarter of 1981 the unemployment rate for white youth aged 16-19 years as 23.2%, but for minorities it was 40.9%.

This disparity is occurring throughout the country. The Vice President's Task Force on Youth Unemployment published in February 1980 reported that four million teenagers are faced with a disproportionate share of problems in obtaining employment. These four million fall into four (4) categories: young women, dropouts, minorities, and youth from poor families. Moreover, the report found that if a youth fits into two of the aforementioned categories, the odds of obtaining employment

are clearly stacked against that individual. This conclusion is based on studies indicating the following:

a. By age 21-22, only 10 percent of whites work in less desirable unskilled jobs; almost 40 percent of blacks do.

b. The unemployment rate for high school dropouts is two to three times as high as the rate for high school graduates. Although the national rate for all dropouts aged 16-21 years is 13.9%, the dropout rate for black youth is 31.1% and for Hispanic youth is 18.1%.

c. By age 25-26, the average hourly wage of young men from poor families who have not attended college is $4.79; for those from non-poor households who have not attended college it is $7.31. For young women, the difference is $3.50 compared to $4.07.

Why do these disparities exist? The Task Force Report concludes as follows: "There is no single explanation for these differentials. Volumes of analysis still do not explain a large part of the difference, leaving discrimination the likely answer."*

Not only are minority youth facing subtle discrimination in their attempt to obtain employment, but they are further plagued by an inability to perform basic skills (such tasks as following simple instructions or reading a bill or check). A recent study of 17-year olds revealed that over 40 percent of all black 17-year olds were unable to perform these basic tasks and, therefore, were functionally illiterate.

---

* A Summary Report of The Vice-President's Task Force on Youth Unemployment, February 1, 1981, p. 13.

In addition to discrimination and literacy problems, minority youth cannot obtain employment because "the best way to find a job is to have a job." These youth are lacking the experience that most employers are now requiring. Babysitting, lawn work and the like are not considered as credible work experience by private employers. Those who have never worked are at a distinct disadvantage. They lack the informal contacts and information about other available jobs that may be gained through having a job. All too often youngsters who have never had a job are ignorant or haphazard about how one locates job opportunities.

Government has become increasingly concerning about youth unemployment and justifiably so from the information reported above. Yet 80 percent of all jobs are in the private sector, and it is projected that private companies will contribute nearly 100 percent of the net job growth in the 1980's. Thus, there must be some kind of cooperative effort between government and private employers to accommodate youth, especially minority youth, into their working ranks. This task is made more difficult because: 1) many companies have moved away from urban centers where the largest proportion of unemployed minority youth exists, and 2) the number of private sector jobs requiring little prior training is rapidly decreasing.

In the past, where no jobs existed or where employers refused to hire teens with certain characteristics, government

created jobs. Under the Reagan administration, summer jobs for youth will remain but will not receive increased funding for the next fiscal year; in fact, CETA monies for employment training in New Jersey will decrease by seven million dollars. In order to stem the tide of minority unemployment, there must be a closer cooperative effort between government and private sector employers, as well as schools. This effort should focus on two areas: a job information delivery system and a training vehicle for youth.

Several communities have attempted measures to ensure that youth are aware of the variety of job functions that exist today. There is a concerted attempt to find ways to improve the flow of job information. For example:

a. Stanley Works, a business located in Hartford, pays the expenses for courses taught in a local high school, thereby ensuring that the skills they need are being taught.

b. The Wisconsin Job Service visits every high school in the state presenting job information and helps to coordinate part-time employment.

c. The Hartford Insurance Company runs a school which is fully accredited by the local school board and in which potential dropouts take courses in the company, work there part-time, and usually are offered jobs upon graduation.

d. Boston, New York and Chicago have a program called Jobs for Youth which is an employment service conducted by community based organization.

These are a few of the successful informational programs identified by the Vice-President's Task Force which are worthy of consideration in this state. Employees of companies in various cities operate programs for teachers and school counsellors to give first-hand knowledge of career opportunities in various fields. In some communities, each local business adopts a local high school to acquaint students with its job possibilities. Such close contact might foster training programs were necessary.

A different set of initiatives is necessary to provide job training for minority youth. Not only must schools, government, and private employers join in a cooperative effort but unions and community based organizations must also participate. The problems underlying youth unemployment are so massive that only a broad based effort will succeed. Community based organizations (for dropouts and those out of school) and school guidance counsellors (for children in school) must provide information on jobs. Unions and private employers must be given incentives to train teens for certain job categories. For example, in New Haven out-of-school youth are participating in a pre-apprenticeship program learning carpentry, painting and home weatherization skills. A similar union initiative in New Jersey is essential for those who are vocationally inclined, but it is doubtful that unions would opt to establish such a program with members' dues. Instead, government monies would be necessary to provide such an incentive.

Private companies have not done enough in the past to provide job opportunities for minority youth. Tax incentives are a beginning, but training programs are also necessary. Without training furnished by the company, the minority youth hired will be unable to seek upward mobility from the low level jobs for which they are usually hired. In many instances, without company training the youth will be unable to perform the job. The partnerships which cities have developed to foster increased business activity have not focused on youth unemployment. Such a partnership in Chicago (a coalition of twenty businesses and community groups, half from the city's major corporations and half from its minority enterprises) has made significant gains in establishing summer jobs for teens. This group does not operate the programs but instead works with other city institutions to form partnerships to meet specified needs.

The aforementioned ideas may not work for every city in our State. For any program to operate successfully, it must be tailored to that area's needs. It is essential, however, that these initiatives or other similar ones be explored in New Jersey.

A Postscript: The Impact of Federal Budget Cuts

The cuts in the budgets of federally funded programs threatens to further aggravate the problems outlined in the preceding sections.

Federal cuts in aid to families with dependent children will eliminate 11,000 families with a working parent from the rolls.

The federal government is reducing availability of day care by 35 percent. Currently, publicly supported child care meets the needs of only one-third of the needy eligibles (based on families whose income falls below 80 percent of the poverty level). The budget cutbacks will result in the loss of at least 5,000 slots (estimating cuts at one-fourth of the present program). Five thousand adults will be unable to work or achieve economic and social independence; 5,000 children will be denied safe and constructive activities and some of them will instead be subjected to the expensive nightmare of foster care.

In addition to reducing cash assistance, health, and day care benefits, the federal budget cuts also will cut substantially food and child nutrition programs for minority children.

New Jersey will lose almost $46 million in food stamp benefits in fiscal year 1982 under the federal cuts. These savings will be achieved primarily by eliminating benefits to all families with income over 130% of the poverty level,

deducting the value of school lunches from a family's food stamp allotment, eliminating a separate child care deduction and an expanded medical deduction for the elderly in the determination of a family's benefits, and eliminating inflation readjustments in benefit levels. Approximately $12 per child also will be subtracted from the monthly allotments of families with children eligible for free and reduced price meals. This will adversely affect 195,000 children in New Jersey.

Furthermore, the Department of Agriculture has proposed regulations to reduce the amount of meat and vegetables in school lunches, while the bread and milk allotment is cut from eight pieces a week to five, from eight ounces a day to six. These lunches will now supply less than one-third of the daily nutritional value and only 17 percent of the calories needed.

All the cuts will have a disproportionate impact on minority children in New Jersey.