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ABSTRACT

A Congressional hearing was held to focus on problems faced by schools due to students who have been exposed to drugs, and ways the federal government can help teachers and administrators ameliorate the crisis of student exposure to drugs. The topics discussed included teachers' difficulties in dealing with the increasing number of drug-exposed children; prenatal and perinatal drug exposure; the role of special education in dealing with drug-exposed children; children exposed to crack; the need for a government initiative consisting of treatment and education; research and experience that indicates that drug-exposed children can be taught; early intervention programs sponsored by the Office of Special Education and Rehabilitative Services of the Department of Education; and programs to train teachers to deal with drug-exposed students. Testimony and prepared statements were presented by three committee members and nine individuals representing various organizations, institutions, or municipalities with an interest in the topic of children's exposure to drugs. (BC)

DRUG-EXPOSED CHILDREN IN THE SCHOOLS: PROBLEMS AND POLICY

HEARING

BEFORE THE

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL HOUSE OF REPRESENTATIVES

ONE HUNDRED SECOND CONGRESS

FIRST SESSION

JULY 30, 1991

Printed for the use of the
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(102d Congress)

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TUESDAY, JULY 30, 1991

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL,
Washington, DC.

The committee met, pursuant to call, at 2 p.m., in room 2359, Rayburn House Office Building, Hon. Charles B. Rangel (chairman of the committee) presiding.

Members present: Charles B. Rangel, chairman, Lawrence Coughlin, William F. Clinger, Jr., Ron de Lugo, Robert K. Dornan, Benjamin A. Gilman, George J. Hochbrueckner, James M. Inhofe, Nita M. Lowey, Michael G. Oxley, Donald M. Payne, and Jim Ramstad. Also present were Representatives Wayne Owens of Utah and Tom Lantos of California.

Staff present: Edward H. Jurith, staff director; Peter J. Coniglio, minority staff director; James Alexander, press secretary; Linda Bloss, minority staff assistant; Jennifer Ann Brophy, professional staff; George R. Gilbert, staff counsel; David Goodfriend, staff assistant; Michael J. Kelley, staff counsel; Marianne Koepf, staff assistant; Steve Skardon, professional staff; Mary Frances Valentino, minority staff assistant; and Melanie T. Young, minority professional staff.

OPENING STATEMENT OF HON. CHARLES B. RANGEL, CHAIRMAN

Mr. RANGEL. Let me sincerely apologize to our witnesses for the delay in getting this hearing started.

It's unfortunate that at this very same time the Ways and Means Committee is deliberating whether or not to extend the unemployment benefits, and the problem is whether or not there's a will in the committee to have the President declare it an emergency or the will to actually allow the extension of taxes that would be necessary to pay for the bill.

This is the bind that the Congress has put itself into with the budget agreement. And, therefore, it's quite a dilemma.

In addition to this, the Ways and Means Committee will be considering whether or not to vote for a gasoline tax with the transportation bill.

It's shameful that all of these things take priority as we talk about the future of our Nation and how we're going to treat our children, and whether or not we're prepared to make the investment in people as we are with the infrastructure.

In any event, we're going to open the meeting, and I guess the ranking members that are available also serve on the Ways and Means Committee. And I will be able to be in the chair until the vote is taken.

So I would encourage staff to work on the members right now and to make every effort to make certain that our witnesses are not any further delayed.

My friend and colleague, Larry Coughlin, has returned, so the meeting will officially open as we hear today from experts as we look at one of the most tragic aspects of the Nation's drug crisis—children who, without committing any wrong, have come into society with all types of problems, and now they are about to enter the school system.

Last year we witnessed the first indication of the impact of these affected children, and this afternoon we'll focus on the problems that are faced by the schools due to these infants that have been exposed to drugs.

We have heard from teachers around the country indicating that they see differences in the characteristics of the children that they have to teach. We do hope that professionally they will come together and play a leadership role in seeing that our nation focuses on the problems of these children because teachers may need a different type of training in order to identify, counsel and get these children on the right educational track.

It would be tragic if drug-exposed children were just labeled "difficult children" without the benefit of professional analysis, and just be doomed to fail because of the stigma of drug abuse attached to them.

We do hope that we'll be able to see what we can do to avoid an explosion in the number of children being born drug-impaired, and we hope that we can get some ideas from our witnesses as to the direction our country should be going.

We'll have a panel of outstanding witnesses that would help this Select Committee to seek legislative options for the future, and the Congress is indeed looking to us for leadership and we look to you for guidance.

[The statement of Mr. Rangel follows:]

OPENING STATEMENT

CHARLES B. RANGEL, CHAIRMAN

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

DRUG-EXPOSED CHILDREN IN THE SCHOOLS:

PROBLEMS AND POLICY

TUESDAY, JULY 30, 1991

TODAY'S TOPIC IS ONE OF THE MOST TRAGIC AND INTRACTABLE FACETS OF THIS NATION'S DRUG CRISIS. CHILDREN WHO WERE EXPOSED TO DRUGS IN THE WOMB FACE A MYRIAD OF CHALLENGES; SO DOES THE SOCIETY INTO WHICH THEY EMERGE. THE UNITED STATES IS EXPERIENCING AN EXPLOSION IN THE NUMBER OF DRUG-EXPOSED CHILDREN. SOME HOSPITALS REPORT THAT OVER TWENTY PERCENT OF THEIR DELIVERIES ARE INFANTS WHO WERE PERI-NATALLY EXPOSED TO DRUGS. EACH YEAR, WE SEE MORE AND MORE SUCH BIRTHS. BUT HOSPITALS ARE NOT THE ONLY INSTITUTIONS AFFECTED BY THIS PHENOMENON. AS THE CHILDREN GROW UP, THEY ENROLL IN A SCHOOL SYSTEM LARGELY UNPREPARED TO ACCOMMODATE THEM. LAST YEAR, WE WITNESSED THE FIRST RIPPLE OF AN IMMINENT TIDAL WAVE AS THOUSANDS OF DRUG-EXPOSED CHILDREN ENTERED THE CLASSROOM. THIS AFTERNOON, WE WILL FOCUS ON PROBLEMS FACED BY SCHOOLS DUE TO DRUG-EXPOSED STUDENTS AND HOW THE FEDERAL GOVERNMENT CAN HELP TEACHERS AND ADMINISTRATORS TO AMELIORATE THE CRISIS.

OVER THE LAST YEAR, TEACHERS AROUND THE COUNTRY HAVE OBSERVED AN UNUSUALLY HIGH PROPORTION OF KINDERGARTEN STUDENTS FUNCTIONING AT LOW LEVELS AND EXHIBITING BEHAVIORAL PROBLEMS. MANY VETERAN TEACHERS SAY SUCH CHILDRENS'

CHARACTERISTICS ARE DIFFERENT FROM OTHER PROBLEM PUPILS. UNABLE TO CONCENTRATE, OVERWHELMED BY THE SLIGHTEST STIMULATION, SUFFERING FROM DELAYED SPEECH DEVELOPMENT, DRUG-EXPOSED CHILDREN ARE OVERWHELMING AMERICA'S TEACHERS, MANY OF WHOM HAVE NO FORMAL PREPARATION FOR DEALING WITH THIS KIND OF DISABLED STUDENT. TEACHERS FEEL ALONE. ALTHOUGH THEY KNOW A PROBLEM EXISTS, THEY OFTEN DO NOT KNOW HOW TO IDENTIFY, LET ALONE COUNSEL, DRUG-EXPOSED CHILDREN. AND THEY RARELY RECEIVE GUIDANCE OR ASSISTANCE.

UNABLE TO COPE WITH DRUG-EXPOSED CHILDREN WHILE PAYING ENOUGH ATTENTION TO THEIR OTHER STUDENTS, TEACHERS OFTEN WILL SEND THESE DIFFICULT-TO-HANDLE CHILDREN TO SPECIAL EDUCATION. IN NEW YORK CITY, SPECIAL EDUCATION REFERRALS INCREASED FROM 1,071 LAST SCHOOL YEAR TO 1,600 THIS YEAR, DUE LARGELY TO THE DRUG-EXPOSED. THE REST OF THE NATION EXPERIENCED A SIMILAR TREND. SPECIAL EDUCATION SERVICES, HOWEVER, ARE UNABLE TO ABSORB ALL DRUG-EXPOSED CHILDREN. SUCH SERVICES CAN COST THREE TO FIVE TIMES AS MUCH AS REGULAR EDUCATION.

DRUG-EXPOSED CHILDREN SHOULD NOT BE CONSIDERED DOOMED TO FAILURE. WE SHOULD NOT DESIGNATE THEM A "BIO-UNDERCLASS" OR A "LOST GENERATION." OUR SOCIETY

DOES NOT CONDEMN EPILEPTICS TO ASYLUMS OR EXCLUDE THE BLIND FROM THE WORKFORCE. INSTEAD, WE ENDEAVOR TO INCORPORATE HANDICAPPED PEOPLE INTO THE MAINSTREAM. BY THE SAME TOKEN, WE SHOULD NOT GIVE UP ON DRUG-EXPOSED CHILDREN BEFORE WE HAVE EVEN TRIED TO HELP THEM. AS SOME OF TODAY'S WITNESSES WILL REPORT, WE KNOW THAT DRUG-EXPOSED CHILDREN RESPOND POSITIVELY TO THERAPY. WE KNOW THAT THEY ARE NOT NECESSARILY LESS INTELLIGENT THAN OTHER CHILDREN. OUR CHALLENGE IS TO FIND THE BEST WAY TO INTEGRATE DRUG-EXPOSED CHILDREN INTO SCHOOLS SO THAT THEY MAY BE PRODUCTIVE MEMBERS OF SOCIETY. A FAILURE TO DO SO WILL NOT ONLY BE DETRIMENTAL TO THE CHILDREN IN QUESTION BUT TO ALL THEIR CLASSMATES WHO WILL NOT RECEIVE TEACHERS' FULL ATTENTION.

SCHOOLS ALONE CANNOT BE RESPONSIBLE FOR CURBING THE CRISIS OF DRUG-EXPOSED CHILDREN. WE MUST IMPROVE DRUG TREATMENT FOR WOMEN, ESPECIALLY PREGNANT WOMEN, IN ORDER TO PREVENT MORE SUCH CHILDREN FROM BEING BORN. LESS THAN ELEVEN PERCENT OF DRUG-ABUSING PREGNANT WOMEN RECEIVE TREATMENT. SOME DRUG TREATMENT PROGRAMS EXCLUDE PREGNANT WOMEN ALTOGETHER. WITHOUT A DOUBT, ANY ATTEMPT TO ADDRESS THIS CRISIS MUST INCLUDE IMPROVEMENTS IN WOMEN'S DRUG TREATMENT. MANY OF MY COLLEAGUES AND I

HAVE CONSISTENTLY CALLED FOR SUCH IMPROVEMENTS AND I AM CONFIDENT WE WILL PREVAIL.

WHILE IMPROVING WOMEN'S DRUG TREATMENT AND PREVENTION IS IMPORTANT, HOWEVER, IT WILL NOT HELP THOSE CHILDREN ALREADY BORN. JUST AS A LACK OF ADEQUATE TREATMENT WILL LEAD TO ESCALATING NUMBERS OF DRUG-EXPOSED CHILDREN, INSUFFICIENT RESOURCES FOR EARLY THERAPY WILL LEAD TO BIGGER PROBLEMS WHEN THESE CHILDREN REACH ADULTHOOD. TODAY'S DRUG-EXPOSED CHILD WITHOUT REHABILITATION COULD BE TOMORROW'S REPEAT OFFENDER, WELFARE RECIPIENT, OR DRUG ADDICT. THAT IS WHY THIS COMMITTEE HAS CHOSEN TO LOOK AT THE POPULATION OF DRUG-EXPOSED CHILDREN ALREADY BORN. WHATEVER RESOURCES ARE SPENT TO REHABILITATE THESE CHILDREN WILL BE RETURNED SEVERAL TIMES OVER IN GREATER PRODUCTIVITY AND AVOIDED WELFARE AND LAW ENFORCEMENT EXPENDITURES.

CHILDREN BORN TO DRUG-ABUSING MOTHERS DO NOT ONLY COME FROM THE INNER CITY. THIS SCOURGE CUTS ACROSS ALL SOCIO-ECONOMIC AND RACIAL BOUNDARIES. THE PERCENTAGE OF WOMEN WHO USE DRUGS DURING PREGNANCY IS VIRTUALLY THE SAME AMONG BLACKS AND WHITES, URBAN AND SUBURBAN POPULATIONS.

THE PROBLEM WE FACE WILL UNDOUBTEDLY GET WORSE. ESTIMATES OF THE NUMBER OF DRUG-EXPOSED CHILDREN BORN EACH YEAR RANGE FROM 375,000 TO 739,000. THESE NUMBERS WILL INCREASE; THE FASTEST-GROWING POPULATION OF DRUG ABUSERS IN THE UNITED STATES IS ADOLESCENT GIRLS, MANY OF WHOM WILL SOON BE MOTHERS. THE MARCH OF DIMES TELLS US THAT, BY THE YEAR 2000, WE COULD HAVE AS MANY AS FOUR MILLION DRUG-EXPOSED CHILDREN IN OUR SCHOOLS. INNER CITIES WILL BE PARTICULARLY HARD-HIT. SOME RESEARCHERS PREDICT THAT, BY THE END OF THE DECADE, UP TO SIXTY PERCENT OF ALL INNER CITY STUDENTS WILL BE PERI-NATALLY DRUG-EXPOSED. NEW YORK CITY ALONE WILL HAVE 72,000 CHILDREN WHO WERE EXPOSED TO CRACK IN THE WOMB. WE MUST ACCEPT THE REALITY OF THIS TREND AND PREPARE FOR IT. OUR SCHOOLS ARE THE PRIMARY LINE OF DEFENSE IN THIS WAR AGAINST SUFFERING.

WE HAVE BEFORE US AN OUTSTANDING PANEL OF WITNESSES, MEN AND WOMEN WHO DEVOTE THEIR LIVES TO THE EDUCATION OF OUR COUNTRY'S YOUTH. ALL OF US AGREE THAT THIS PROBLEM CANNOT BE IGNORED. THE QUESTION BEFORE US IS, HOW DO WE BEST CONFRONT THIS CHALLENGE? WHAT ARE THE IMMEDIATE AND LONG-TERM NEEDS OF TEACHERS AND SCHOOLS IN HELPING DRUG-EXPOSED CHILDREN? ARE CURRENT FEDERAL PROGRAMS

SUFFICIENT? IF NOT, HOW CAN THIS GOVERNMENT IMPROVE THEM? AND WHAT ARE THE RISKS IF NOTHING IS DONE?

THE SELECT COMMITTEE ON NARCOTICS WILL LOOK INTO LEGISLATIVE OPTIONS FOR ADDRESSING MANY OF THE ISSUES RAISED TODAY. I LOOK FORWARD TO HEARING YOUR TESTIMONY. IT WILL HELP MY COLLEAGUES AND I FORMULATE A SALIENT, IMPLEMENTABLE PROPOSAL TO THE CONGRESS.

Mr. RANGEL. The Chair recognizes Mr. Coughlin.

OPENING STATEMENT OF HON. LAWRENCE COUGHLIN

Mr. COUGHLIN. Thank you very much, Mr. Chairman. I have a prepared statement that I ask be entered into the record in its entirety.

I want to thank all of our witnesses today for coming to discuss the impact drugs are having on our children.

Certainly, drug-exposed children were robbed of their chance to live drug-free lives before they were ever born. Now, at no choice of their own, our schools are faced with the task of handling this new group of disadvantaged children in the classroom. The Administration has placed drug-exposed babies and pregnant women at the top of its priorities for treatment. To this end, with the problem of prenatally exposed children, you'd better start with the mother.

In 1990, approximately $60 million was made available to the Federal Government through demonstration grants to improve the quality of treatment and expand its availability for pregnant addicts, adolescents, and prison inmates.

The Administration's budget request for the Office of Substance Abuse Prevention in 1992 is $52.4 million, up $6.7 million from 1991. OSAP's programs for pregnant women and infants is second only to OSAP's high-risk youth program which is budgeted at $450 million for fiscal year 1991.

In addition, H.R. 2810, The Drug Treatment and Prevention Act of 1991, which the chairman and I have introduced, provides for the needs of pregnant women and drug-exposed children. Contained in H.R. 2810 is a provision which would require States to develop statewide treatment and prevention plans in order to improve accountability in the way that Federal funds are spent.

Mr. Chairman, I look forward to the witnesses today. I regret to say that I'll have to go between this and another meeting across the way on transportation.

Thank you, Mr. Chairman.

[The statement of Mr. Coughlin follows:]

OPENING STATEMENT OF THE HONORABLE LAWRENCE COUGHLIN
JULY 30, 1991
SELECT COMMITTEE HEARING ON THE IMPACT OF DRUG EXPOSED CHILDREN IN OUR SCHOOLS

THANK YOU, MR. CHAIRMAN. I WANT TO THANK ALL OF OUR WITNESSES TODAY FOR COMING BEFORE THE COMMITTEE TO DISCUSS THE IMPACT DRUGS ARE HAVING ON OUR CHILDREN.

DRUG EXPOSED CHILDREN WERE ROBBED OF THEIR CHANCE TO LIVE DRUG FREE LIVES BEFORE THEY WERE EVER BORN. NOW AT NO CHOICE OF THEIR OWN, OUR SCHOOLS ARE FACED WITH THE TASK OF HANDLING THIS NEW GROUP OF DISADVANTAGED CHILDREN IN THE CLASSROOM. THE ADMINISTRATION HAS PLACED DRUG EXPOSED BABIES AND PREGNANT WOMEN AT THE TOP OF ITS PRIORITIES IN TREATMENT. TO END THIS PROBLEM OF PRENATALLY EXPOSED CHILDREN, ONE MUST START WITH THE MOTHER.

IN 1990, APPROXIMATELY $60 MILLION WAS MADE AVAILABLE FROM THE FEDERAL GOVERNMENT THROUGH DEMONSTRATION GRANTS TO IMPROVE THE QUALITY OF TREATMENT AND EXPAND ITS AVAILABILITY FOR PREGNANT ADDICTS, ADOLESCENTS AND PRISON INMATES. THE ADMINISTRATION'S BUDGET REQUEST FOR THE OFFICE FOR SUBSTANCE ABUSE PREVENTION IN 1992 IS $52.4 MILLION, UP $6.7 MILLION FROM ITS 1991 BUDGET REQUEST OF $45.7 MILLION. OSAP'S PROGRAM FOR PREGNANT WOMEN AND INFANTS IS SECOND ONLY TO OSAP'S HIGH RISK YOUTH PROGRAM, WHICH IS BUDGETED AT $450.7 MILLION FOR FY' 91.

ALSO, H.R. 2810, "THE DRUG TREATMENT AND PREVENTION ACT OF 1991," WHICH I INTRODUCED ON JUNE 27 OF THIS YEAR, ADD WHICH IS CO-SPONSORED BY 59 OF OUR COLLEAGUES, INCLUDING THE CHAIRMAN OF THIS COMMITTEE, PROVIDES FOR THE NEEDS OF PREGNANT WOMEN AND DRUG EXPOSED CHILDREN. CONTAINED IN H.R. 2810 IS A PROVISION WHICH WOULD REQUIRE STATES TO DEVELOP STATEWIDE TREATMENT AND PREVENTION PLANS IN ORDER TO IMPROVE ACCOUNTABILITY IN THE WAY FEDERAL FUNDS ARE SPENT. THE PLANS MUST INCLUDE INFORMATION AS TO HOW STATES WILL EXPAND AND IMPROVE EFFORTS TO PREVENT DRUG USE BY PREGNANT WOMEN, CONTACT AND TREAT PREGNANT DRUG USERS, AND PROVIDE APPROPRIATE FOLLOW-UP CARE TO THEIR AFFECTED NEWBORNS.

SINCE THERE IS NOT A TYPICAL PROFILE FOR A DRUG-EXPOSED CHILD, ESPECIALLY THOSE EXPOSED TO CRACK, MEETING THEIR EDUCATIONAL NEEDS HAS BECOME A COMPLEX TASK. IT ISN'T UNTIL THESE CHILDREN BECOME OF SCHOOL AGE THAT THE EXTENT OF THE DAMAGE CAUSED BY THEIR MOTHERS' DRUG USE BECOMES APPARENT. THE DEPARTMENT OF EDUCATION IS CONCERNED WITH THE IMPACT THESE CHILDREN ARE GOING TO HAVE ON OUR SCHOOLS. THE DEPARTMENT OF EDUCATION'S GRANTS FOR INFANTS AND FAMILIES IS A VITAL COMPONENT OF THE ADMINISTRATION'S EFFORT TO OFFER EARLY INTERVENTION SERVICES FOR DISABLED CHILDREN. FOR FY' 92, $128.8 MILLION WAS REQUESTED FOR THE PROGRAM, WHICH IS A 10% INCREASE OVER THE FY' 91 APPROPRIATION.

MEETING THE NEEDS OF DRUG EXPOSED CHILDREN IS A TWO-PRONGED INITIATIVE CONSISTING OF EDUCATION AND TREATMENT. WHILE THE HOUSE HAS MET THE PRESIDENT'S REQUEST FOR THE DEPARTMENT OF EDUCATION'S DRUG FREE SCHOOLS AND COMMUNITIES GRANTS PROGRAM, THE PRESIDENT'S 1992 BUDGET REQUEST OF $49.5 FOR EMERGENCY GRANTS TO SCHOOLS WAS CUT ALMOST IN HALF, TO $25 MILLION.

THE HOUSE HAS ALSO NEGLECTED THE TREATMENT PRONG. THE HOUSE CUT THE OFFICE FOR SUBSTANCE ABUSE PREVENTION'S BUDGET FOR FY' 92. THE PRESIDENT REQUESTED $281.6 MILLION FOR TREATMENT AND PREVENTION PROGRAMS FOR HIGH RISK YOUTH AND PREGNANT WOMEN AND INFANTS, COMMUNITY YOUTH ACTIVITY GRANTS, COMMUNITY-WIDE PREVENTION PROGRAMS, AND TRAINING PROGRAMS. THE HOUSE APPROVED ONLY $268.5 MILLION FOR THESE PROGRAMS UNDER OSAP WHICH IS $13.1 MILLION BELOW THE PRESIDENT'S BUDGET REQUEST.

THE PRESIDENT'S BUDGET IS PROOF THAT THE ADMINISTRATION CONTINUES TO RECOGNIZE THE SERIOUSNESS OF OUR COUNTRY'S DRUG PROBLEM, AND CONTINUES TO BACK ITS COMMITMENT WITH SUBSTANTIAL FUNDING REQUESTS.

I LOOK FORWARD TO HEARING FROM OUR WITNESSES ABOUT THEIR EXPERIENCES AND IDEAS FOR HELPING DRUG EXPOSED CHILDREN SUCCEED IN SCHOOL.

Mr. RANGEL. Well, both of our statements will be entered into the record without objection.

If there are any other statements that members have, they will also be entered into the record.

[The statement of Mr. Ramstad follows:]

JIM RAMSTAD
THIRD DISTRICT, MINNESOTA
JUDICIARY COMMITTEE
SMALL BUSINESS COMMITTEE
SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL
DISABILITIES TASK FORCE COCHAIRMAN

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STATEMENT OF HON. JIM RAMSTAD

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

HEARING ON DRUG-EXPOSED CHILDREN

JULY 30, 1991

Mr. Chairman, I applaud your leadership in calling this hearing on this heart-wrenching aspect of the drug epidemic. The problem of cocaine babies, fetal-alcohol syndrome, and other prenatally exposed children in our schools needs national attention.

The 100,000 babies born in 1989 to women who used drugs during pregnancy are about to begin school. Another 400,000 will be born this year. Everyone in this room is aware of the magnitude of the problem. But the solutions seem elusive. Some partisans will accuse the Administration of not devoting sufficient resources to the needs of drug-exposed children. Others will charge that throwing money at the problem is not the answer.

Mr. Chairman, this problem of children prenatally exposed to drugs is far too tragic for normal political discourse.

I have held several "crack babies" and have felt their uncontrollable shaking and endless shrieking, unlike any other babies. I have heard the medical diagnoses--prenatal drug exposure resulting in severely premature birth, extremely small for gestational age, placed in neonatal intensive care, intensely colicky, neurological impairments, underdeveloped cranium, autism, blindness, attention deficit disorder, hyperactivity, severe learning disability, and other severe abnormalities and emotional disorders.

I plead with my fellow members of this Select Committee to reach a consensus on legislative options for addressing this tragic problem. We must confront this enormous challenge and make specific proposals to the Congress, combining elements of prevention, education, treatment and intervention.

Mr. Chairman, I look forward to hearing from this distinguished panel of experts to point us in the right direction.

Mr. RANGEL. If there's no one else seeking recognition at this time, I'd like to call the first panel. Judith Burnison, executive director of National Association for Perinatal Addiction, Research and Education; Allan Shedlin, Jr., director of the Elementary School Center; from my own district, Dr. Evelyn Davis, a pediatrician, Harlem Hospital; William Schipper, executive director, National Association of State Directors of Special Education.

Let me share with the panel that we certainly appreciate you taking time out to share your views with us. And because of our legislative agenda, we're going to ask you to restrict your oral testimony to 5 minutes with the understanding that your entire statements will be entered into the record without objection from the committee.

And we'll start now with the executive director of the National Association for Perinatal Addiction, Judith Burnison.

TESTIMONY OF JUDITH BURNISON, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION FOR PERINATAL ADDICTION, RESEARCH AND EDUCATION; ALLAN SHEDLIN, JR., DIRECTOR, THE ELEMENTARY SCHOOL CENTER; EVELYN DAVIS, PEDIATRICIAN, HARLEM HOSPITAL; AND WILLIAM SCHIPPER, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF STATE DIRECTORS OF SPECIAL EDUCATION

Ms. BURNISON. Thank you.

My name is Judith Burnison. I am the executive director of the National Association for Perinatal Addiction, Research and Education. We are a multidisciplinary association of professionals who work with addicted pregnant women, their children, and their families.

We are most grateful to Chairman Rangel and the committee for their interest in intervention strategies for children now entering the school system who were exposed to drugs prenatally.

I can assure you that helping these children is uppermost in the minds of educators all over the country. Some administrators and teachers are fearful. They have read and seen on TV stories that depict drug- or alcohol-exposed children as little monsters, uncontrollable, and uneducable. Some people have labeled them "a lost generation."

That picture is distorted, unfair to the children, and certainly unproductive. Writing off hundreds of thousands of children as lost will only create a self-fulfilling prophecy and will burden various social service, education, and medical agencies to their limits when, in fact, with intervention for the mothers, children, and families, most of these children have the potential to become productive adults.

The National Association for Perinatal Addiction, Research and Education—as we are called NAPARE—has seen hundreds of these children up close. We have worked with their mothers in treatment, with the infants and toddlers, and with the families. What we have documented provides hope for concerned citizens and insights and guidelines for the social welfare and education systems.

NAPARE is in the sixth year of the oldest longitudinal study of the development progress of 300 children who were prenatally ex-

posed to illicit drugs. The study is funded by the National Institute for Drug Abuse—NIDA. The mothers were in drug treatment before the children were born, so we have complete histories of the drug exposure, the family situation, and the child's home environment. Most of the families receive public aid.

Here are some of the major findings in the NAPARE developmental study:

Almost 100 percent of these children test within normal range cognitively. They can be taught; they can learn.

While all exhibit signs of neurobehavioral deficiencies as infants, the majority of them at ages 3 and 4 have achieved levels of social, emotional, and intellectual development that place within the normal range.

Thirty to forty percent of the cocaine-exposed children continue to display problems, with varying degrees of severity, in language development and/or attention. Attention difficulties range from mild distractibility to attention-deficit disorder with hyperactivity. However, less than 5 percent are true cases of attention-deficit disorder with hyperactivity.

Overall, what we are finding in the NAPARE study is good news. But why is our news good and some other's so bad? Let me examine some facts.

The mothers of these children received drug treatment. Many continued to receive therapy throughout, although they are in recovery. Treatment helped alleviate the classic risk factors—no prenatal medical care, poor nutrition, and generally poor health. In another NAPARE study that was published in the Journal of the American Medical Association, March 24, 1989, it was reported that treatment begun early results in an improved outcome for the pregnancy. It does not eliminate all of the effects on the infant but outcomes did improve in terms of less prematurity and less low birth weight.

Since the use of any illicit drug or alcohol puts the infant at risk, programs which effectively speak to adolescents and women of child-bearing age about the dangers of drug or alcohol use during pregnancy are very important.

Another fact: after the babies were born, the mothers were asked to voluntarily bring them to the clinic at specific time periods for well-baby care and a series of developmental evaluations. Parents are given specific techniques for providing the consistent, predictable care that an easily overstimulated child requires.

When it is appropriate, the children are referred to physical therapists, speech therapists, 0 to 3, and Headstart programs.

The parents also get help with essentials such as transportation to and from the clinic, child care for siblings, and the services of a social worker. They feel connected to this program because they and their children are treated like special people, not statistics or cases.

Contrast this to what awaits most pregnant drug abusers and their infants. First, very few treatment programs will accept them. When the NAPARE study began, it was the only program in the Chicago metropolitan area that would take a pregnant drug abuser on Medicaid.

If the mother has no treatment, the fragile, drug-exposed infant goes to an environment that exacerbates its behavioral problems. Many of the problems they may exhibit in school begin now. The infant may be exposed to the risks of poor nutrition, little medical care, a chaotic lifestyle, possible abuse and neglect, and passive exposure to illicit drugs.

Babies born severely premature or small for gestational age begin life in neonatal intensive care units. The ones that are deserted by their mothers go to boarder-baby nurseries with not enough caregivers to provide the soothing and nurturing.

Some drug-exposed infants go to foster care homes where caretakers have not been adequately trained for their special needs. You are looking at a large population of not only children but also women and families that need intervention.

The latest figures from NIDA estimate the number of infants prematurely exposed to illicit drugs to be 554,000 to 739,000. These figures represent 14 to 18 percent of all newborns. Not all of these infants are cocaine-exposed. NIDA estimates cocaine exposure at 4.5 percent, marijuana exposure at 17.4 percent, and alcohol exposure at 73 percent.

A NAPARE study in Pinellas County, FL, found that low-income minority women were 10 times more likely to be reported as drug users, but urine tests showed middle-class women were using illicit drugs at virtually the same rate. We can now expect the schools in every community to have drug-exposed children in their classrooms.

The annual costs of intrauterine drug exposure have been estimated to be: cocaine, $33 million to $1 billion for the neonate and $351 million to $1.4 billion in the first year; alcohol, $375 million for the neonate; and tobacco, $652 million for the neonate and $351 million to $852 million postneonate.

Since my time is up, let me just tell you one or two more quick facts. An average stay for an infant whose mother has received no prenatal care in the State of Illinois for 20 days of its life is $1,500 a day or $31,000 for the first 20 days of its life.

In 1989, the extra costs of caring for 2,500 cocaine-affected children by the Illinois Department of Children and Family Services was estimated to be $60 million annually. That was in 1989.

Mr. RANGEL. Ms. Burnison, we promise you that your written testimony is not only going to be read, but it's going to be studied, and this is actually what we wanted for the staff and for the members. But in order to make certain that we hear all of the witnesses, we're going to have to try to stick by the timeframes.

Ms. BURNISON. OK.

[The statement of Ms. Burnison follows:]

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TESTIMONY TO
U.S. HOUSE OF REPRESENTATIVES
SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

JULY 30, 1991

My name is Judith C. Burnison and I am the Executive Director of the National Association for Perinatal Addiction Research and Education. We are a multidisciplinary association of professionals who work with addicted, pregnant women, their children and their families.

We are most grateful to Chairman Rangel and the committee for their interest in intervention strategies for children now entering the school system who were exposed to drugs prenatally.

Of all the hundreds of questions about perinatal addiction that come to our office in Chicago, the one we have heard most often for the past 18 months is "What information can you give us on working with the drug-exposed children now coming to our classroom?"

Some administrators and teachers are fearful. They have read and seen on TV stories about drug-exposed children that depict them as little monsters, uncontrollable and uneducable. Some people have labeled these children a "lost generation."

We believe that picture is distorted, unfair to the children, and certainly unproductive. Writing off hundreds of thousands of children as "lost" will only create a self-fulfilling prophecy and will burden various social service, education and medical agencies to their limits when, in fact, intervention with the women, children and families could be productive and less costly in the long run. Most of these children have the potential to become productive adults who will lead normal lives.

The National Association for Perinatal Addiction Research and Education --- we are called NAPARE -- has seen hundreds of these children up close. We have worked with their mothers in treatment, with the infants and toddlers, and with the families. What we have seen and documented provides hope for concerned citizens and, we hope, insights and guidelines for the social welfare and education systems.

NAPARE is in the sixth year of the only longitudinal study of the developmental progress of 300 children who were prenatally exposed to illicit drugs. The study is funded by National Institute for Drug Abuse (NIDA). The mothers were in drug treatment before these children were born, so we have complete histories of the drug exposure, the family situation, and the child's home environment since birth. The families of most of our children receive public aid.

Here are some of the major findings in the NAPARE developmental study:

Almost 100 percent of these children test within normal range cognitively. They can be taught, they can learn.

While all of these children have exhibited signs of neurobehavioral deficiencies as infants, the majority of them at ages three and four have achieved levels of social, emotional, and intellectual development that places them within the normal range.

Thirty to forty percent of the cocaine exposed children continue to display problems, with varying degrees of severity, in language development and/or attention. Attention difficulties range from mild distractibility to attention deficit disorder with hyperactivity. Less than five percent are true cases of ADDH.

The attentional problems seem to be related to the types of self-regulatory problems we see in cocaine exposed infants. They have low thresholds for overstimulation and frustration. They react by losing impulse control or withdrawing. Obviously, either reaction would be a problem when a child is in a classroom with 20 or more other children.

Overall, what we are finding in the NAPARE study is good news. But why is our news good and some other's so bad? Look at the facts:

The mothers of these children received treatment for their addiction. Many continue to receive therapy although they are in recovery. Treatment during pregnancy helped alleviate the classic risk factors to a successful pregnancy -- no prenatal care, poor nutrition, and generally poor maternal health. In another NAPARE study that was published in the Journal of the American Medical Association, March 24, 1989, it was reported that intervention or treatment begun early in the pregnancy results in an improved outcome for the pregnancy. It does not eliminate all of the effects on the infant but the outcome did improve in terms of less prematurity and less low birthweight.

Since the use of any illicit drug or alcohol puts the infant at risk, programs which effectively speak to adolescents and women of child-bearing age about the dangers of drug or alcohol use during pregnancy is very important.

Another fact: After the babies were born, the mothers were asked to voluntarily bring them to the clinic at specific time periods for well-baby care and a series of developmental evaluations. Parents and caregivers are informed of the results of the developmental tests and they are given advice and training on how to handle and comfort a drug-exposed infant. As the children grow, the parents are given techniques for providing the consistent, structured and predictable care that an easily over-stimulated child requires.

When it is appropriate, the children are referred to physical therapists, speech therapists, Zero to Three and Headstart programs.

The parents, most of whom receive public aid, also get help with such essentials as transportation to and from the clinic, child care for siblings if needed, and the services of a social worker. They feel connected to this program because they and their children are treated like special people not statistics or "cases."

Contrast this to what awaits most pregnant drug abusers and their infants: First, very few treatment programs will accept pregnant drug abusers. When the NAPARE study began, it was the only program in the Chicago metropolitan area that would take a pregnant drug abuser on Medicaid.

After birth, the fragile, drug-exposed infant goes to an environment that exacerbates rather than alleviates its behavioral problems. With its mother, if she has received no drug treatment or counseling, the infant may be exposed to the risks of poor nutrition, little medical care, a chaotic lifestyle, possible abuse and neglect, and passive exposure to illicit drugs.

Babies born severely premature or small for gestational age are placed in neonatal intensive care units which are extremely overstimulating. The ones that are deserted by their mothers go to "boarder baby" nurseries with dozens of babies overstimulating one another and without enough caregivers to provide the soothing and nurturing that will help them develop self-regulatory abilities.

Some drug-exposed infants go to foster homes where caretakers have not been adequately trained to meet their special needs. These babies may be shifted from home to home, preventing them from forming the necessary attachments and forcing them to adapt to different caregiving patterns.

Early harsh or unsettling experiences in early childhood compounded by the neurological deficits caused by drug exposure in-utero can establish a pattern of behavior that becomes a barrier to learning.

Our research at NAPARE cannot predict what a drug-exposed child will be like when it is 10 or 15 or 20 years old. We do know that,

based on the children we have seen -- 300 of them since they were born -- early intervention for mother, child, and family seems to make a difference. These children are not a lost generation, they are eager to join others of their age group in going to school, playing Little League, joining the Scouts, and other things all children do.

We have been asked to comment on what the Federal government should do to provide intervention programs for the drug-exposed children already born and what makes a good intervention program.

You are looking at a population of not only children but also women and families that need intervention. The latest figures from NIDA estimate the number of infants prenatally exposed to illicit drugs to be 554,000 to 739,000. These figures represent 14 to 18 percent of all newborns. Not all these infants are cocaine-exposed. NIDA estimates cocaine exposure at 4.5 percent, marijuana exposure at 17.4 percent and alcohol exposure at 73 percent.

A NAPARE study in Pinellas County Florida found that low-income minority women were 10 times more likely to be indentified as drug users but urine tests showed that low income and middle income women were using illicit drugs at virtually the same rate. We can expect that all schools will have drug-exposed children and their concomitant problems in the classroom.

The annual costs of intrauterine drug exposure have been estimated to be:

Cocaine $33 million to $1 billion for the neonate and $351 million to $1.4 billion in the first year.

Alcohol $375 million for the neonate

Tobacco $652 million for the neonate and $351 million to $852 million post neonatal.

What is driving these costs? First of all, lack of prenatal care. Poor women do not get prenatal care because even if they want it, care is not accessible. They lack transportation to the clinic or hospital; they have no one to care for other children; no facilities are located in their communities; and, if addicted, they fear criminal action or that their children will be taken away from them.

We calculated the cost in Illinois for prenatal care with treatment for a cocaine using pregnant woman to be $5000. Barring complications, the delivery and neonatal care after delivery would be $2,000 for a total of $7,000. A cocaine user who had no prenatal care or treatment would likely deliver her child prematurely and the child would require care in the neonatal intensive care unit. Average stay of these children is 20 days at

$1500 per day. So the cost for no treatment and prenatal care plus the cost of delivery ($2,000) and care for the infant in intensive care for 20 days would average $31,000. In Illiinois, we calculated the extra cost of caring for 2500 cocaine affected children in the care of the Department of Children and Family Services to be $60,000,000. Since we are talking about neonatal care, we have not calculated medical care and other special services for the impaired child later.

Second, if a woman wants to go into treatment, there may be no program that will take a pregnant addict or a program has an opening for a pregnant addict. The problems of transportation, child care and fear mitigate against being able to get treatment.

Many treatment programs are inadequate and do not retain their patients, A 30 day detox program will not put an addict into recovery. The road to recovery is long and full of relapses. Programs should treat addiction as a disease and address its roots -- poverty, lack of education, sexual and physical abuse, lack of child care and job training. Programs should be culturally sensitive and include training in parenting, good nutrition for the family, and use of social services and the social support system. We have had a 70 percent retention rate in a treatment program that included a strong medical care and social services component. Our developmental study represents a 65 percent retention rate from the treatment program. The parents recognize they are getting good services that help them be good parents.

Third, women may have trouble accessing services because providers within the community do not coordinate their efforts. As a speaker at a NAPARE conference commented,"Everyone likes coordination but no one wants to be coordinated." Limitations put on use of funds, procedures for using funds, and turf squabbles get in the way of coordination. Another speaker said that the social welfare system tends to "categorize" the delivery of services when there is now a desperate need to treat children at risk with integrated services within the context of the family.

The NAPARE developmental study has found programs like WIC, Headstart and Zero to Three can be very important as pre-school intervention tools for the children and their parents or caregivers. Funding for these programs is getting scarcer when it should be growing. There is plenty of evidence that they can make a difference and that they are well-accepted in the communities that need them most.

Third, on a management level, clinical and social service programs duplicate efforts or are not coordinated to work together in providing things needed to make treatment successful -- food, shelter, transportation, child care, and therapy for family members.

Solutions for the problems of drug-exposed children and their impact on schools begin with prevention. More effective programs based on a real understanding of the nature of addiction and what leads woemn to abuse drugs and alcohol should be offered through schools, WIC, and other routes that reach young women even in pre-teen years.

Education for professionals, such as doctors and teachers, is needed to help them identify and refer or treat the child who has been drug exposed and the woman who is a user. "Denial" is not only used by addicts to mask their problems. Many physicians believe only low income, minority women are drug or alcohol abusers when addicts can be found at all levels of society or physicians choose to avoid identifying users among their patients.

We are hearing of school systems that don't believe they have a problem while the teachers are begging for training to help the children they are seeing in their classrooms. NAPARE recently completed a survey of all 50 states to determine if drug-exposed children were being included in the definitions of at-risk children that would make funds available under PL 99-457 for special education needs. What we found that only five states have approved fourth-year funding definitions that include maternal substance abuse as a criteria for eligibility. Eight states reported they planned to include children exposed to drugs. Several states include this category with qualifications, four states did not include maternal substance abuse as a condition for funding and six more states did not address the needs of these children in their draft definitions.

Despite strong evidence that drug exposed children are as educable as children with other genetic handicaps and perhaps can progress further, the availability of early intervention will bypass many children.

The problem of how to help drug exposed children is very complex and seeking solutions is frustrating. The one route toward solutions that NAPARE totally disavows is criminalization. Dragging a woman into court, throwing her in jail, and other punitive measures will only drive women away from treatment and from prenatal care. Fear won't cure addiction any more than it will cure poverty, lack of ecucation or illness. It won't make a drug-exposed child better able to handle its emotions or behavior.

We thank you for this opportunity to share with you what we know about treatment and approaches to helping drug-exposed children become functioning, stable members of society. As you deliberate the course that legislation and funding should take, we hope you will call on us if we can be of service. Thank you.

Mr. RANGEL. I apologize for the interruption, and call on Allan Shedlin, the director of the Elementary School Center.

TESTIMONY OF ALLAN SHEDLIN

Mr. SHEDLIN. Good afternoon. I'm Allan Shedlin, Jr., the executive director of the Elementary School Center, a national advocacy research and resource center with an interdisciplinary membership of child-serving professionals from across the country. Our center is located in East Harlem in New York City, and I'm pleased to be here.

I'd like to introduce my remarks by reminding you that as every child knows, childhood is much more serious than its reputation.

I'd like to begin by sharing a recent experience which establishes a broader context for my remarks and which will put my testimony in a broader perspective.

The problems of drug-affected children often in drug using and abusing families cannot be viewed in isolation. Just about a month ago, I attended a sixth grade graduation—that's 11- and 12-year-old children—at P.S. 146 in East Harlem. It is one of the schools in which our center has been working to redefine the role of the school in a changed and changing American society.

Picture this scene if you will in the school's auditorium on 106th Street. The school has 56 percent African-American children, 43 percent Latino, and 1 percent other. Ninety-five percent are eligible for free lunch.

Because we're working in this school, I had some understanding of what it was like for the children to look as they did that day. The 12-year-old girls in their white dresses and beautiful white gloves wobbling down the aisle because they weren't quite used to walking on their new heels. The boys walking down the aisle craning their necks because they weren't used to wearing ties.

And they were preceded by an honor guard and flag bearers, and the flag bearers very formally came down the front of the auditorium, put their flags in their holders, and took their pledge of allegiance to the United States of America.

And I found myself overwhelmed at that moment with an extraordinary sense of anger that the United States of America was not taking its pledge of allegiance to its children. That's the broader context of my remarks.

I would like to commend you, Mr. Chairman, for focusing national attention on the needs of young children who still bear the scars of their prenatal exposure to crack, alcohol, and other drugs.

Your letter of invitation to this hearing cogently pointed out the existence of these children, the needs of their families, especially their addicted parents, and those are the schools that are too often unequipped to adequately carry through on their mandate to educate all our children.

I welcome your invitation enthusiastically because the timing of your hearing could not have been better. Last week our organization and six other agencies cosponsored an institute entitled "Educating Children from the World of Crack: Myths and Realities Concerning Children Prenatally Exposed to Drugs and Alcohol."

In spite of stifling summer heat, we had 150 organizations from 10 States represented, and they included teachers, and supervisors, and pediatricians, and a whole interdisciplinary realm of child-caring professions.

Before getting into the meat of my testimony, I'd like to share an anecdote about a second grade teacher in the Bronx. The second grade teacher had heard all year from her kindergarten colleagues how different the children were this year in her class. What a different array of problems they presented to her at a time where she was already feeling very overwhelmed.

The second grade teacher decided to give up one of her preparation periods and went down to the kindergarten classroom. After observing for a half hour the differences in the behavior of these children, she marched herself to the principal's office—this is a veteran teacher—and submitted her resignation effective 2 years from now for fear that she would have to deal with the children she saw in the kindergarten because she felt unequipped to deal with them.

My testimony will be very quickly now whipping along in three parts. First, I'll answer the question about why we held the institute; second, what we learned, which is pertinent to this hearing; and, finally, share some conclusions and recommendations.

We held the institute because we believed that as a Nation we have precipitously raised the ante, and you can spell ante either with an "E" at the end, or an "I" at the end if you prefer, on growing up.

The children we have heretofore described as being at risk are now more aptly described as being in deep trouble. Everybody knows the precarious states of our Nation's—state of our Nation's schools, especially those in urban areas of concentrated poverty.

We believe that any additional burden at this time of rising class sizes and shrinking budgets is the straw that could break the camel's back for many teachers and schools.

Our speakers at our institute helped us to see that these children are more like other children than different, and that they should be seen as children first and victims second.

What did we learn? We learned that drug addiction does not discriminate. Drug and alcohol abuse occurs among rich and poor, black and white. We focused, however, on poor children with drug-using parents, as they often have unstable home lives, and the threats of violence, hunger, or homelessness, and AIDS compound the hardships imposed by their prenatal exposure.

One Head Start teacher told us she had co-opted the stop, drop, and roll drill that's taught to help children save themselves when burning, and she now uses that when taking her children out for a walk to go to the park because of gunfire in her neighborhood.

Second, we learn that some children prenatally exposed to crack and other drugs are indiscernible from their nonexposed peers by the time they hit kindergarten.

And third, we learned that with early intervention and support of home environment, even babies who appear severely affected at birth can often enter mainstream classrooms once they reach school age.

Fourth, we learned successful strategies for working with children who need special help.

And fifth, we learned that it is sometimes difficult to sort out which of the increasingly disturbing and inappropriate behaviors that children are manifesting in school are due to prenatal exposure to drugs and alcohol and which are due to new social realities which are part of the world of crack.

The children who have been prenatally exposed to drugs and alcohol are an acutely vulnerable segment of our society: a growing population of school-aged children who suffer from the double jeopardy of prenatal drug exposure and of growing up in a drug abusing environment. These children have been placed at risk biologically, developmentally, socially, emotionally, academically and often economically. The odds really have been stacked against them. To address this damage, we as a society must summon the best we can offer to improve their odds so they can grow up to be productive and contributing citizens.

The challenges these children bring for schools are magnified by the fact that their arrival in school demands increased resources at precisely the time that austerity budgets are the rule and resources are being cut back.

Many Americans are asking: why if we are able to find resources for bailing out savings and loans institutions and bailing out nations in the international community, have we not been able to find the necessary resources to adequately invest in our own children?

It is too late to be proactive for hundreds of thousands of these children and their families. And, we are clearly seeing the consequences and the crippling costs—human, social, and economic—of our current reactive responses. But it is not too late to be proactive on behalf of the subsequent legions of children whom we continue to place at risk by our unwillingness to adopt and enact the types of policies and initiatives which can reverse this social malignancy which we have allowed to grow.

Despite their often cruel handicaps, these children are not doomed. There are a variety of hopeful initiatives underway and many dedicated professionals are devoting themselves to developing new strategies. They should revive our finest caring traditions and create a sense of urgency to join forces for our most vulnerable citizens—our children. We can do no less.

I will enter into the testimony our specific recommendations. I would also like to let you know that we prepared a video for today, which we now don't have time for. And I didn't just find that out; I found it out last night. But it is available to you.

It is a video which allows you to hear the voices directly of the mothers who prenatally exposed their kids to drugs and alcohol, and the second part is the direct testimony of the teachers who work with these children.

I was hoping you could hear that today because it's one thing to hear from us experts and another to hear directly from the folks who are most directly involved.

Mr. RANGEL. There's no reason why we can't hear it, except that we thought we spelled out in the letter of invitation that today we were restricted to the 5 minutes. But if you would allow us to reproduce the tapes or leave them with us, I can assure you that we would look forward to hearing from those tapes.

[The statement of Mr. Shedlin follows:]

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Testimony

by

Allan Shedlin, Jr.

Executive Director
Elementary School Center

July 30th, 1991

"Drug-exposed Children in the Schools: Problems and Policy"

U.S. House of Representatives

Select Committee On Narcotics Abuse and Control

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July 30th, 1991

"Drug-exposed Children in the Schools: Problems and Policy"

U.S. House of Representatives
Select Committee On Narcotics Abuse and Control

Good morning. I am Allan Shedlin, Jr., the Executive Director of the Elementary School Center. I would like to introduce my remarks by commending you Mr. Chairman, for focusing national attention on the needs of young children who still bear the scars of their prenatal exposure to crack, alcohol, and other drugs. Your letter of invitation to this hearing cogently pointed out the existence of these children, the needs of their families -- especially their addicted parents -- and those of the schools that are too often unequipped to adequately embrace them.

I welcomed your invitation enthusiastically because the timing of your hearing could not have been better. Last week my organization, the Elementary School Center, and six other agencies and institutions -- from New York City's Department of Health and its Public School system to Westchester County's Drug Task Force to the U.S. Public Health Service -- co-sponsored an Institute entitled: ***EDUCATING CHILDREN FROM THE WORLD OF CRACK: Myths and Realities Concerning Children Prenatally Exposed to Drugs and Alcohol.***

In spite of stifling heat and summer vacations, 150 organizations from 10 states sent representatives that were hungry for information and guidance. We had pediatricians and nursing supervisors, regular and special education teachers, college professors and deans, social workers and child welfare experts, nutritionists and speech pathologists, foundation officers

and policy analysts, Head Start and day care teachers, child development specialists and educational directors. All levels of government were represented as were all sectors and disciplines.

Why Was Such an Institute Held?

What motivated the Elementary School Center to hold such an Institute? We are a national advocacy, study and resource center committed to elementary and middle level schools and their constituents: children, families and staff. We believe that as a nation, we have precipitously raised the ante/anti on growing up. The children we have heretofore described as being "at risk" are now more aptly described as "in deep trouble." Everybody knows the precarious state of our nation's schools, especially those in urban areas of concentrated poverty. We believe that any additional burden at this time of rising class sizes and shrinking budgets is the straw that could break the camel's back for many teachers and schools.

What motivated our participants to come to the Institute? Some may have been spurred by the hysteria on this topic whipped up by the media. Who can forget the *Time* magazine cover with the sad-eyed little boy and the "Crack Kids" headline? Most participants, however, came because they work with such children and want to better understand and respond to the needs of their students or patients. Others wanted knowledge so they could make more informed decisions or set more realistic policies. Most were also drawn by the opportunity to help shape an agenda for assisting drug-exposed youngsters.

I think it's important to note that at the beginning of the Institute, we referred to drug-exposed children as "these children," and that at the end of our two days together, we agreed to call them "our children." *Our speakers helped us to see that "our children" are more like other children than different and that they should be seen as children first and victims second.*

What Was Learned?

What did we learn? First, we learned that drug addiction does not discriminate. Drug and alcohol abuse occurs among rich and poor, Black and white. We did focus, however, on poor children with drug-using parents as their often unstable home lives and the threats of violence, hunger, homelessness, and AIDS compound the hardships imposed by their prenatal exposure. One Head Start teacher told us she's co-opted the "stop, drop, and roll" drill that's taught to help people save themselves when burning, and uses it when taking her students for a walk outside when gunfire occurs.

Second, we learned that *some* children prenatally exposed to crack and other drugs are indiscernible from their non-exposed peers by the time they hit kindergarten. Third, we learned that with early intervention and a supportive home environment even babies who appear severely affected at birth can often enter mainstream classrooms when school-age. Fourth, we learned successful strategies for working with children who need special help. And fifth, we learned that it is sometimes difficult to sort out which of the increasingly disturbing and inappropriate behaviors that children are manifesting in school are due to prenatal exposure to drugs and alcohol and which are due to the new social realities which are part of the "world of crack".

That was the good news.

The bad news was that the programs that succeed in helping drug-exposed children are often costly and even with successful track records, they have trouble scraping sufficient funding together. Such programs are staff intensive, can usually serve only small numbers -- like two teachers for 12 children -- and may require special settings with isolated time-out areas for hyperactive children. Children of normal intelligence may be sent to special education because that's one of the few federal funding streams available to ensure small class sizes.

And, there's an issue that's been tragically overlooked in all the publicity surrounding the incidence of drug-exposed births -- the impact the few seriously disabled children have on their classmates and teachers. Even if only 5 to 10 percent of the estimated 100,000 children who were born exposed to crack in 1986 and are entering kindergarten this year are still moderately to severely disabled -- nobody really knows the percentage of children who continue to be affected by school age -- their impact will be staggering. Any disruptive child affects the learning going on in a classroom. So it's not just one child we have to worry about, it's that child's 20, 25, 30 or even 40 classmates as well.

I'd like to share an anecdote about a veteran second grade teacher working in a school serving the Bronx's Co-Op City. This past year, this life-long educator kept hearing from an overwhelmed kindergarten teacher about the hyperactive and violent behavior some of her students were exhibiting. So, one day, she took a walk down the hall and observed in the kindergarten class. Of the many disruptive behaviors she saw, she noticed one little boy trying to gouge out the eye of one of his classmates. This veteran professional vowed to put in her retirement papers before that child and others like him made it into her classroom.

That story may be extreme, but it echoes the stories we heard again and again of teachers feeling overwhelmed and calling for help because they were encountering problems they had never seen before. Help, by the way, was rarely available.

In addition, the supportive services that the families of such children need just aren't there. Such services include drug treatment for women -- especially residential treatment that allows them to bring their children -- WIC, housing, and parenting classes. It's incredible to me that only 1 percent of the federal drug prevention budget goes to drug treatment programs specifically for women, with an even smaller percent going for treatment for pregnant women.

Conclusion and Recommendations

Institute participants reached a general consensus on many issues. First, we agreed that it is not especially important to identify how or why a child became disabled. What is important is a thorough assessment and a plan of action. This leads to a second important point: in some ways addressing the needs of these children presents us with an opportunity. It compels us to form active working partnerships across the spectrum of child-serving professions, *which is good practice for all children.* And, the educational challenges presented by these children should force us to look carefully for their strengths and skills so we can build upon them and develop individual learning and teaching strategies, which again is *what we ought to be doing for all children.*

As I said earlier, the time of this hearing is ideal. One week earlier and I would not be able to share with you the following recommendations from Institute participants. In the interest of time, I will share those most uniformly agreed upon. Believe me, there were many more made by the concerned and caring professionals we assembled.

First though, I would like to offer my own recommendation. Judging from what I observed and heard last week in addition to the research I have been doing over the last few months, there is a desperate need for a national resource center for information on drug-exposed children. Such a center should offer the usual statistics and demographics. More importantly, however, it should offer all information available on program models that work. And it should begin to propose specific policy recommendations.

For Educators

- Schools have increasingly taken on a stabilizing role in children's lives. They must be enabled to do by design what we currently expect them to do by default. And they must become the locus of child advocacy because schools are where the children are.
- Legislators should fight the temptation to divert money from regular education to special services for the drug exposed. Instead, more funding -- or at least more flexible funding -- must be available to improve the educational process for all students.

- Expand the Head Start model down to birth and up through the sixth grade, always emphasizing prevention and the family. This would include:
  - Parent training and self-assessment and development;
  - Small class sizes;
  - Developmentally appropriate practices;
  - Home-based interventions and support which impact on the bonds developed between teacher, parent and child;
  - And, consultation opportunities through built in resources such as health, and social and nutrition services.
- Elementary school and Head Start teachers must be helped to identify the stresses in children's lives, and then provided with necessary supports so those problems can be addressed.
- Schools should become more of a community resource. There should be tutoring, recreation, and job training available.
- More in-service training on addiction must be available to teachers if they are to both identify it and work with families so affected.
- Provide financial incentives for staff development, in-service and pre-service training and education for staff who commit to working with children and families at risk. Incentives would include forgiveness of loans or low-cost tuition for additional training.
- The federal government should provide support and technical assistance to all states keeping them up-to-date on how different states are funding special and regular education courses.
- To be successful, interventions for all special needs children must begin at birth, not only in tracking them but in providing enriched educational opportunities.
- There must be better coordination between those systems serving children 0 to 3 and those serving children between the ages of 3 to 21.

Social and Health-Related Services

- More culturally sensitive services should be provided in the community -- from parenting instruction to child development training to nutrition counseling.
- "Human Resource Centers" should be created which are community-based and provide information on pre and postnatal care and the effects of parental drug use on the unborn.
- More home-based interventions must be developed as they are more effective and less threatening to parents. They are especially effective when child-focused strategies are explained and taught to parents.

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[The statement of the Elementary School Center, as shown on videotape, follows:]

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"THESE CHILDREN: Mothers' Perspectives"
"THESE CHILDREN: Teachers' Perspectives"

Transcript for Short Version

Prepared for Screening before House Select Committee on Narcotics Abuse and Control (July 30, 1991).

Contact: Allan Shedlin, Jr., Executive Director, Elementary School Center

MOTHERS

NARRATOR:

The women you will meet in this film have a special story to tell. It is a story of the ravages of drug addition, and it is a story of the life-altering power of the recovery process.

These women are mothers who knew their discussion would be shared with educators, social workers, administrators, public health officials and policy makers. They were willing to take part in the hope that you will better understand the world they live in and their longing -- like that of so many others -- to maintain a drug-free life for themselves and their children.

MILCA: Well I'm an ex-crack addict myself so I know. There is a lot more women out there in the street. Basically because I don't think they have any problems getting the money to support their habit, that's number one. Number two they suppress so much that they don't know that there are places that they can go to talk to somebody about these problems they're having. Whether it's with jobs, with their husband, with the children. Or maybe starting off very young, being a child themselves when they have their firstborn, you know, and not understanding that it's okay, you're not the only one that's gone through it. I've gone through it and you don't have to drug over it. But they don't know this.

CATHY: My kids they make meetings and they're a part of the meetings. As far as I'm concerned, as much as *I'm* in recovery, *my kids* are in recovery. You know my kids do not hang out with children of parents that are active -- they hang out with recovering children. I have to be there and make sure what's going on and not run. When the responsibility is overwhelming I want to run. You know because I can't handle it... I've been doing this for so long by myself I feel like I wanna break.

MILCA: I went to the school... It was like the firing squad. The principal, assistant principal, counselor and a school psychologist were there. We sat down and we're about to begin the meeting, you know, concerning my son. So a woman flips open a paper and she says, Oh, well we'll start from 1986. I says, no. We're going to start now. Whatever my son has done from 1986 I'm not interested I'm interested in *now* -- what he has done now. The principal looked at me because he was figuring, you know, a mother being quiet, listening to all of the bad things her son has done. The thing was that I opened up and I let them know that I was a recovering addict. And I'm saying, look -- the reason that I'm not interested is because he had a reason for doing whatever he did from 1986. Because I'm a recovering addict and I was never there for him. I said, but I'm responsible now, *today* -- and I want to know *today* what's going on.Today I have a bond which I never had before with the teachers in my son's school -- all of them, including the counselor and the dean. Let them know that they're also a part of your life with the child. You've got to get involved with the teacher.

SARA: I feel educators need to be more educated as far as what they're involved with. You know, because a lot of them don't know, they don't, they have no idea what substance abuse is really about and the disease concept and what they're really dealing with. It's easy to say that the teacher should do this and the teacher should do that. It's a lot of responsibility for teachers as well to try to reach all these children.

TEACHERS

MICHELE: So your ability to be teachers in that traditional role is changing dramatically...

HELEN: It doesn't exist any more..

JOSE: I think we've also become parents in the classroom. That's it..

PATRICIA: They call me "mommy."

JOSE: I have some call me "dad."

PATRICIA: My parents are a mix of very, very poor parents, very young and poor, and middle class parents. And what they have in common is that they have these children who are so difficult in the home and obviously in the school, that in spite of their economic differences they're lost. They *want* to be good parents. And they call me every day. It's an every day kind of thing -- I can spend two hours on the phone a night. And it really cuts into, obviously my life, my time as a teacher in preparing.

HELEN: I have watched many parents come in here with low self-esteem, confused. But truly when you looked underneath it all, all they were looking for to a great extent was the same thing that the children needed -- they need someone to care, someone to be concerned.

INA: I think we also have another problem and I don't know if you people do. I find there are times when I'm at physical risk and I am not talking about from the children. I am talking about from the volatile, violent parents. We have been threatened in our school... we recently had a child who had to be removed from a home and a father came with a gun. So there are physical problems that we face... where you're concerned sometimes about walking to your car that I am in jeopardy.

And sometimes you say, I care about children. I want this child to get help if they're in danger. But I also care about myself and my family. Am I physically going to be in danger? Who is going to help me? Who is going to protect me?

PATRICIA: It's really very serious and they are thinking about upping the kindergarten sizes. As it is I've been trying to mainstream some of my children who could possibly go into a regular setting for maybe an hour a day in certain areas. And I can't because the kindergarten teachers are overwhelmed. The classes are 27 children or more, and they have children with real problems that they can barely cope with. Not that they're not professionals but in that kind of a setting with such a large class they can't do it.

For the first time last year, I was confronted with a class that made me think, is this what I want to do with my life? For the first month there I said, maybe I'm not in the right setting. I mean I don't even know if I have the background. I've been teaching special ed for seven years and I have above a master's and I sit there and say, what am I going to do with this problem. And I'm alone!

HELEN: I know for myself -- you were asking when did you feel this overwhelming feeling. This year -- I mean this year really. And I've always considered myself a trouper, it's like you know I can handle it. You know. But this year just a few weeks ago we have a staff psychologist who comes in and talks to the parents as well as the children and we refer children to her. And I told her you know, I have to tell you I just broke down and cried -- I'm at my limit. I don't know what to do.

ROSIE: We're a business economy and only if you show profit at the end of the year, in the black, do they pay attention to you and become willing to invest more money so you can make a bigger profit. And nobody wants to invest in education because they don't see the bottom line as a profit... our children are not profitable commodities.

INA: *We* also need more training and we need more facts. I attended a seminar last week where a physician got up and said, this is what we see with children of substance abuse who have been neonatally exposed. The different kinds of physical things that are happening to their bodies. So the teacher doesn't say, oh I wasn't doing anything wrong, they can't do that. But there is hope. I was given hope because I listened to a physician and the physician said that if we get them soon enough they can make it. But we need those facts, we need research. Let us know what's really happening in their brains and in their bodies, and with more facts at least we have a chance.

Mr. RANGEL. And, of course, my good friend Dr. Davis, we are so appreciative of the job that you've been doing at Harlem Hospital with Dr. Haggerty.

We have been joined by Ben Gilman of the committee, Mike Oxley, Congressman Clinger, Congressman Ramstad, Congressman Inhofe, and also Major Owens who serves on the Education Committee, one of the leaders in child education in the Congress, and Mrs. Lowey from New York.

And now we'll hear from Dr. Davis.

TESTIMONY OF EVELYN DAVIS

Dr. DAVIS. Good afternoon, Congressman Rangel.

Let me say that I'm absolutely delighted to have been asked to come and to present information that I think is somewhat shattering, but it's the honest information I can bring from Harlem.

As a developmental pediatrician who works in pediatrics, in child-adolescent psychiatry, and in rehab medicine, and as one who has lived in Harlem for an entire lifetime—in fact, I live right across the street from the hospital—I think I am in a position to talk about the spectrum of abnormalities I've seen in these youngsters and also to talk about some of the children who never present to me, as a development specialist.

I think the big question is: what do the some 700,000 youngsters born per year affected by drugs present with? Indeed, many of these children are never diagnosed. Indeed, many of these children will go on and be unrecognized.

But I think enough of these youngsters are presenting to me as a physician that I can shed some light on the issue. Cocaine certainly remains the No. 1 illicit drug of choice amongst pregnant women. The New York Times says cocaine use is on the decline. I think all of the numbers from the city, the State, the Federal Government, pretty much say that, yes, cocaine use across the board is on the decline.

Unfortunately, at Harlem Hospital, the use of cocaine by pregnant women this year actually increased. We are now running a rate of about 13 percent of all deliveries being affected by cocaine.

In fact, when I go to the prenatal clinic and talk to our pregnant women, the number gets closer to 25 percent. And, indeed, I think if we look at some large cities such as Detroit, and perhaps New Haven, the numbers are closer to 40 percent. The problem is absolutely not disappearing.

I think if we're going to answer some of the questions presented to our panel, we need to look at what the problems are that we are seeing in some of these youngsters. I'm going to be very brief and not give you a whole list of abnormalities, but I think they really do have some implications for the society as a whole.

What I did was to look at youngsters presenting to me in the developmental clinic between the beginning of 1986 and the end of 1990, and attempt to come up with a spectrum of abnormalities seen in such youngsters.

This is what we found very briefly:

The majority of mothers were polysubstance abusers, and I think most of us know that. The typical cocaine-using person uses other

drugs, with alcohol being the most commonly used drug. Well over 50 percent of our pregnant women use alcohol. And it's no surprise that right now we are well aware that alcohol is a neurotoxin.

It took us 25 years to recognize the fact that alcohol does something to the developing brain. I certainly hope it doesn't take 25 years for us to recognize the fact that cocaine does something to the developing brain.

Unfortunately, the scientific community has created a myth. And for years, we as a group said cocaine was not addictive. We overlooked the fact that cocaine is a vasoconstrictor and affects all parts of the body. Cocaine is a devastating neurotoxin.

In looking at the youngsters who presented to our clinic, we realized that the mean age of the mother was 27 years. The typical cocaine-using mother is not a teenage mother. It is an older woman, a woman who has pretty much given up on society, a woman who has been deserted by society, and in many instances by her male partner, and very often it's a mother who plays Russian roulette. She really does not think of the outcome of her pregnancy.

In fact, the biological mother of our patients is present only 25 percent of the time. Most of our caretakers are foster mothers and grandparents. In fact, the grandparents are the unsung heroes in this whole saga.

Prematurity continues to occur in the drug-affected child to a rate of about 30 percent at Harlem. Head circumferences in our children affected by drugs were below the fifth percentile in about a third of our children.

Now, a small head, a small cranium, means a small brain. If the brain doesn't grow, the head doesn't grow. This certainly has implications for the school system. Children who are severely microcephalic cannot process information, cannot think logically.

Growth retardation continues well beyond infancy.

Some of the more startling data which I think has implications for the school system involve the finding that roughly 90 percent of the children are language-delayed. These are youngsters who do not coo on time, do not babble on time. They very often reach age 2 without having said the first two words that most children say—namely, mommy and daddy. Many of these youngsters who are ages 4 and 5 cannot speak in phrases. They are speaking in single words.

Indeed, many of these youngsters, in fact, when they speak, they really aren't quite sure of what they're saying. Some of them don't quite understand what they're hearing.

Most of the youngsters, if one looks at them very clearly, have subtle signs. I don't want to paint such a terrible picture, but it's very clear that many of these youngsters have subtle disabilities that will not present themselves until the child enters school.

Some of the more startling data concerns hyperactivity which was mentioned previously, children who seem to be wound up like a motor, youngsters who cannot focus attention, and an alarming rate of autistic disorder.

We know that autism is a developmental abnormality with many related features. In some instances, German measles can trigger it. I am seeing the rate of autism that one would never see in connec-

tion with any other neurotoxin. I am simply saying that we absolutely have to study the problem.

Just to sum up, since I have only a couple of minutes, let me just say that, No. 1, the Federal Government absolutely has to be a clearinghouse for information. We at Harlem sit on a dynamite amount of information that doesn't get publicized.

No. 2, early intervention programs absolutely work. I am my own social worker. I know they work. I'm responsible for all of the service needs of the youngsters I care for, service programs that begin at birth of the child and go on through school age.

We at Harlem have a board of ed, Harlem Hospital-sponsored programs—that's a preschool program for kids perinatally exposed to drugs. It is a family-focused program where we involve all members of the family, and we involve local schoolteachers.

We are attempting to our best ability to get schoolteachers to rotate through the hospital so that they can see the kids who are exposed to drugs, so that they can see the strategies that work.

Thank you.

[The statement of Dr. Davis follows:]

TESTIMONY ON
DRUG EXPOSED CHILDREN
EFFECTIVE INTERVENTION - JULY 30, 1991

U.S. HOUSE OF REPRESENTATIVES
SELECT COMMITTEE ON
NARCOTICS ABUSE AND CONTROL

Cocaine remains the number one illicit drug of choice among pregnant women in the United States with New York City registering a staggering 20 - fold increase during the past decade.

Between January 1986 and December 1990, approximately 1,900 children were born at Harlem Hospital Center with urines positive for cocaine. This represents 13% of all births at the hospital during that time. Informal surveys of our mothers attending its general prenatal clinic reveal a rate closer to 25%. Approximately 9% of these children were referred to me for behavioral and developmental assessments at the Harlem Hospital Pediatric Developmental Clinic. The spectrum of abnormalities seen have tremendous implications for school systems throughout the country and the society as a whole. The findings were as follows:

1. The majority of the mothers were poly-substance users with alcohol being used by over 50%. Alcohol can significantly interfere with growth and development.

2. Mean age of the mothers was 27 years.

3. The biological mother was the caretaker in only 25% of the cases.

4. The majority of the caretakers were grandmothers and foster mothers.

5. Prematurity occurred in over a third of the cases.

6. Head circumferences were below the fifth percentile in one-third of the cases.

7. Interference with growth continued well beyond infancy.

8. Delays in language skills were noted in 90% of the children. Delays were seen in all age groups.

9. Most children presented with abnormalities by 18 months.

10. Delays in fine motor, gross motor and play skills were noted to a lesser but significant extent.

11. Hyperactivity and short attention spans were noted in over 30%.

12. Hypertonicity was noted in 30% with some of the children showing signs of cerebral palsy.

13. Autistic disorder, a rare disorder said to occur with a frequency of 3 - 10 children per ten thousand live.births was present in 8% of the children ... an alarming rate.

Explosive behavior, difficulty interacting with peers, difficulty with transitions, indiscriminate attachments and feeding disorders were all noted to a greater degree in this population than in other groups presenting to the clinic.

Effective early intrevention programs work. There simply are too few of them. The Harlem Hospital Center program for drug-exposed infants and their mothers is sponsored by the Visiting Nurse Service. It is family focussed and involves home visits and assessments and interventions for the mother and child. The program begins at the birth of the child. Unfortunately, we can service only 20 families. A psychiatrist, play therapist, social worker and a developmental pediatrician make up the staff. Children are referred to other specialists as needed. The program helps in myriads of ways to bring about a healthy caretaker - infant bond.

Pre-school programs are essential for all high risk children. There are numerous pre-school and daycare programs; however, only a few of them can effectively treat the drug-exposed child and his family. In February 1991 the New York City Board of Education collaborated with Harlem Hospital Center setting up a pre-school therapeutic nursery for 2 - 4 year old children exposed to drugs in utero.

There are seven children in each class plus two special educator teachers, a speech therapist and a play therapist. Psychiatrists from Harlem Hospital provide treatment for those children requiring in-depth therapy. A major component of the program involves outreach to School District 5, our neighborhood school district. Teachers from the district have already begun to rotate on an 8 week basis through the school in order to become familiar with the spectrum of disabilities and intervention strategies that work.

Parent/caretaker involvement is essential. The typical caretaker of a drug-exposed child is a grandparent or foster parent. They are at times overwhelmed by the problems of the child.

Effective programs for drug-exposed children are insufficient for the number of children needing services. "Zero to Three" Legislation has been passed. It is a reality in only a limited number of communities. Monies have to be allocated to educational departments for the specific purpose of re-training teachers. They are so eager to learn how to deal with this population; however, this does not appear to be anyone's priority at the moment.

The Federal Government must expand its research in the field. We must develop effective drug treatment protocols that work. Medical experts must be given opportunities to perform long term research studies to document what drugs do to the developing fetus. Research must be done to determine the degree to which the environment exacerbates the problems faced

by these children. Harlem Hospital is part of the New York State Consortium on Drug Effects on the Fetus. We will be submitting a grant in the Autumn to study the effects of cocaine and other drugs on the developing fetus. We will also investigate the role played by the environment. Research projects such as these should be funded.

As an Afro-American physician who has worked at Harlem Hospital for seven years and lived in Central Harlem for an entire lifetime, it is clear that cocaine is creating problems with children not previously seen. Many in the field have said that we are actually looking at problems of poverty. Harlem has always been poor! We are seeing something far beyond poverty. Cocaine and alcohol are neurotoxins and the effects seen in our children were, to a large extent neurological in nature. Roughly 15% of the drug-exposed children I see at the hospital have handicapping conditions that will require a lifetime of care. The majority of drug-exposed children, however, will do well if their needs are recognized early and intervention provided. With early intervention many of these children will not require special education after age 5 years. The Federal government must take the lead. The monies are not available at the City and State levels. The very well being of our nation is at stake.

Respectfully submitted,

ED/bms
7/25/91

Evelyn Davis, M.D.
Assistant Clinical Professor of Pediatrics
Department of Pediatrics AND
Department of Child and Adolescent Psychiatry
Harlem Hospital Center
New York City

Mr. RANGEL. Thank you, Dr. Davis.

Now, we'll hear from Dr. Schipper who represents the National Association of State Directors of Special Education. I assume these would be teachers?

Dr. SCHIPPER. These are the State administrators of special education programs at the State level, State departments of education.

Mr. RANGEL. That would include teachers?

Dr. SCHIPPER. No. These are the people who administer programs which teachers operate in.

Mr. RANGEL. They would not necessarily be teachers.

Dr. SCHIPPER. Correct. These are State directors of special education who are responsible for State policy, State regulations, and implementation of State and Federal programs for students with disabilities.

TESTIMONY OF WILLIAM SCHIPPER

Dr. SCHIPPER. Thank you for the opportunity.

My name is Bill Schipper. Besides representing my constituents here, I think we're here because of our experience in running three major national seminars on this topic in the past 3 years; one in Washington, DC, one in New York City, and one in Atlanta, GA.

The information I'll present will supplement these folks and will give it all—the information I'll present in the written testimony is based from the experts that we have involved in those—in those particular seminars.

First, to set some context—the number we use for—or the incidence that we use is about 10 percent of all babies born since 1985 are born to substance abuse mothers. Ten percent equals about 3.75—or 375,000 children annually, going in the direction of 400,000 children annually.

As a percentage, 10 percent of all children born left unattended, if that percentage is correct left unattended, would equal the percentage of school-age children in today's special education system, K through 12.

Today's K through 12 special—students in special education programs are about 10 percent of the total school-age population. What we have coming through into the schoolhouse door is a number of children addicted or born to crack-addicted mothers.

It could possibly overwhelm the special education system as we know it today. It definitely will overwhelm the existing intervention programs that we have today, the infants and toddlers program that is now 5 years old, and the preschool programs that are set up in the States for 3- to 5-year-old children.

One of the conclusions of all of this—and it's an obvious conclusion—is that no single program, or no single entity, or no single thing in this country can solve or adequately deal with this problem. It's going to require a major coordination, major integration of services, major cooperation and consolidation of people's energies and efforts.

And that is beginning to develop through our part H programs and are still in their early stages of maturity. But it's beginning to develop there.

What I'm trying to point out as a context is—the systems that we have in place are immature, are underfunded and underdeveloped. As a context, as a point of comparison, the—what we call the early—for the program for infants and toddlers, what—in our jargon, the part H program was originally designed in anticipation of serving a population of about—something between 100,000 and 160,000 children annually.

Today, in the fifth year of that program, we have more than 250,000 children in that program, and it's just beginning to accept the children born to crack-addicted mothers which may be another 10 percent of all babies born, or 375,000 children, which could triple the existing number of children served by an already underfunded program.

That's in the birth to 2-year-old program which is the vital program; which our preceding speakers have already said is the vital program for remediating or intervening adequately with these children.

So in terms of your invitation for advice on what you might do to help in these programs, would be to help Major Owens in his efforts to develop and expand and fund adequately this program.

And other efforts in the—like the one that's now in the Senate that has this bill called the Children of Substance Abusers Act, which is looking for sponsorship in this House. That is worthy of some kind of attention to take a look at.

One of the things I'd like to endorse that was said by Dr. Davis is that one of the major things that we need soon, immediately, yesterday, in this country, is some kind of an information response to—or an information clearinghouse, information dissemination center on this topic, primarily dealing with—for practitioners and intervention folks who are the day-to-day people dealing with these children because these children are very, very different from normal experience and require very different tactics.

And they're going to need information nationally coordinated that comes from the research community and the folks who already have these children in their programs to find ways to accept that information and create it and convert it for practitioners, and also to find ways to disseminate information in support of the adult practitioners of these children because we're finding, at least we're told, a very, very high burnout rate.

That's going to be very dangerous for the educational system, the foster care system, and the early intervention system, if we don't find ways to support the adults who are dealing with these children.

Thank you.

[The statement of Dr. Schipper follows:]

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Statement of

The National Association of State Directors of Special Education

to

The House Select Committee on Narcotics Abuse and Control

July 30, 1991

Presented by:
Dr. William V. Schipper
Executive Director

Mr. Chairman and members of the Subcommittee. The National Association of State Directors of Special Education (NASDSE) appreciates the opportunity to present the following statement regarding programming for infants and children exposed in utero to illicit drugs and alcohol. Our membership includes the administrators of education programs for children with disabilities in the Departments of Education in the 50 States, the District of Columbia, and the jurisdictions. Since 1988, our organization has taken an active role in bringing the plight of infants and children exposed to drugs and alcohol and their families to the attention of the educational community. During the past three years, achieving adequate and appropriate programming to address the needs of these children and their families has been one of our highest priorities. As part of that effort we brought together experts from the education and medical communities at national and state seminars, the most recent being in New York in May of this year, to develop policy recommendations and strategies that address this emerging critical issue. Our statement today reflects the thinking of those experts and incorporates several of the strategies recommended at those seminars.

Drug use in our society has reached epidemic proportions, affecting the lives of communities, parents and children throughout our country. The costs of this epidemic are high, and, as documented most recently in the excellent articles published by the Washington Post, are particularly dramatic for the babies and young children who are exposed to drugs before their birth. It has been documented that as many as 375,000 babies each year are born having been exposed to drugs while in utero. This translates to one drug exposed infant born every 90 seconds, and this may be a conservative estimate. Reports from inner cities indicate that the national prevalence rate may actually be much higher. In New York City alone, it is estimated that there will be 72,000 drug exposed children by the year 2000. These numbers are only estimates, based on documented cases of fetal drug exposure. More accurate figures are not now available because of such factors as failure to report identified fetal drug exposure, pregnant women who do not seek prenatal medical care, and inconsistency in medical screening. There appears to be little or no abatement in overall drug use in our country. Without stepped up prevention and follow-up interventions, we can

expect the problems resulting from illegal drug use to continue long into the future.

Thirty percent of women between 18 and 34 years of age admit to a history of illicit drug use. It is imperative to understand that these women have no typical profile. It is a popular misconception that use of crack and other illicit drugs by women during pregnancy is confined to the Afro-American, Hispanic, and other minority populations in urban areas. This is simply not true; the problems of drug abuse cut across all socio-economic strata and racial groups. We are beginning to learn that drug abuse by middle and upper class women is substantial and increasing. However, we know less about the children born to these women, however, because they have better access to health care, are able to afford private medical services, do not need to interact with the public health system and, thus, are not as readily reported as drug users.

The long term effects of drugs and alcohol on children are not fully understood, and therefore, there is no agreement among physicians, educators, social workers, and human service professionals regarding the full impact of drug exposure on children. However, it is known that maternal substance use contributes to poor pregnancy outcomes. A single dose of crack or cocaine in a pregnant women can cause the blood pressure at the placenta to rise five to ten times above normal. The effects on the fetus vary depending on individual circumstance, such as what point in fetal development such drug use occurs. We know, however, that the resulting problems often include extreme hyperactivity, uncontrollable mood swings, language delays, disorganized thinking, lapses in short term memory, poor coordination, difficulty with fine motor skills, and physical defects such as low birth weight, prematurity, decreased head circumference, and intestinal damage.

If as a nation we are going to adequately address this problem, there are certain fundamental concepts that must be fully understood and conveyed to policy makers, practitioners, and the general public: 1) Many children that have been drug exposed can lead fully productive lives given proper early intervention; 2) All children exposed to illicit drugs while in utero are not necessarily disabled as defined by the Individuals with

Disabilities Education Act, and, therefore, are not necessarily in need of special education; 3) However, all children exposed to illicit drugs while in utero are at risk of experiencing developmental delays and life long complications and are in need of comprehensive, integrated interventions that include social, health, and educational services; 4) Failure to address the needs of these children and their families early on will result in greater costs to society; and 5) Emphasis on prevention activities, i.e. education about the risks associated with drug use, prenatal care, adequate nutrition, access to health care, and other human services needs to become a high priority relative in our country's war on drugs.

Infants exposed to crack cocaine, and other illicit drugs while in utero face a life of struggle not only because of the potential physical and emotional damage they may experience, but also as a result of societal perceptions. These children have been branded as the "Crack Babies," "Drug Babies," "The Lost Generation," "The Shadow Children," "Boarder Babies" and many other terms that convey a message of hopelessness and despair. These children are not hopeless and should not be written off. These children can fully participate in society and lead rewarding, fulfilling lives given the proper health care, social services, and educational interventions.

Our nation's schools will play a critical role in meeting the needs of children who have been exposed to substance abuse in utero. As described by other witnesses testifying today, a number of school districts, particularly in areas of high drug use, have already developed school-based programs specifically designed to provide services as early as possible to the first generation of such children.

Already, many of these children are finding their way into special education programs. Data indicate that the number of 3 - 5 year old children enrolled in special education in Los Angeles and Miami has doubled since 1986, and New York City last year alone saw a 26% increase in the number of 3 - 5 year old children in special education programs. We believe a substantial number of these children have been exposed in utero to drugs.

There is no question that many of these children will require special education and related services in order for them to succeed in schools. State and Federal laws require schools to provide free and appropriate public education to children with disabilities. This takes the form of special education, or specially designed instruction to meet the unique needs of a child with an identified disability, and related services that are needed to help a child with disabilities to benefit from their educational program. Related services include physical therapy, occupational therapy, counseling, and transporation, but not medical services except for the purposes of evaluation and diagnosis of an educational disability.

A significant number of children may not require special education and related services but will continue to be identified as in need of special education because other services and help may not be available. Others will not qualify, but will be at-risk of failure in school.

Our schools need to be prepared to meet the diverse needs of all children who come through their doors, including the growing number of children exposed prenatally to drugs and other forms of substance abuse. While some of these children will require specially designed instruction through special education programs, others will demonstrate less severe educational problems and will require special attention within the general school program. Educational programming by the schools is a necessary part of services that are needed by the children we are talking about today; but alone it is insufficient to meet their broader needs.

There is no single solution to the complex, escalating problem of substance abuse, but we are sure of what will not work. As you may know, the special education system like other human services has evolved into a categorical program with specific eligibility criteria and funding designated for a targeted population. Yet many of the infants, children, and youth served in special education also need and receive services from the health, mental health, social service, and welfare systems.

Where children are well served, service systems have worked out the difficulties of coordinating their efforts and focus their interventions on the needs of the child, often within the context of the family unit. When service systems operate independently from each other, constrained by differing eligibility criteria, restrictive funding streams and sometimes conflicting program requirements, we see fragmentation and duplication of services, inefficient use of scarce resources, and complex bureaucracies that make accessing needed services a nightmare for the child's family or guardians. All too often, the maze of State and Federally funded programs, categorically oriented to address the needs of a particular population, make such coordination at the local level a difficult challenge for service providers.

States and communities are confronted with the task of collaborating and coordinating services across diverse agencies and funding sources to the meet the needs of infants and children, yet are constrained by a lack of programmatic and funding flexibility. In order to engage the States in a partnership with the Federal government in developing and improving services for children exposed to drugs, we would caution against enacting narrowly defined legislation that limits, rather than enhances, the ability of States to respond creatively to the problems their citizens are experiencing. If the needs of these children are to be appropriately addressed, states will need assistance in developing comprehensive, coordinated, multidisciplinary, interagency services at the local levels.

Over the last five years, the Federal government has been engaged with States in an effort to develop such a system of support for infants and toddlers with disabilities through Part H of the Individuals with Disabilities Education Act, administered by the U.S. Department of Education. In 1986, Congress enacted PL 99-457 which authorized a formula grant program to assist States in establishing a statewide, comprehensive, coordinated, multidisciplinary, interagency system to provide early intervention services for infants and toddlers with disabilities and their families. Federal support for this program was intended to provide the resources necessary for the planning and coordination of such a system across existing programs and services at the State and local level. Under the Part H program, all

States have developed an interagency coordinating council to oversee the development of the service delivery system and, within about two years, all States hope to be providing early intervention services to all eligible children on a statewide basis. I stress the term hope, because the financing of this early intervention system in many States is proving difficult. The limited Federal funding for Part H is intended for planning and coordination activities; State and local revenues are supposed to pay for the actual delivery of early intervention services to children and families. At present, resources within many of the States are not adequate to finance service delivery.

An important component of this legislation pertains to infants and toddlers who do not have disabilities but are at risk of having substantial developmental delays. We know that many infants and toddlers that have been exposed to illicit drugs in utero do have substantial impairments qualifying them for Part H services; many others are at-risk of experiencing developmental delays, and therefore may not necessarily receive appropriate intervention. Under the curent statute, states retain the right to determine eligibility criteria for early intervention services and therefore have the option to serve at-risk children. The lack of fiscal resources has inhibited states from doing so. When Congress authorized the Part H Program in 1986, it was envisioned that 100,000 - 160,000 eligible infants and toddlers would be served. Given the prevalence of infants exposed to cocaine and other illicit drugs, as many as 300,000 - 375,000 infants and toddlers might also be eligible to receive these services. While Part H programs in the States are creating the systems of service delivery that can address the early intervention needs of young children, at this time resources are inadequate to provide such services to all children who might benefit from them.

The National Association of State Directors applauds your attempt to address the needs of these infants and children. You can be assured that special education provided by the public schools for children age 3 and above, and early intervention services for infants and toddlers with disabilities and their families will play an important role in each State in meeting the needs of children exposed prenatally to illegal drugs. However, these types of

services designed for children with disabilities are insufficient if we are to maximize the potential of these children and minimize the effects of their mothers' drug use.

A proposal we feel would make significant and positive contribution to increasing States' ability to serve these children and their families has been introduced this year in the Senate. This proposal, the Children of Substance Abusers Act (COSA), has recently been folded into S. 1603, the Alcohol, Drug Abuse and Mental Health Block Grant. The COSA proposal would support the development in States of comprehensive and coordinated health, developmental, and social services to families where substance abuse is present, while providing States the flexibility needed to apply Federal funds to needs within their own service delivery systems.

Under this bill, services would not be limited to children exposed to drugs in utero, but would also be directed to children whose parents or guaridans abuse drugs and alcohol. The bill requires community-based service delivery and encourages the maintenance of family structures by providing home visiting services. The COSA proposal also establishes a much needed training program for professionals that work with these children. At present, the COSA legislation does not have a sponsor in the House. We encourage you to carefully review this bill and consider taking the leadership on it in the House.

We would also urge this Committee to consider how the Federal government can assist States and communities in accessing the information they need to faciliatate their prevention efforts as well as to assist them in the identification of children in need of services and to develop services and interventions that are needed. While increasingly available particularly through the schools, information and education for children, families, educators, and health care professionals regarding the effects of drug exposure is still insufficient. A particular problem exists in reaching high risk populations who do not access health care or other public services which could provide information about the prevention and effects of substance abuse on children. Further, [illegible]rs and others at the State and local levels need to know about the experiences of others who have successfully developed

programs for children exposed to drugs and their families. They need to know what works, how they have put together effective services, and what is required to do so.

So that other communities around the country do not have to reinvent the wheel, so to speak, it would be particularly helpful to capture and describe successful experiences and to make this information widely available to the education, health and social service networks operating at the national, State and local levels. To do this, support is needed, first to identify and describe what works and under what conditions in diverse settings, and second to package this information in usable forms for professional organizations, clearinghouses, and other entities that are actively engaged in exchanging information about successful practice with their constitutents in the field. Organizations like ours for example have in place mechanisms for sharing information about effective practice with our members who, in turn, can work with established networks in their States. Other professional organizations in health, education and social services have similar mechanisms.

If we have access to information about how best to meet the needs of children who have been exposed to drugs in utero, we assure you we will use every means possible to disseminate it broadly and to use it in working with our colleagues in other fields to promote the collaborative relationships needed to improve services at the State and local levels, as well as to infuse such knowledge into the professional training programs of our universities and organizations.

We appreciate the opportunity to provide input to you on the needs of infants and children exposed in utero and whose parents abuse alcohol and drugs. We welcome your efforts and leadership, and offer to you our assistance.

Mr. RANGEL. Let me thank the panel, let you know that we've been joined by Congressman de Lugo of the Virgin Islands, Congressman Hochbrueckner from New York, as well as Congressman Lantos from California, who is not a member of the committee, but has joined us because of his deep-seated interest in this issue.

I am impressed by the number of Members of Congress present who are not on the committee but have an interest in this subject and, quite frankly and honestly, the number of Members that have left their regular committees to come here this afternoon to hear your testimony.

So I do hope that you appreciate the fact that you're making an outstanding contribution, notwithstanding the fact that 5 minutes seems like an extraordinarily short time to deal with such an important and sensitive subject. But this is only the beginning.

Dr. Schipper, from all of the testimony I've heard, it appears as though this problem is a time bomb not only for the children affected, who may not be properly identified and treated, but also for teachers who may not even know how to work with these problem children.

This is especially so in view of Dr. Davis' dramatic testimony about the number of children that are abandoned. Most don't know their fathers, so I don't even know how they get to the word "Dada." And if their mothers have left them, too. God knows what's in the classroom.

Now, I don't hear too much outrage about this. I don't hear it from the churches, the synagogs, the teachers' unions—it's not a part of collective bargaining. I don't hear Mayors and Governors putting demands on the Congress. Why are we not hearing more outcries from these individuals and organizations?

Dr. SCHIPPER. All right. My opinion—first, in the context, crack hit the streets in 1985. The first babies were born in late 1985, early 1986. Those babies are now 5 and 6 years old. They're just beginning to hit the schoolhouse door.

The people who know about these babies and these children are represented on this panel or the preschool folks, the lab school folks, the pediatricians, the clinicians, and so forth, the hospital folks. They know about those babies, but the school people don't know yet.

Mr. RANGEL. I thought they could read and write and be prepared to do what they're trained to do. I mean, it's not as though this is some great secret.

Dr. SCHIPPER. The educational system's typical reaction is to react when it's in front of your face.

Dr. SCHIPPER. These children are going to hit the face this September in every school building in America, and they're not ready.

Mr. RANGEL. I'm surprised we were unable to hear from the national labor unions that organize teachers or the associate professional association of teachers. That's why I was pressing you so hard trying to make a teacher out of you. [Laughter.]

Dr. SCHIPPER. OK. Go ahead.

Mr. RANGEL. But it just seems that we all have a responsibility to be prepared for what's coming. It's not these children's fault, and we know they're coming.

Mr. SHEDLIN. Mr. Chairman, as a teacher, may I volunteer for this? I want to help you out a little bit in answering that question. First of all, the testimony given in our video I hope will be able to be part of this record too because we have a transcript of it for you.

Mr. RANGEL. Without objection.

Mr. SHEDLIN. Thank you. We talk directly to the teachers, and what you've said is absolutely what they're saying. They are overwhelmed and overburdened, and that little anecdote I told about the second grade teacher submitting her resignation. Let me make it sound even worse.

I met yesterday with the executive director of the National Association of Elementary School Principals. It was shocking to me to discover that this year 25 percent of the elementary school principals in this Nation retired—25 percent in 1 year.

It is not projected that this will happen over the next few years. But because of general budget pressures there were sweet packages made to encourage early retirement and that's what happened.

The point is that not only are teachers feeling unprepared for the kinds of children that they find in their classrooms, but principals also, who need to be making major decisions about how the monies are spent in their schools and what happens in them, are also feeling overwhelmed.

One of the recommendations that came out of our Institute is that we must have both in-service workshops—for those in the school right now—and preservice courses—for those entering the professions like principals and teachers. So you're absolutely right in assuming that what you're seeing is an extraordinary sense of frustration and desperation from the teachers.

Mr. RANGEL. Well, Mr. Shedlin, I would like the record to reflect that, notwithstanding the budget cuts, the teachers were a part of the negotiations. And my real question was whether or not these children were a priority during contract negotiations.

Mr. Coughlin.

Mr. COUGHLIN. Thank you, Mr. Chairman.

Mr. RANGEL. Excuse me. Let me interrupt you. I've just got a call that they're taking a vote on the extended unemployment compensation, so I'll ask Mrs. Lowey whether she will chair while I'm going, and I'll be back as soon as possible. Sorry for the interruption.

Mr. COUGHLIN. Thank you, Mr. Chairman.

My question is for Ms. Burnison. The number of drug-exposed infants born annually is estimated to be somewhere between 375,000 and 500,000. Do you see the number increasing or decreasing in the next 5 years?

Ms. BURNISON. I think you have to understand how that number was arrived at. I think that the number probably is much, much greater than that. A lot of the figures that are known at this time are known through urine toxicologies, and they're not through questioning the mothers themselves.

I think if we went back and had obstetricians who could do more accurate drug histories and lifestyle histories of their patients, we would find the number to be much, much higher, since all we're capturing through urine toxicologies are those women who have in-

gested a drug within 24 hours prior to delivery. So I think you'll find the numbers right now are much, much higher.

Mr. COUGHLIN. My second question is directed to the educational experts on the panel. As educational experts, are you finding parents of drug-exposed children to be confrontational or receptive?

And the second part of the question is directed to your feelings on whether we should have a program of civil commitment or compelling the entrance of pregnant women into a treatment program for protection of their unborn baby.

How would you feel about that?

Ms. BURNISON. We feel very strongly that taking the criminalization route is not productive for mother or child.

Mr. COUGHLIN. It's not criminalization; it's just compelling treatment through some civil commitment to a treatment program.

Ms. BURNISON. Well, we find that all of the women and the families that are in our program are very receptive to treatment, and they are very anxious to know about the medical needs and the developmental needs of their children, and they come willingly. It's a voluntary program, and we have a very high retention rate.

I think that one thing I'd like to add to the testimony, to talk a little bit about one of the problems with the funds educationally that I think you should all know. There are only five States in this country that define at-risk children as being eligible for the funds of Public Law 99-457 for special education needs.

I think that's one of the reasons why we're not seeing an outcry from teachers in this country is that there aren't funds available and that drug-exposed children are not included in at-risk children in the definition for special education at this time.

I'm sorry. What was the other part of your question?

Mr. COUGHLIN. The question was whether parents are being receptive, and I think you replied that they were being receptive.

I guess one of the reasons for the question is that this committee some time ago had a field hearing, where we heard testimony that there were cases of multiple births of drug-addicted children. Obviously that mother was not receptive to treatment.

Ms. BURNISON. As we travel around the country and do a lot of training, we find that there are two main barriers to success. One is transportation, and one is child care needs. And that if you're able to provide transportation and you're able to provide child care for the other siblings, that the mother and the families are very receptive and very willing to enter treatment. But you have to be able to overcome those two main barriers to treatment, as well as making sure prenatally there is health care available.

Mr. COUGHLIN. Do any other members of the panel have any opinions on that?

Dr. DAVIS. Let me respond to the question regarding the drug-using mother.

As one who works in psychiatry, I have to say that we are dealing, in terms of the drug-abusing person, with a medical illness, and I don't characterize these as combatted, confrontational-type individuals.

I view them as individuals who really have been dealt a difficult deal in terms of life as a whole. I mean, we have no idea unless we

live with these individuals what their lives are like. Many of them have actually given up on society as a whole.

I think once you engage them in treatment—I'm not talking particularly about drug treatment—but in treatment, per se, around issues involving their entire lifestyle, you realize that you're dealing with a human being, a sacred human being who basically wants to get off the drugs if he can possibly get off the drug.

I have never had a drug-using mother who has not been interested in the well being of her child. Yes, she may go out and get pregnant again and again, just as many of our HIV-positive mothers get pregnant again and again. But to say that they have no interest or no concern about the well being of her child would be actually wrong.

So the bottom line is that we've got to provide treatment services to these women.

Mr. COUGHLIN. And they willingly undertake the treatment services?

Dr. DAVIS. Well, let me say this. Part of treatment involves getting them to the point to realize that they need treatment, and that's a big task because there are some treatment programs that are there waiting for the crack-using person to enter. And one has to get that person across the threshold. It's something that we are engaged in now at Harlem Hospital.

In some instances, it may involve going to the home and making home visits. So I've now begun to make home visits.

So I think it's a simple model to say that if you have treatment centers all over the country, that women are going to come in droves to the treatment center. I think we really have to be more sophisticated and we basically have to say that treatment centers have to have some element of outreach.

And I think we do have to paint another picture of the drug-using mother in particular. Many of these individuals are literally caught up in something they cannot get out of. If we're talking about a population of 50 percent of mothers using drugs, not all of them were destined to be drug addicts. I think this is one drug that the scientific community simply cannot deal with.

You know, we've been able to get people off heroin. We've been able to get people to stop using LSD. Cocaine is incredibly powerful, and we simply have not met that task.

Mr. SHEDLIN. Let me add a quick perspective on this also. If you folks get a chance to look at our videos which talk to recovering addicts directly, very dramatic answers to your questions will be provided in terms of their ability to respond to programs.

It's equally shocking and dramatic to have discovered that only 1 percent of the Federal drug prevention budget, as far as I can see, goes to drug treatment programs specifically designed for women, with an even smaller percentage going for treatment of pregnant women.

That doesn't mean that only 1 percent of the people served in the programs are women. What it does mean is that when you begin to tailor your programs directly for the clients you find an extraordinary receptivity. I would describe what Dr. Davis was talking about as a "drive to health" and would add that these mothers have a passion to do whatever they can for their children.

Mr. COUGHLIN. Very briefly, please. We have other members.

Mr. SCHIPPER. OK. I have a different story. From the people that we listen to, the experts and the researchers that we listen to, who have talked to us through our seminar programs. The first thing is we don't understand the overwhelming addiction of this new drug, crack. It's very difficult to understand how all-consuming this drug becomes to the person who takes it.

We can understand it somewhat by looking at women who are pregnant and then give birth, and the way they treat that situation compared to others. That's one way to take a look at how compulsive this is.

One of the after effects once these babies typically are born, the correlation between the women walking away from their child is very high. I think we'll all find that that's not a normal behavior where a woman as soon as she gives birth will get up and walk out of the hospital, abandon the baby, or pass the baby off to grandma, or sister, or cousin, or somebody else in order to pursue this crack addiction.

The same syndrome and scenario occurs during pregnancy. Their compulsion is to pursue the crack addiction, not to take care of the growing baby in the uterus. And when the people do want to take care and respond in that direction, the programs and the services they go to are inadequate to meet their needs and their demands.

There's a whole array in the literature about what I mean by that inadequacy. One of the things that we have to watch for, and we did a test case on, is the foster family system which is now taking on these babies, and the grandmother system. They enter the grandmother system until that doesn't work, and then they go into a foster system and that's what we're wanting—that's beginning to wobble and break under the weight of these children.

I just have a different story about the normal motherhood situation with these babies.

Mr. COUGHLIN. Thank you, Madam Chairman.

Mrs. LOWEY [presiding]. Thank you.

Mr. Inhofe.

Mr. INHOFE. Thank you.

I found this real interesting. I want to, I guess it may call for a response, but at least offer something here. You've been talking a lot about Harlem. We've been talking about some of the areas in which this has manifested itself.

I am from Tulsa, OK. I have a daughter-in-law who's a pediatrician. I have a daughter who teaches. There seems to be—I'm very active in the area of child abuse—there seems to be from our experiences a direct relationship to the economy, to drug abuse, to child abuse, and many other things.

It happened that Oklahoma preceded the Nation into this recession. We went in—I guess in 1982. But, anyway, our statistics have shown then that that is where the incidence of involvement in these drugs that ended up with the result that you so accurately described today, has taken place even out in Oklahoma. And now those young children have been born and we're seeing a dramatic increase.

Now, I don't know—clinically speaking, Dr. Davis, maybe this would be addressed to you. It seems obvious to me since we're expe-

riencing this out in Oklahoma and it came after our recession, the incidence of these abnormalities and other problems, there is now clinically speaking a direct relationship between the incidence of drug addiction with the pregnant mother and the results.

Dr. DAVIS. Let me say that this is one of the most controversial areas around.

Mr. INHOFE. Before you answer, I might say that you might use our experience out there in establishing your relationship because it's one of these post hoc ergo proctor hoc things perhaps that it did happen in Oklahoma.

Dr. DAVIS. See, how to begin. There is no general consensus at the moment about what cocaine does to the developing fetus. I think the most noncontroversial thing has to do with what it does to blood vessels in general—to the fetus, to adults, you name it, and that is that it constricts blood vessels.

And in the process of the constricting blood vessels, we get a whole variety of abnormalities which I've listed. You get small babies. You get preterm babies. You get babies who don't develop in the normal fashion motorically—that is, movement-wise.

Certainly, the drugs have affected inner cities, inner minority cities in particular, to extents that none of us are aware of. You know, if you walk the streets of Harlem every day you'll see it because it's out there blatantly.

In smaller communities—I just came back from a family reunion in North Carolina—small rural communities, cocaine is prevalent all over the place, be they minority communities or nonminority communities. It is very clear to me that people across this land are using cocaine. Black and white, as you said, rich and poor, professionals as well as nonprofessionals. You'll find lawyers, doctors, you name it, using cocaine. Basically because they can't get away from it. It is so addictive.

My own feeling is that you're going to find a problem wherever you go. I don't think there is any community anywhere in this country that has not been affected.

I think when individuals from higher socioeconomic groups are involved in the whole drug business, my feeling is that the family supports that are there, the money that's available for preschool programs and for intervention strategies, will perhaps make the problem not seem as grim as it seems in Harlem.

But the problem is all over the place. It's very clear that coming from a good family where there are lots of family supports, where the child is understood as a child with problems, it's very clear that youngster is going to turn out much better than the youngster who's in a household where the family is still torn asunder by drugs, or where you have an overwhelmed grandmother who is 80. I have grandparents who are 80 taking care of five preschoolers.

It's very clear that the outcome is going to be much better, and I think in terms of the recession issue and the problems of society leading to drug use, we can't overlook that either. All of the pressures of society are leading to an increase in drug use, which goes back to someone's question about whether or not it's on the increase.

If, indeed, cocaine use is on the decrease, and it is in some areas, I can assure you unless we meet the problems of society, there are

going to be other drugs taking over. We've already begun to see that in terms of heroin use going up.

That's a roundabout way to answer your questions.

Mr. INHOFE. Thank you.

Ms. BURNISON. I just want to add something to what Dr. Davis was saying. That in the Pinellas County study in Florida—Pinellas County is St. Petersburg and Clearwater Beach, which is a predominantly white area, not a minority area. The study that was done by our organization was with the private physicians, not with public health clinics.

We found that white women were using drugs at a slightly higher rate than minority women. I think it's very important that people in this country understand the addictive process. People do not understand addiction and that powerful hold that it has on the user.

I think there is a tremendous amount of training that needs to be done across all professionals here—teachers, physicians, educators. People need to understand that addiction is a disease and it is very powerful, and it needs to be treated as a disease.

Mrs. LOWEY. Thank you.

Mr. Ramstad.

Mr. RAMSTAD. Thank you, Madam Chair.

Before I ask Mr. Shedlin a question, I just want to thank you for that last comment because I think that's the bottom line. The governments at all levels need to understand the disease concept, which is real. And once we all have that perspective, I think we can more adequately address the problem.

My question, Madam Chair, Mr. Shedlin, we hear the redundant theme that we don't have a handle on the numbers. It seems to me that's the place to start. In my State of Minnesota, we passed a State law mandating reporting of drug addicted babies—those who are affected prenatally.

Would you advocate that course of action? I'd like to hear from the other panelists as well as to a mandatory reporting requirement.

Mr. SHEDLIN. It's obviously a very sensitive issue which needs to be carried out, it seems to me, with great care and understanding of what it takes to do that.

As one thinks about the numbers, there is another variable that needs to be put into the hopper here which makes things a lot worse. And that is that we haven't spent very much time understanding that whatever numbers we're talking about, those numbers need to be multiplied—hold on now—the numbers need to be multiplied by somewhere between 20 and 40!

And the reason I'm saying that is because each of these children will end up in a regular classroom, and in this classroom, depending upon the State and what's going on in a particular locality, the numbers of classmates will be between 20 to 40 other children.

And it is really just mere common sense to begin to understand that because many of these children are more demanding of their teachers' time, it means that there is less attention available for those 20 to 40 other classmates. So the numbers themselves are pretty frightening. But the numbers multiplied by the reality of

what's going on in each individual classroom are even more frightening.

Dr. DAVIS. We've always reported them. Harlem Hospital, in fact, between the years 1983 and 1988, always tested every single newborn baby. It never changed the numbers. It never changed the outcome.

The only thing that happened was that we reported them. The babies wound up going into foster care. And more and more women continue to take drugs and have more babies.

So simply reporting the cases to CWA [child welfare authority] without doing anything else, doesn't do anything more than indicate what numbers you're dealing with at the time of delivery. It certainly gives us no inkling as to what numbers we're dealing with in terms of absolute drug usage.

It's been mentioned before that, you know, by using your standard urine toxicology, you're only identifying those mothers who used drugs during the last 3 or 4 days of her pregnancy. Women are very smart. They know how to clear their urine very rapidly. You know, they drink cranberry juice or bottles of vinegar or use herbal teas. They can do all kinds of things to cloud the picture.

So simply reporting at delivery doesn't do much at all. What we need are really very good, very sensitive prenatal programs that identify the drug-using mother and provides her with some form of treatment. I don't mean drug treatment, per se—of course that's absolutely essential—but treatment around issues involving her life because those are the things that lead to drug use in general.

I think, again, just reporting mothers, giving her a record with CWA, is just one thing, but it does nothing to prevent increasing numbers from developing.

Mr. RAMSTAD. Madam Chair? Just for a followup, if I may.

I couldn't agree more, doctor, and certainly I didn't mean to imply that reporting in any way is a panacea to addressing this problem because it's certainly not. But it seems to me those numbers are illusive because several of the witnesses testified here, and our staff has tried to find the numbers.

It seems to me that's a starting point at the very least. How dramatic is the incidence of this problem? I certainly agree with you. I mean, a State like mine which prides itself on being the leader in the country as far as addressing chemical health problems, has only eight beds for pregnant addicted women.

So that's a terrible indictment of the system as far as addressing this audience and those people who need treatment. So I certainly appreciate your response and totally agree with what you said.

My only reason for asking that is it's necessary to get a better handle on the part of experts on the actual incidence of prenatal exposure.

Dr. DAVIS. We will continue to test. Now, we don't test everyone. We test those suspected cases. We also send the report off to CWA, but as of 1991, New York State law has now changed. There is no more a mandated case of taking the child away from the mother.

What will be happening over the next several months is that they will accept the case temporarily. If the mother's lifestyle seems to be in keeping with rearing the child, if she has voluntari-

ly gotten herself into a program, then the youngster will not be taken away and she will have no record against her.

But indeed the State will continue to collect its records. And I think that's the way we have to go. I certainly am in favor of continuing to test and to have the State departments record the numbers because I think unless we do have a handle on the accurate numbers, no one in Congress is going to get excited about it.

I feel that we just are looking at the numbers as they truly are. You know, if we report 13 percent, the mothers are admitting 25 percent, yet deep down in the underground they're telling me 50 percent, I think we're dealing with a tragedy on our hands.

Mr. RAMSTAD. Thank you, Madam Chairman.

Mrs. LOWEY. Mr. Oxley.

Mr. OXLEY. Thank you, Madam Chairwoman.

Dr. Davis, you talk about the mothers avoiding the testing and your recognition that they're smart enough to do that. If they're so smart, why are they so dumb as to take drugs when they know they're pregnant in the first place?

Why would somebody with that kind of intelligence do something so foolish and irresponsible? The average age of these women is 27. They must know the dangers of using cocaine and having a child, and they certainly must know that smoking crack is illegal.

How do you explain that discrepancy?

Dr. DAVIS. I just think we're dealing with an illness. Something—an overwhelming, compelling need for something. Where reason is simply thrown out the window. That's basically what we're dealing with. It is a medical illness.

We talk about the knowledge we have about the effects of cigarette smoking, obesity. That's my problem, you know? We continue to do those things that we know are harmful to us.

But I don't think we've ever seen anything like crack before. We have not. Nor have we ever seen anything like the entrepreneurs which come into the schoolyard across the street from where I work and hand out crack vials free of charge to young kids and tell them to take it to their parents, which we've seen time and time again.

You know, when you're dealing with something like this, and you know you can get someone hooked in two tries, then you're not talking about using one's sense. You're talking about something that's taking over one's entire being.

Mr. OXLEY. And yet we had instances of alcohol abuse for a long, long time, long before crack.

Dr. DAVIS. Right.

Mr. OXLEY. And as a matter of fact, the testimony indicated quite clearly that alcohol is probably the No. 1 problem——

Dr. DAVIS. It is.

Mr. OXLEY [continuing]. In the prenatal sense.

Dr. DAVIS. Yes.

Mr. OXLEY. And yet we've known about the potential for problems with the children born to alcohol-abusing mothers, so it is a constant theme we go through.

One thing I didn't hear, and maybe I won't hear it is the question of individual responsibility here, individual responsibility for a

soon-to-be-born child. In some cases we hear of two or three babies born crack-addicted to the same mother.

At some point, it seems to me, whether one is addicted or one is ill or whatever it may be, perhaps there should be at least some element of personal responsibility in this situation. It's very difficult for me to be convinced that a woman who is 27-plus years old, who ostensibly has knowledge about the effects of the abuse of cocaine or alcohol or other drugs on her child, perhaps her second or third child, doesn't bear some degree of personal responsibility.

And I have to tell you that there are a lot of people out there who might find that their tax money is being spent for special education programs for these children who might ask, "Whose fault is it?" Is it the fault of the society? Or is it the fault of the schools? Or is it the fault of the parent?

And I would suggest if we're looking for fault in this kind of situation, we ought to look at the personal responsibility that some of these mothers lack before we start assigning blame to the rest of society and asking our constituents to pay for that personal irresponsibility.

Now, that's just a fact of life, and that's a thing that all of us as politicians have to face. You have to understand that my constituents are not going to be particularly sympathetic if I stand in front of a group in a town meeting and wring my hands and tell them how tough these folks have had it. Because, frankly, there are a lot of people in the same socioeconomic condition who don't abuse drugs, who have perfectly healthy kids, who are being asked to subsidize the irresponsible ones.

Dr. Schipper, did you have a comment on that?

Ms. BURNISON. I have a comment.

Mr. SCHIPPER. Well, I'll go first.

Ms. BURNISON. OK.

Dr. SCHIPPER. I don't know about fault. We can find all the fault we want, wherever we want to find it, but that doesn't respond to the situation. What we've got—if we have half the problem that we're portraying here, we've got a national disaster on our hands. OK? We've got to look at that.

And it is—that television commercial, "We can pay now; we can pay later." The costs now are enormous, but they're a drop in the bucket compared to the costs later. I'm talking about all kinds of costs, including dollar costs, responsibility costs, and a face-up to our commitments as a democratic society and how we treat our individuals in our society.

But the costs today are nothing compared to what the cost will be in the future to this Nation if we don't respond in some radical way.

Mr. OXLEY. Thank you.

Ms. BURNISON. I think we have to look at these women as addicted first and pregnant second. It's not as if we have a population of women who knew they were pregnant and then decided to become drug addicts.

Again, I don't think we understand the addictive process here and the failing of the health care system to provide the services these women need to break the cycle you are talking about.

I think it's a multidisciplinary problem that affects all agencies and crosses all disciplines.

Mrs. LOWEY. Mr. Clinger.

Mr. CLINGER. I just wanted to get a thermometer on the degree of hopelessness we're talking about here. What are the prospects of rehabilitation of a crack-addicted woman, whether pregnant or not, first? And secondly, how hopeless is the child born of a crack-addicted mother?

In other words, is that child permanently disabled? Do we know enough at this point? You indicated that crack only hit the streets 6, 7 years ago. Do we really know enough now to know how hopeless we are in dealing with this, as you say, national tragedy?

Dr. DAVIS. If I can respond just very quickly, and I will just respond as a physician from Harlem Hospital. About 15 percent of the children I see will have lifetime handicapping conditions—15 percent.

Mr. CLINGER. But now that's of the children born——

Dr. DAVIS. Of the children who I see, right. So I speak for no other community.

These are youngsters who are mentally retarded. It's true that if you look at the group as a whole, mental retardation is not characteristic. But if you work in a medical center as I do, and if you see the entire spectrum of disabilities, you have to admit that mental retardation is present in some of these youngsters.

We have to admit that cerebral palsy, to an alarming extent, is there. This is secondary, perhaps not to the direct affect of the drug, but to the level of prematurity and low birth weight which are the most confounding factors in this whole business.

Certainly, I talked about autism which we are seeing to an alarming degree. That is a lifetime handicapping condition; plus levels of blindness due to prenatal strokes in the infant itself.

So we are seeing medical complications that perhaps don't get into the lay press, but this is medical information. But it does say that about 85 percent of these youngsters will be able to make contributions to society if we're able to deal with them early on.

Early intervention works, but it makes no sense to throw 5-year-old youngsters prenatally exposed to drugs into the public school system without having worked with them to begin with and without having worked with their families. This is not a hopeless generation of youngsters.

And, you know, we may sound as if we are in the doldrums and that this is a hopeless situation. I really want to correct that view. I am saying that from where I sit, seeing some of the worst affected of the children, I can still say that the overwhelming majority of these youngsters can do well if we know how to intervene with them, and the intervention does have to come early on.

There are behavioral abnormalities that I've not seen in my career, but we do know enough to deal with this, and we can change these youngsters over time.

In terms of the crack-using mother, I have to say that addiction is addiction. It is a lifetime disease. In many instances, even recovered alcoholics have to maintain their own form of treatment, even if it's their own self-treatment.

The same goes for the addict. It is a lifetime job to remain drug-free. Moneys are absolutely essential to create the necessary treatment programs for them, and I don't think we can expect miracle cures in terms of the addicted pregnant woman or any person addicted to crack.

But I have to agree with my colleagues here that if we're not willing to admit that this is a national tragedy, we will have overlooked the possibilities of intervening at a time when we can do it. If we wait 10 years down the road and feel that, well, these people have done bad and we don't owe them anything, our Nation's well being will be at stake.

Mr. SHEDLIN. Let me add a quick afterthought to that as well. We just completed, as previously mentioned, a 2-day institute on the implications for schools of children prenatally exposed to drugs and alcohol with people from approximately 150 institutions and agencies in 10 States. We left that institute feeling pretty optimistic.

I recognize that our optimism hasn't come through to you today from our comments. That's because we're also alarmed. We were optimistic because we heard about programs that were working. I would be much less optimistic if the majority of folks in the Congress of the United States thought about these women as being "dumb" because they are abusing drugs when they know better. Taking drugs is an act of desperation.

Would you in a like manner call the alcoholics "dumb," and all of those women who are smoking cigarettes while they're pregnant "dumb?" It's not dumb. It's a disease, it is an act of desperation when one resorts to crack—so one needs to look at the broader social context.

Mr. GILMAN. Would the gentleman yield? I thank the gentleman for yielding.

Just one question, and I know our time is running very rapidly here.

You mentioned early intervention as probably one of the best things we can do. What else should the Congress be doing to help? I think we all recognize the crisis nature of all of this.

Dr. DAVIS. Fund all kinds of research programs as opposed to pulling back on the moneys that were initially available for researchers in the field. I'm part of a New York State consortium, a group of 10 different hospitals that will be applying for Federal funding in the fall to really look at the effects of cocaine on the developing fetus, to try to ferret out those items in the environment that also have an impact. But we're talking about an application actually for a multimillion dollar research project.

I really think the Federal Government has to take the lead in this whole episode.

Mr. GILMAN. What should we be researching? What particular areas should we be looking at?

Dr. DAVIS. We need to look at the scientific question. What does cocaine do to the developing fetus? One has to look at literally thousands of children to answer that question. One also has to look at a control population.

I'm a clinician. I'm not a researcher. But over the last couple of years I've begun to do research. That's why I work about 100 hours a week.

Mr. GILMAN. Doctor, you say——

Dr. DAVIS. Those are the programs that have to be funded.

Mr. GILMAN. You're also noting that early intervention is an important aspect.

Dr. DAVIS. Right.

Mr. GILMAN. What can we do to help bring about greater early intervention?

Dr. DAVIS. Moneys have to be allocated. Section H——

Mrs. LOWEY. Excuse me, Dr. Davis, but I believe Mr. Owens had a question before we recess.

Would you like to——

Mr. OWENS. Well, I'll wait until I come back.

Mrs. LOWEY. Oh, fine. Then why don't you finish and then we'll recess.

Dr. DAVIS. Section H has been passed, so there is legislation available to reach the 0 to 3 population of youngsters with identified problems. But that program has not been implemented across all State lines. Certainly on the local level I have many more children who need help than I can find available.

But the bottom line is that all kinds of early intervention programs that are family-oriented do work.

Mr. GILMAN. Thank you.

Thank you, Madam Chairman.

Mrs. LOWEY. If the panel will excuse us, we're going to recess for 5 or 10 minutes until we vote. We shall return. Thank you very much.

[Recess.]

Mr. RANGEL [presiding]. The Chair would like to resume the hearing. Members have additional questions before we move on to our next panel.

Mrs. Lowey was inquiring, as was Mr. Owens, when we recessed.

Congressman Owens.

Mr. OWENS. Mr. Chairman, I'd like to direct my question to all of the panelists. Despite the fact that many of us are quite familiar with these practices—having heard in testimony like this—it's still depressing, especially since some of us have recently been involved in reauthorizing bills which only authorize pilot programs and very small demonstration projects which are just a drop in the bucket compared to what is needed.

And even while we do this at the State and local level, we find that they're rolling back on the commitment and making cuts instead of adding more funds for these kinds of programs.

So we're going to have to make some hard decisions. We're going to have, unfortunately, some triage taking place. And the question I'm posing is: can there be an intelligent way to deal with these hard priorities that will have to be set?

For example, the child is obviously the innocent victim. I think this is a pro-child society and we want to do everything possible to save children. So, when we have to make those hard choices about what funds are available, and what is to be used, and you can't provide money for treatment programs for mothers at the same

time you provide money for intervention programs for children, how can we best make those kinds of choices?

I just want to focus on one little aspect of it. Is the intervention program helped by retaining the mother and having the mother rehabilitated at the same time you're trying to provide for the intervention—the best intervention possible to help the child later in life? Or are they possibly separate?

Should we just focus on the children? Are children better off in many cases receiving maximum resources, even if that means a surrogate parent or a foster care situation; and the rehabilitation rate for mothers is so low we probably should not invest our money that way? What would you say?

Ms. BURNISON. I think that the research will bear the fact that at any stage during the pregnancy, at any one of the trimesters, anything you can do to alleviate the drugs or the alcohol and to make this woman drug-free, will definitely help the outcome of the child, even if it's in the third trimester.

So I think we have to concentrate as much of our effort as possible into the health care system to provide the prenatal care and the drug treatment that is necessary to help the mother during the pregnancy to become drug-free to make the outcome of the child the best.

Mr. OWENS. Once the child arrives and you have a situation where funds are limited——

Ms. BURNISON. Once the child——

Mr. OWENS. Is the aid—the intervention program for children—to try to always make certain that there's a program there for the mothers and spend a great deal trying to reclaim—rehabilitate the mother?

Ms. BURNISON. Well, I think if we want the outcome of the child to be the best, then we have to start with the pregnancy in the mother. And if that has not been possible, then the next best effort is to concentrate on early interventions for the child, beginning at the moment of birth.

I mean, the sooner that you can provide interventions, and the sooner you can provide medical support and developmental support and whatever kind of interventions and treatment the child needs, the better the outcome and the better the prognosis for the development of the child.

I think that you can see from longitudinal studies such as ours that we have 300 children that are doing very well, that had early interventions and when you look at those children against children that have had no interventions, you'll see that our children are in the normal range because they have had early interventions, and that's the goal that we all want to try to strive for.

Mr. OWENS. The problem is that less intelligent—not less intelligent—but less informed people are going to make these decisions. People that have power to make decisions are going to make decisions about how money is spent. And if it comes down to the fact that we don't have enough money for an individual program and a treatment program for mothers, or for adults, you're going to—you don't have to make the decision now or give me the answer now.

But, we hope we can call on you to help us make those hard decisions. It may be that we can look at it over the long run and it's

only going to be temporary that we don't have enough money to take care of all the priorities.

But, if we only have money at a given point to take care of some of the priorities, what are the first priorities? And how can you help us make those decisions; be prepared to help us make those decisions in the future is what I'm trying to say.

Mr. RANGEL. You cut the other person's program. [Laughter.]

Mr. SHEDLIN. I would expand what the parameters of the questions are, and I'm sure you would too. One of the groups at our institute last week ended with this motto: "Bail out the children before the savings and loan institutions." So I think it would be too bad to have the question posed to restrict the options, e.g., should we use it in prenatal programs or for reclaiming a few children afterward? We really need to pose the alternatives in a much broader way.

Mr. OWENS. I came here at that point. We were already together on that one. I need your expertise to deal with the finer points. If we can't do that, then what?

Mr. SHEDLIN. What I'm suggesting is that you can count on us to help you with the other issues as well.

Dr. DAVIS. Let me just say this. We have a very small pilot program that's run collaboratively with Harlem Hospital by the visiting nurse service. And we target the drug-using mother at the time of delivery. We have enough space for only 20 mothers and their babies, and this is a program that's been in operation for about 3 years.

The attempt is to keep the mother and the baby together. All kinds of services are provided by those of us working at the hospital. We have now lost only two of those mothers. In other words, only two of those babies were taken away from the mothers.

Now, that's an early intervention program beginning at birth that is somewhat costly. But believe me, if we can keep those mothers together with their children and keep them virtually drug free, it is worth every effort.

If I look at my entire population of drug-using mothers, just about 75 percent of them have disappeared and so their youngsters are in foster care or they are with grandparents. That's not what we want to see in the future because these are mothers who will simply go and get pregnant again. There is a loss that they experience.

So unless we are willing to put the money up front, we're going to lose the game. Period.

Now, I will say this: there are many instances where we are working with the child and the mother is totally out of the picture. In those instances, yes, all of the money has to be devoted to that youngster and that caretaker, whether it's a grandparent or father. Some fathers are still around. Or whether it's a foster parent. And our efforts do go in that direction.

But where there's a biological mother available, even if she's not willing to step foot in the hospital, I will make a visit to the home and in a very indirect way try to let her know that there are different modalities that we're now beginning to use, including acupuncture and biofeedback.

So there's no way to solve the problem by throwing the mothers out of the picture. I mean, that's just not going to work. They will simply continue to have more and more babies as we have seen at Harlem Hospital.

Mr. OWENS. Thank you, Mr. Chairman.

Mr. RANGEL. Mrs. Lowey.

Mrs. LOWEY. Thank you, Mr. Chairman.

I want to thank the panel for your testimony. In particular, I want to thank you for your focus on early intervention, and I just want you to know that many of my colleagues agree that if you're not going to pay now, you're going to be paying later.

And I think that's the kind of documentation, such as the program you were just talking about, Dr. Davis, that we really need because some of my less believing or skeptical colleagues have to be convinced that if you're not going to pay for early intervention, you're going to pay for welfare. You're going to pay for housing the homeless. You're going to be paying for prison later on.

So we need your help in substantiating these "theories" because we believe it and we've seen it, for those of us who have been out in the community. And I think that focus is very important.

I've introduced a bill. Several of us are on the Education and Labor Committee, and I've introduced a bill called Link Up for Learning. And I would appreciate your comment on it.

The basic focus is that these are new kinds of families, new kinds of children, and we have to be ready whether we like it or not. And the idea of Link Up for Learning is to provide those kinds of social services in the school or in a local community center, so the youngsters who are going to school get what they need.

Again, we think it's more cost effective. So that the parent gets parenting education. The child is assured of health education. All kinds of support services. We think it's more cost effective. The new school for the new communities for the new America, essentially, is what we're talking about.

The second area that I'd like your comment on is another bill which was passed by the last Congress, which I introduced, which calls for training of drug counselors. My experience, be it with Renaissance, from my experience, in in-school programs or out-of-school programs, we've got to find a way to get more people adequately trained to deal with these youngsters. And I would appreciate your comments on both of those plans.

Mr. SHEDLIN. Let me make a quick response on that. We are working in two schools in East Harlem and like you we agree that the American family is fundamentally different than it was not so long ago, and the conditions which describe children in this country are fundamentally different but the schools are basically the same.

Thus we have recommended the need to redefine the role of the school as the locus of advocacy for all children. At the elementary school center we have been working with two schools to demonstrate what such a school would look like.

Mrs. LOWEY. Is that district 4?

Mr. SHEDLIN. It is district 4, and it does not suggest, by the way, that "one-stop shopping" as it's come to be known, is the only answer at all to this, but rather that the school must be the locus

of child advocacy. The school, together with all of its community agencies—must decide which is the best entity to provide the needed services for children.

So I basically agree with your Link Up for Learning.

As far as your question about the need for pre-service and in-service education, it's absolutely key. And I will leave the copy of our video with you because the agony of your not having an opportunity to see it here today is because I realize that a lot of the questions you asked are so eloquently answered by the teachers and by the recovering addicted mothers who we interviewed.

Mrs. LOWEY. Thank you.

Dr. Schipper, I think it was, that talked about the need for an information clearinghouse to find ways to disseminate information. Now, perhaps I should save this for the Assistant Secretary of Education, but I'd appreciate your comments first.

I find it amazing that this information isn't out there. You know it. We know it. We know that we're approaching a national disaster. And yet the Department of Education does not have any kind of clearinghouse, doesn't have any kind of a system currently to disseminate information, to pass on to other school districts the kinds of successes you've had, Dr. Davis, so that they can be replicated.

One of the concerns of the chairman and myself is that there are a lot of exciting things going on there, yet we are wasting taxpayer dollars repeatedly on programs that don't work. And I think one of the major roles of the Department of Education, or OSAP, or all the other agencies that we have out there would be really to look at the programs that are working and replicate by disseminating that information throughout the country.

Would you comment?

Dr. SCHIPPER. I don't think they're negligent. I think all the clearinghouses that we have in place were stimulated or legislated by Congress. It started there and it got passed off to—I think they're waiting. It wouldn't take much for you to get something going. I'm just suggesting it, I'm sure. I'm sure they could find some discretionary money and get something going.

Mrs. LOWEY. It isn't—find some discretionary money. It seems to me I've heard about this clearinghouse idea dozens of times.

Dr. SCHIPPER. OK. But I mean——

Mrs. LOWEY. Would it stop there?

Dr. SCHIPPER. I mean, I'm sure they have mechanisms in place that can be expanded to do the things we're talking about.

Mrs. LOWEY. So it's not doing it now. I just wanted to——

Mr. SCHIPPER. Correct.

Mrs. LOWEY. With all the billions of dollars in the budgets out there, knowing that we have a disaster on our hands, you're saying, "There is no clearinghouse. This information is not being disseminated."

Dr. DAVIS. That's correct.

Dr. SCHIPPER. It's just getting that we're beginning to have information. We now know we're going to have a problem that's not going to go away. We now know this problem is going to be encountered in every location in this Nation. We now know that those problems, many of them, are the same. OK?

So, fundamental information that's experienced and discovered and learned by folks in hospitals and in clinics and in programs, research centers, and so forth, in some way, if somebody would take the initiative to batch it up and then package it and get it back out to everybody that's going to experience these things that, to me, would be the logical thing to do.

Mrs. LOWEY. Logic. I would agree with——

Ms. BURNISON. There is one clearinghouse that is in existence. It just was funded. OSAP just awarded a major contract to LU&ICF here in Washington, and there are three major subcontractors, of which we're one; also NASADAD and the National Perinatal Information Center in Providence.

This part of this whole contract is to pull together what you're suggesting. It's a perinatal prevention clearinghouse and resource center for maternal substance abuse.

And this is in the formative stages right now. But basically one of the large components is to do exactly what you're suggesting—to pull together information about maternal substance abuse, about the developmental aspects of the children, and to put this together, in one clearinghouse pull all the information that is in other clearinghouses together into this clearinghouse and provide that one source of information that you're requesting.

Now, how far the funding will be able to extend into adding a piece of that to what happens when these kids get to school and following into the school-age range children, I'm not sure the funding exists. But the funding exists to at least pull together what we know now. And perhaps with supplemental funding into a resource center such as this, you can add on the education.

Mrs. LOWEY. My time has expired. [Laughter.]

Mr. RANGEL. What insight. [Laughter.]

I want the panel to know we deeply appreciate your testimony, and we appreciate the fact that Major Owens, who has been a leader in this area, and has the relevant legislative jurisdictions, will be here to guide our committee as to how we can support these kids.

Whenever we talk about early intervention, I assume that we also are talking about preventing addiction and preventing pregnancy, and that's taken for granted.

Thank you so much. Your entire statements will be in the record as indicated.

Our next witness is the Assistant Secretary of Education, Robert Davila, from the Office of Special Education and Rehabilitation.

Mr. Secretary, we welcome you. Your testimony is very necessary to the direction which the Congress is going to take. We are fortunate to have someone as well informed on this subject as yourself, and we anxiously await to hear your testimony with the understanding that you can deliver it in any fashion that you feel most comfortable; your entire written statement will be entered into the record.

I do understand from our previous conversation that after you proceed with your oral testimony, that your able assistants will be able to respond to questions that members of this panel may have.

Mr. Coughlin.

Mr. COUGHLIN. Thank you, Mr. Chairman.

We welcome you and await your testimony.
Thank you, Mr. Chairman.

TESTIMONY OF ROBERT DAVILA, ASSISTANT SECRETARY OF EDUCATION, OFFICE OF SPECIAL EDUCATION AND REHABILITATION, ACCOMPANIED BY JUDY SCHRAG, DIRECTOR, OFFICE OF SPECIAL EDUCATION PROGRAMS; AND WILLIAM MODZELESKI, DIRECTOR, DRUG PLANNING AND OUTREACH, OFFICE OF ELEMENTARY AND SECONDARY EDUCATION

Mr. DAVILA. Thank you very much, Mr. Chairman, and members of the committee.

I have with me this afternoon Judy Schrag, Director of Special Education Programs in the Department of Education, and William Modzeleski, Director of the Office for Grant Planning and Outreach, Office of Elementary and Secondary Education.

It is a pleasure to appear before you to discuss programs of the Department of Education for children prenatally exposed to drugs. The programs I will be describing this afternoon are administered by the Office of Special Education and Rehabilitative Services [OSERS] which is primarily responsible for providing services to children with disabilities and their families.

OSERS has developed a solid base of effective, validated, early intervention practices for children with disabilities that we think holds great promise for children whose developmental delays are due to prenatal drug exposure.

Department funds—a series of demonstration grants primarily intended to develop models of services delivery that can be adopted by communities across the Nation. Through these projects, we have identified a set of practices that have become standards in early intervention programs for children with disabilities or children who are at risk for disabilities, including children prenatally exposed to drugs.

In one of our outreach programs, now in its sixth year at UCLA, children who have been prenatally exposed to drugs receive regular medical care and early identification of developmental delays, and their families receive education and training in child care and accessing community services.

This family-centered, community-based program provides services through a multidisciplinary team consisting of social workers, pediatricians, and public health nurses. It uses a holistic approach to the needs of the infant, the needs and dynamics of the family, and the needs and roles of community agencies and service systems.

In an OSERS-funded demonstration project for high-risk infants, including those prenatally exposed to drugs, researchers at George Washington University provide infants, their families, and child care providers with comprehensive identification, neonatal intensive care unit—pardon me—child care providers with comprehensive identification, intervention, and referral services.

The project begins in the neonatal intensive care unit at the hospital and continues through supportive intervention and referral to community-based programs. A central feature of this project is integrated programming responsive to the unique needs of the indi-

vidual child, parent, and day care providers through home-based consultations, parent support groups, and child care provider training groups.

Through these projects and others for children with developmental delays, or those at risk for developmental delays, OSERS has identified the elements of an early intervention program. First, it should be family centered. The most effective early intervention programs address the needs of the whole family, their goals, and resources.

Second, an early intervention program should be community-based. Third, service providers should collaborate. Often complex health and education needs of young children with disabilities or at risk for disabilities due to prenatal drug exposure or other causes have demonstrated to be best addressed through the collaboration of multidisciplinary teams of people trained to work together to meet child and family needs.

Fourth, the early intervention program should facilitate transitions that children with disabilities and their families experience as they move from infant programs to preschool programs to school.

Finally, early intervention programs should provide training to improve skills of staff who provide early intervention services.

In addition to funding model demonstration projects in the area of early intervention, OSERS administers a program for infants and toddlers with disabilities, which is authorized under part H of the Individuals with Disabilities Education Act [IDEA].

This program awards grants to States for planning, developing, and implementing coordinated, comprehensive, multidisciplinary statewide systems of early intervention services for children with disabilities from birth through age 2 and their families.

The law provided a 4-year phase-in period for States participating in the program and required full implementation by the fifth year of participation. Currently, 38 States are in year 4, and approximately 247,000 infants and children are receiving services.

Under part H, infants and toddlers prenatally exposed to drugs n ay, at the State's discretion, be served as children with developmental delays or as children at risk for developmental delay. Approximately half of the States are serving children who are prenatally exposed to drugs. States have the opportunity to expand eligibility for services under part H at any time, and they may choose to do so as funds become available.

Part B of the IDEA, which guarantees a free appropriate public education to every eligible child with a disability through the age of 21, was amended in 1986 to require States to extend this service to all eligible 3- to 5-year olds by July 1, 1991.

As a result of the mandate, 367,428 children aged 3 through 5 received part B services in the 1990–91 school year.

Future efforts to address the children—the needs of children prenatally exposed to drugs will build on the best practices that have been identified by the field and through some of our previous projects where we maintain our support of early intervention projects that focus on infants and toddlers and their families.

It will also increase our emphasis on interventions for the preschool and the school-age population, so that schools can better

meet the educational needs of these children as they move through the system.

These interventions will include preservice and inservice training activities for teachers, principals, and other school staff. The Department is working with the Department of Health and Human Services to jointly develop a technical assistance package for preschool, including Head Start, and elementary schoolteachers that concentrates on meeting the educational needs of children prenatally exposed to drugs.

We will also focus attention and support on finding ways to provide appropriate services to children who are prenatally exposed to drugs in the least restrictive environment. That is, a regular classroom.

This is consistent with special education statutory requirements to serve children with disabilities in the least restrictive environment.

Finally, I would like to describe a program we will fund this year that has significant implications for the future. A new early childhood research institute, which we expect to fund for 5 years at an annual level of approximately $800,000, is the only federally funded research institute to focus specifically on interventions for this population.

The purpose of the institute is to develop, field test, and disseminate new and improved collaborative interventions for infants, toddlers, and preschool-aged children who are developmentally delayed, at risk for developmental delay, or disabled because of maternal use of alcohol or drugs, especially crack cocaine and other street drugs. The interventions included in this program will be community-based, coordinated, and family centered.

In closing, we have a number of projects and validated interventions that support children prenatally exposed to drugs and their families. Not all children prenatally exposed to drugs will require special education. But when they do, coordinated, comprehensive, early intervention services involving the family hold the best promise of preparing these children for success in school and enabling them to achieve their full potential.

Thank you, Mr. Chairman, for the opportunity to be here. My full testimony will be disseminated. My colleagues and I will be pleased to answer any questions you may have.

[The statement of Mr. Davila follows:]

STATEMENT OF

ROBERT R. DAVILA

ASSISTANT SECRETARY FOR SPECIAL EDUCATION
AND REHABILITATIVE SERVICES

U.S. DEPARTMENT OF EDUCATION

ON

EARLY INTERVENTION SERVICES FOR CHILDREN PRENATALLY EXPOSED TO DRUGS

BEFORE THE

HOUSE SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

UNITED STATES HOUSE OF REPRESENTATIVES

JULY 30, 1991

Accompanied by: Judy A. Schrag, Director
Office of Special Education Programs
and
William Modzeleski, Director
Drug Planning and Outreach
Office of Elementary and Secondary Education

Mr. Chairman and Members of the Committee:

It is a pleasure to appear before this panel to discuss programs of the Department of Education for children prenatally exposed to drugs. The programs I will be describing this afternoon are administered by the Office of Special Education and Rehabilitative Services (OSERS), which is the component of the Department primarily responsible for providing services to children with disabilities and their families. OSERS has developed a solid base of effective, validated early intervention practices for children with disabilities that we think holds great promise for children whose developmental delays are due to prenatal drug exposure.

Th Department funds a series of demonstration grants primarily intended to develop models of service delivery that can be adopted by communities across the nation. Through these projects, we have identified a set of practices that have become standards in early intervention programs for children with disabilities or children who are at risk for disabilities, including children prenatally exposed to drugs.

In one of our outreach programs, now in its sixth year at UCLA, children who have been prenatally exposed to drugs receive regular medical care and early identification of developmental delays, and their families receive education and training in

child care and accessing community services. This family-centered, community-based program provides services through a multidisciplinary team consisting of social workers, pediatricians, and public health nurses. It uses a holistic approach to the needs of the infant, the needs and dynamics of the family, and the needs and roles of community agencies and service systems. The model developed and disseminated by this project facilitates a stable and responsive environment for infants and families who may live in violent and chaotic circumstances The multidisciplinary staff promote the continuity of health care and developmental services. The family training component develops the competencies of parents, foster parents, and extended family members, and results in increased confidence and skill as they care for children who were born with health problems or developmental delays that may be associated with prenatal drug exposure.

In an OSERS-funded demonstration project for high-risk infants, including those prenatally exposed to drugs, researchers at George Washington University provide infants, their families, and child care providers with comprehensive identification, intervention, and referral services. The project begins in the neonatal intensive care unit at the hospital and continues through supportive intervention and referral to community-based programs. A central feature of this project is integrated programming responsive to the unique needs of the individual

child, parent, and day care provider through home-based consultations, parent support groups, and child care provider training groups. Like the UCLA project, an outcome of this project will be a replicable model that can be adopted by other communities.

Through these projects and others for children with developmental delays or those at risk for developmental delays, OSERS has identified the elements of an effective early intervention program. First, it should be family-centered. The most effective early intervention programs do not focus solely on the child but address the whole family, their goals and resources. Second, the early intervention program should be community-based. For all young children with special needs, including children prenatally exposed to drugs, improved outcomes are most readily obtained when programs are community-based and utilize the social and educational systems accessible to the family in their own community. Third, service providers should collaborate. The often complex health and education needs of young children with disabilities or at risk for disabilities due to prenatal drug exposure or other causes have been demonstrated to be best addressed through the collaboration of multidisciplinary teams of people trained to work together to meet child and family needs. For example, effective teams have included pediatricians, social workers, and public health nurses. Fourth, the early intervention program should facilitate the

transitions children with disabilities and their families experience as they move from infant programs to preschool programs to school. Planning for the transition process is now recognized as a necessary component of effective early intervention programming for children and families in need of specialized programs. Finally, the early intervention program should provide training to improve skills of staff who provide early intervention services. OSERS research has identified training in identification, assessment, and intervention as critical components of a training program.

In addition to funding model demonstration projects in the area of early intervention, OSERS administers the Program for Infants and Toddlers with Disabilities, which is authorized under Part H of the Individuals with Disabilities Education Act (IDEA). This program awards grants to States for planning, developing, and implementing coordinated, comprehensive, multidisciplinary statewide systems of early intervention services for children with disabilities from birth through age 2 and their families. The law provided a four year phase-in period for States participating in the program and required full implementation by the fifth year of participation. Currently, 38 states are in year four, and approximately 247,000 infants and children are receiving services.

Under Part H, infants and toddlers prenatally exposed to

drugs may, at the State's discretion, be served as children with developmental delays or as children at risk for developmental delay. Approximately half of the States are serving children who are prenatally exposed to drugs. States have the opportunity to expand eligibility for services under Part H at any time, and they may choose to do so as funds become available.

Part B of the IDEA, which guarantees a free appropriate public education to every eligible child with a disability through the age of 21, was amended in 1986 to require States to extend this service to all eligible three- through five-year-olds by July 1, 1991. As a result of the mandate, 367,428 children aged three-through-five received Part B services in the 1990-91 school year. The Grants to States and Preschool Grants programs provide a combined per child share of $1204 for the three-through-five age group. Children prenatally exposed to drugs are eligible for services if they have one or more of the disabilities specified under the IDEA and require special education.

Future efforts to address the needs of children prenatally exposed to drugs will build on the best practices that have been identified by the field and through some of our previous projects. While we maintain our support of early intervention projects that focus on infants and toddlers and their families, we will also increase our emphasis on interventions for the

preschool and school-age population so that schools can better meet the educational needs of these children as they move through the system.

These interventions will include pre-service and in-service training activities for teachers, principals, and other school staff. The Department is working with the Department of Health and Human Services to jointly develop a technical assistance package for preschool (including Head Start) and elementary school teachers that focuses on meeting the educational needs of children prenatally exposed to drugs. We expect to produce an in-service training video and associated material that will be available for distribution to preschool programs (including Head Start) and elementary schools across the country. In addition, we will be looking at ways to link OSERS' projects serving the needs of children prenatally exposed to drugs with community-based substance abuse programs serving women and their children.

We will also focus attention and support on finding ways to provide appropriate services to children who are prenatally exposed to drugs in the least restrictive environment. This is consistent with special education statutory requirements to serve children with disabilities in the least restrictive environment. It is also consistent with the national education goal to prepare all children to develop the life skills that will enable them to grow up and be productive members of the community. Recently, we

have been concerned by reports in the media and elsewhere that suggest that children prenatally exposed to drugs must be placed in special classes. Early evidence from research indicates that most children prenatally exposed to drugs can be educated in the regular classroom with appropriate early intervention services. Our activities will be designed to promote the inclusion of these children in regular classroom environments to the greatest extent possible. To this end, we intend to support model demonstration projects where children with disabilities will receive services in the types of settings in which young children without disabilities will participate.

Finally, I would like to describe a program we will fund this year that has significant implications for the future. A new Early Childhood Research Institute, which we expect to fund for five years at an annual level of approximately $800,000, is the only federally-funded research institute to focus specifically on interventions for this population. The purpose of the Institute is to develop, field test, and disseminate new or improved collaborative interventions for infants, toddlers and preschool-aged children who are developmentally delayed, at risk for developmental delay, or disabled because of maternal use of alcohol or drugs, especially crack cocaine and other street drugs. The interventions included in this program will be community-based, coordinated, and family-centered. Dissemination of information is an important part of this project, and we are

requiring that information be shared with other research institutes, clearinghouses, technical assistance providers and others so that successful intervention techniques can be replicated.

In closing, we have a number of projects and validated interventions that support children prenatally exposed to drugs and their families. Not all children prenatally exposed to drugs will require special education. But when they do, coordinated, comprehensive early intervention services involving the family hold the best promise of preparing these children for success in school and enabling them to achieve their potential.

Thank you, Mr. Chairman, for the opportunity to be here. My colleagues and I will be pleased to respond to questions.

Mr. RANGEL. Thank you, Mr. Secretary, not only for your informative testimony but for your patience with our scheduling as well.

One thing it seems like everyone agrees on, and that is that early intervention is the area on which we should concentrate. If that is so, why is it that we don't have funding programs for all of the children that are born exposed to drugs? Why is it we don't have early intervention education programs?

It seems that you're the most proud of demonstration projects.

Mr. DAVILA. It is important to understand that our part H infant and toddlers program, the funding for that program is not primarily intended for services but for the purpose of helping the States to plan and maintain a coordinated statewide system of services to children who are disabled or developmentally delayed, at the discretion of the States, and which are becoming developmentally delayed.

So the program really is intended to coordinate funding from other sources. Part H infant and toddlers program is on a last resort basis which means that other funds available must first be used before funds from this program can be applied.

Mr. RANGEL. I'll try it another way. If we were children that were exposed to drugs through no fault of our own, and somehow missed out on all of these demonstrations, how would a Member of Congress explain to us why the Federal Government left it up to the States as to whether or not we were entitled to early intervention?

Mr. DAVILA. The data on children who are prenatally exposed to drugs is inconclusive. We do not look at the cause of a child's disability or developmental delay. We look at the child and address the child's needs.

I believe that we need to consider also that States have great flexibility in this program, and children who are disabled, or who are developmentally delayed, are entitled to services under this program.

A service support may not necessarily come directly from part H. Services are guaranteed to this child. So I believe there is a situation here where children who are at risk may also be included. It's important to understand that this is not a demonstration program. It is a grant program. This is with the States. The States make their determination.

Mr. RANGEL. But if you agree that these children exposed to drugs are seriously at risk and should have access to early intervention, and only half of the States participating in part H programs serve this group, what is the Federal responsibility to make up for such shortcomings?

Ms. SCHRAG. My name is Judy Schrag, for the record. Good afternoon, Mr. Chairman, members of the committee.

As Dr. Davila pointed out, the part H program is a 4-year phase-in program, and all States are participating in this program, and we know at this time that about half the States—about 17 of the States are indicating that they are including prenatally exposed—drug exposed children in their definitions and in their service pattern.

The extent to which all States will include these children as part of their at-risk population will depend on the resources that they

are able to mobilize within the States, supplemented by the Federal resources level. It will also depend on how they can get all their service delivery systems in place.

In addition to serving these children within the definition of at-risk, many of these children, as Dr. Davila indicated, will be served as a part of the overall definition of eligible students of developmental delay, and they will become eligible and will be served in the part H program.

Until we fully implement the part H program we will not know how many of those children will be covered.

Mr. RANGEL. Mr. Coughlin.

Mr. COUGHLIN. Thank you, Mr. Chairman.

I believe that one of the witnesses on the previous panel suggested that some 15 percent of children that she treated would have some kind of retardation. That can be a fairly staggering figure in terms of the number of children that might need special education.

Is that figure as staggering as that might suggest?

Mr. DAVILA. I don't have information about numbers as reported in earlier testimony. But I believe if a child has a disability or is developmentally delayed, that child could get special services from age 0 to 2, and that child will require special education at the beginning of the school year at age 3. That child will be entitled to full special education.

We try not to label children. We look at children and the needs based on appropriate assessment and diagnosis of their needs. And then we develop a program to meet that child's individual needs. This is a fundamental approach in special education. Many children who have different disabilities may exhibit similar behavior.

Mr. COUGHLIN. I know that the President requested some $49 million for emergency grants to schools. The House cut the President's request almost in half to $25 million. Would that have an adverse impact on this kind of education?

Mr. MODZELESKI. It may, Mr. Coughlin. We don't know as of yet. You're right that the emergency grants were reduced from $49.5 million to $25 million, and the intent of that—those emergency grants were to provide services in those areas most heavily impacted by drug use as well as high crime rates, high referrals to treatment centers. So the only thing we could say is assume that it will have some impact on the areas. We don't know.

The 1991 emergency grants applications are currently under review, so we have no idea of the type of services that are actually being provided in 1991.

Mr. COUGHLIN. I also know that the President requested some $281.6 million for treatment and prevention programs for high-risk youths and pregnant women and infants, communities activities programs, community-wide prevention programs, and training programs. But the House also cut this by about $13 million below the President's request. Is that likely to have an adverse impact on these——

Mr. MODZELESKI. Again, these are programs that are operated by the Department of Health and Human Services and primarily by OSAP and other agencies, but I would assume that they would have an impact—an adverse affect on the population we're talking about.

Mr. COUGHLIN. Thank you, Mr. Chairman.

Let me yield to Mr. Owens.

Mr. OWENS. Yes, Mr. Secretary, I'm quite familiar with many of the things that you mentioned in your testimony. However, I think all of us would appreciate it as a ray of hope here if you could expand on the early childhood research institute. What is the timetable with respect to the operation of that institute?

Mr. DAVILA. I will ask Dr. Schrag to respond. That program will be under her administration.

Ms. SCHRAG. Yes, Mr. Owens, that research institute will be funded prior to the end of this fiscal year in September. We are prefunding it tomorrow, and it will operate for 5 years, as Dr. Davila indicated, for approximately $800,000 per year.

The responsibility of this institute will be to gather up some of the research, practice, and good efforts that you heard from the previous panel and to help develop vehicles for dissemination through some of our other clearinghouses and our centers and so forth.

In addition, the institute will develop new research, identify new intervention strategies, again, for packaging the different audiences for dissemination through our various centers and clearinghouses and institutes.

Mr. OWENS. And you expect to begin when?

Ms. SCHRAG. It will begin October 1 of this year.

Mr. OWENS. The Department operates it directly?

Ms. SCHRAG. No, we will be funding a center to do that, a research center, and will——

Mr. OWENS. So what starts in October? The process of funding?

Ms. SCHRAG. No, the actual center will begin in October. We are funding it between now and September. We have received applications, and we are tomorrow pre-funding the winner. And then we will provide the funding between now and September 30. Operation will begin October 1.

Mr. OWENS. In view of the kind of testimony we heard before, do you think it'll be possible? This morning in the Education and Labor Committee we passed out of committee the bill reauthorizing part H of the Individual Disabilities Education Act, and that's going forward.

The authorization is for $220 million. The present appropriation is far below that. One of the reasons that it is obvious that we're not doing more out there, of course, is that States are reluctant to commit the kind of resources necessary to come up to par and meet all the requirements for the fifth year of part H.

We have full cooperation—bipartisan cooperation—on the bill that passed the Education and Labor Committee this morning.

Would you be willing to join us in trying to get a full appropriation for that amount? And, in view of the emergency that we have, can we have your cooperation in trying to move beyond that in the future with an amendment to increase the authorization? The program is authorized for 3 years, and I think 3 years is too long to wait for increasing that effort. I just wondered if you could—if we could look forward to your cooperation on trying to move to meet the emergency that's been enunciated here today?

Mr. DAVILA. This is a very important program that provides valuable services, and we are in support of anything that will improve our little children. These are very difficult economic times, and so there is to be among all of our other considerations——

Mr. OWENS. I think what Mr. Rangel was trying to get at before was, can we have a greater commitment from the Federal Government? Can we have some leadership from your department; alerting them to the fact that we have an emergency here, a national emergency, and we'd like to have greater leadership from the Federal level to meet that emergency?

You don't have to answer that. I just—I'll close with that comment.

Mr. RANGEL. Mr. Secretary, I've had some difficulty in finding from the various cabinet officials exactly where the real priorities are in the war against drugs. And, quite honestly, with every Secretary of Education, I could not really find a major commitment to the drug issue.

Mr. Bennett gave me a red pamphlet. Mr. Cavazos gave me a coloring book. [Laughter.]

But you deal specifically with demonstration programs that really earmark funds for children who have disabilities which could be caused by exposure to drugs.

Earlier this week, we had hearings with the Attorney General. And after we got past death sentences and flexibility with the Constitution on search and seizures and the crime bill, I asked him whether or not he thought it was in the national interest to try to prevent people from getting involved with drugs in the first place and going to jail.

He not only agreed but felt quite proud of a program that he said that he was initiating, called "weed and seed." And the whole idea was to weed a community of criminal elements and at the same time to seed that community with coordinated special services, and housing, and job training, and education, and tax incentives for industry to help the community rebuild.

The committee members—Republicans and Democrats—were pretty excited about this initiative. And I wonder whether or not you might be able to support a program that takes away the discretion of a State but will maintain the funds specifically targeted to areas with high rates of drug addiction?

Would you be able to say that, notwithstanding maximum discretion for local and State governments to decide who is disabled and how much assistance should be granted, that the President's war against drugs can include federally mandated education programs?

We would say that every agency and department would allocate whatever resources were necessary in a comprehensive way, such as you indicated in your testimony, and that the Federal Government would set a formula to designate areas with the highest rates of drug addiction for your demonstration projects.

Does that idea excite you at all?

Mr. DAVILA. Yes, it does. And I believe that the problems we are talking about are not going to be controlled by education alone. I think they cut across all institutions in the community. It will become so important to us to be real clear on our priorities collectively and not have us separated by all these different groups.

Mr. RANGEL. But the Attorney General said the same thing. In other words, all of the resources would combine to make certain that we're working with foundations, local and State governments, and the Federal Government, so that any member of this committee who represents an area with high rates of drug addiction would be able to say that the Governor included his community in this project; it would be mandatory.

Mr. DAVILA. I understand then the issue——

Mr. RANGEL. Well, maybe that's a little stronger than what Major Owens got. Why don't you talk with the Attorney General? Because he's anxious to get this program moving forward.

And if we got all of the Cabinet officials to talk about coordinating the limited amount of Federal dollars that are there, then perhaps we will see that early intervention will indeed save our Federal Government money, not to mention the human resources that would be saved by such an initiative.

But if our war is merely to say, "These are the options that local and State government have," there's no need for a Federal Government.

Let's work together because if I can't get you to understand, I might as well hang up the gloves.

Mr. DAVILA. OK.

Mr. RANGEL. Thank you so much. Very informative panel.

I'm sorry. Mr. Payne from Newark, a community that may be familiar with the problem we discussed.

Mr. PAYNE. Thank you very much.

Mr. RANGEL. And Mr. Clinger? I'm sorry.

Mr. PAYNE. I'm sorry that I missed the testimony and have been in and out today. I certainly feel that the questions that we've been dealing with today and the problem certainly are amongst the greatest in our country.

In our community of Newark, as a matter of fact, I have a daughter who teaches kindergarten and is now getting the wave of crack-addicted children in the classroom. And we're finding in a number of our schools in the system that the old problem of dealing with children who are children of former crack-addicted persons are very, very difficult to deal with.

They need a tremendous amount of attention. Many times she said that they have a compulsion to take things off the board just to tear them down or to tear pages out of books, to push and fight one another, and even though she has a teacher aide in the class, it makes it extremely difficult.

I think we have a tremendous responsibility to deal with our educational system to try to come up with new techniques. As a matter of fact, many young children simply lack the basic hugging and giving them kind of encouragement that they're doing positive things.

So I certainly don't have any specific question because I did not hear any of the testimony actually but am very aware of the problem, and we have a number of abandoned children in our community.

We've gotten a tremendous amount of cooperation from people in the community. We have a large number of citizens stepping forth

and taking legal custody of infants and young children from the hospitals, even teenagers.

And many of our friends in Newark and in the suburban areas around our city are taking a strong interest in legal custody and adoption. So it's a project we have going. We call it "Take a Baby Home Week." You know, we just go and take one of those children who needs a home to your house.

And we know if you start with--that it's going to be hard to get tired of it—we don't have a time where you can turn them in. Once you get them, you've got to keep them. But we've been very successful at UMDMJ and hospitals cooperating.

Darlene Cox, who heads the nursing department at UMDMJ, is very encouraged because we've kind of emptied out the abandoned babies section, and so it is a tremendous problem. We will have to put in resources, and I too did not hear much from the Attorney General when he finished about the death penalty.

And I did mention that—without saying any more, that the rich are getting richer, and the poor are getting poorer. I just simply said that the rich are getting richer and the poor are getting prison. He wants to build a lot more of them.

But I think that the answer is really going to be education, targeting areas that need the help, and putting the resources as we did in other problems that we have, whether the Persian Gulf war, or—the resources must be committed if we're going to win this.

Thank you, Mr. Chairman.

Mr. DAVILA. Thank you.

Mr. RANGEL. Mr. Clinger.

Mr. CLINGER. Thank you, Mr. Chairman.

Mr. Secretary, thank you for your testimony today. We heard basically this morning that the phenomenon of the crack babies is of relatively recent origin, going back only 6 or 7 years, and that those children are only now coming into the educational system. And I think Dr. Davis testified that in her practice maybe 15 percent of those would have permanent disabilities of one sort or another.

I guess my question relates to the fact that since this is a relatively recent phenomenon, is the Department going to be studying this phenomenon? In other words, perhaps we'll find that it's a more serious problem than the 15 percent over time.

And I'm just wondering if you have any intention of gathering data about the incidence of crack children in the school system, how serious that problem is now and how serious it is liable to become, or may become if you keep records?

Mr. DAVILA. Data on the number of crack children in our country is inconclusive for the reason that estimates are varied—range from 100,000 to 355,000 children. And we have no consistent uniform program for testing and screening mothers in hospitals throughout the Nation.

And as it was suggested by somebody previously, they have a tendency to test those who may be engaged in other drugs, and so many middle-class and upper-class women who are pregnant and seek private medical care are not tested. And so we have a biased view of the population we are concerned with, so we need to estab-

lish more uniform procedures so that we can have accurate information.

The number of children in the infant and toddlers program and preschool program has grown for different reasons, not all because of the existence of a larger number of prenatally exposed children. You see?

So, for example, in the preschool program for children aged 3 through 5, in 1986 when that program was implemented, incentives were provided to the States to encourage child-parent activities and to bring children in need of special education into the program. And that created a very quick upturn in the number of children.

We can't say how many of those children are drug-exposed or were drug-exposed at the time they came to the program and before then. We don't know that. Why it has been increased is that children who traditionally were not involved in a program, such as children with head injuries for example, children who are medically fragile and others came to the program so there were increases in the number of children served.

But we can't say that we know for sure just how many of these children are in the 3- to 5-year-old program in special education because they were drug exposed. We don't have good, accurate data.

Mr. CLINGER. Is that a concern? I mean, are you going to try and address that to see if you can develop better data?

Mr. DAVILA. Yes, sir; in a way, part of the work at the new child research institute will be doing—what the extent of the problem really is.

Ms. SCHRAG. I also wanted to make a comment. I'm excited by the growing number of States that are developing tracking systems, screening systems to be able to document within their States how many children are prenatally exposed to drugs.

For example, the State of New York, in your area, Mr. Owens, has an infant health assessment program, which is operable in every county. And this fall, as they track and screen the birth certificates and the children born, they will be including this area of prenatal exposure to drugs, this group of children, in their mandatory screening.

I know that the city of New York has been routinely screening birth certificates to try to document how many children are born exposed to drugs. These are exciting screening programs as a part of the part H program, as well as complementary to the part H program.

Mr. CLINGER. I guess I'm concerned though that we're looking at a problem that is 6 years old. We know that certain numbers of those children are going to have perhaps permanent problems, but there could well be others in that universe that are going to have problems further down the line—educational——

Ms. SCHRAG. Yes.

Mr. MODZELESKI. Just to pick up on what Dr. Davila said is that initially in the Department of Education, there are other agencies in the Federal Government, primarily the National Institute of Drug Abuse, who are doing studies in this area.

And rather to duplicate their effort, sir, we will be working and have been working cooperatively with them, and while I don't have specific information, they are conducting a study called "In Utero

Drug Exposure Survey," and that's one that we'll be tracking and following and getting information and feedback to us on.

Mr. CLINGER. Thank you.

Thank you, Mr. Chairman.

Mr. RANGEL. Thank you. If you have any suggestions for the committee, please feel free to let us know. The record will remain open, but you're not restricted by that. You can contact us at any time if you think that we can be helpful.

We have members on this committee that serve on all of the standing committees, and the support that we've gotten from Mrs. Lowey and Congressman Owens is only indicative of the interest that the full Committee has in educational matters.

We thank you for your presence.

Mr. DAVILA. We thank you, sir, and the members of the committee. Thank you very much.

Mr. RANGEL. Thank you.

Mr. RANGEL. Our last panel, Dr. Charlie Knight, the superintendent of Ravenswood School District in Palo Alto, CA (Mayor Coats will be with her); Dr. Diane Powell, director of Project D.A.I.S.Y., Washington, DC; Linda Delapenha, supervisor, primary diagnostic services, Hillsborough County Public Schools in Tampa, FL.

We thank you, first, for your patience. You can see the interest that the Congress has in this matter. We ask that you restrict your testimony to the allotted 5 minutes, so that members would have an opportunity to question. Your entire statement will be entered into the record without objection. And we'll start with Dr. Knight.

TESTIMONY OF CHARLIE KNIGHT, SUPERINTENDENT, RAVENSWOOD SCHOOL DISTRICT, PALO ALTO, CA, ACCOMPANIED BY MAYOR WARNELL COATS; DIANE POWELL, DIRECTOR OF PROJECT D.A.I.S.Y., WASHINGTON, DC; AND LINDA DELAPENHA, SUPERVISOR, PRIMARY DIAGNOSTIC SERVICES, HILLSBOROUGH COUNTY PUBLIC SCHOOLS, TAMPA, FL

Dr. KNIGHT. Thank you, Chairman Rangel.

As a school superintendent, I understand the problem of shrinking resources. Therefore, the board president, Ms. Myrtle Walker, instructed me as superintendent to find other ways to address this problem.

So we began to look at ways to form collaboratives with other agencies that were receiving drugs from various funding sources. From your letter of invitation, it is clear that this committee is painfully aware of the dangerous tidal wave of drug-injured children approaching urban schools, threatening to drown the already struggling teachers and systems.

The very name of this committee indicates that the House appreciates the difficulty of eliminating drugs and speaks instead to controlling them.

My small school district is already reeling from the first crest of the wave of children who enter with more than the usual disabilities resulting from growing up in poverty. At the same time, we see funding eroding from even current programs.

I cannot help but notice that our State legislature seems increasingly less willing to invest in public education now that the majority of students in California are not caucasian.

Last fall when the House of Representatives passed H.R. 1013, Special Education Reauthorization, it recognized the disproportionate number of black children, especially black male children, who were being placed into special education programs and recommended research to find more effective ways to serve this group of traditionally underestimated young people.

It also recognized that in utero drug exposure could result in increasing numbers of children in need of special services. The House bill contained a section calling for demonstration grants to school districts for intervention programs targeted to these children. The House bill contained no categorical funding for these programs.

By the time the bill became Public Law 101-476, that language was gone and the only special funding was for coordinating existing services as part of the program evaluation.

We have a number of throwaway children in California. In November, the Oakland Tribune reported on a study which found that 1 in 3 young black men in California is either in jail, on probation, or on parole.

Today's 18-year-old black man was in second or third grade in 1980. He was more likely to have been identified as educationally handicapped than his Anglo or Hispanic peers. He was more likely to have been retained in a grade than other students. He was more likely to have been suspended. He was, in fact, more likely to have found his public school days to be an experience which alienated and disenfranchised him from mainstream culture.

It should not have been surprising in the mid-1980's when crack cocaine became easily available. It would have met with a large group of 13-year-old black boys whose teenage rebellion was intensified by the low self-esteem they gained from being told they were failures by their teachers, and who had quite reasonably given up on the system for more immediate and tangible rewards.

Enter the teenage black girls whose rebellion is more isolating because their dysfunctional families cannot provide adequate support, and the boys they date are those who have found education to be futile. And the goals of steady employment seem vaporous at best when compared to the instant pleasure of sex and drugs.

The mixture has created a new generation of tragedy. These least prepared mothers have infants who are extremely frustrating to raise.

I truly believe that success is possible with these children. I am not presenting these facts out of bitterness but out of concern for our future as a nation. We have enough research to be certain that children who are successful in school are unlikely to turn to drugs later, and that the most effective way to control drugs is to eliminate the market for them. It is a looking-glass logic which places enforcement before prevention.

For the past 18 months, the Ravenswood City School District has been running a program for infants and young children born toxic-positive and their mothers. The program centers around therapeutic day care. Mothers are required to come to the center several

times each week for drug and family counseling, parent training, preventive health care, and continuing education.

We have formed a consortium with the county child protective services, the Health Department of San Mateo County. We are currently serving in our center 44 children.

Let me just make a couple of comments with reference to what Congress may be able to do to assist us with this problem. First, we need to develop programs around child care. Second, the program needs to be in the community and run by credible community-based organizations. Third, the programs need to be long term.

Fourth, the program needs to require mothers to attend parent counseling at least several times a week. And fifth, the program needs the assistance and cooperation of State and county agencies.

This program that we are currently implementing is extremely effective. The OSAP office has been very supportive in helping us implement the program.

May I say to you that the task we face is formidable. However, it is neither so expensive nor so difficult that we should abandon our effort. Your leadership in assuring research and demonstration and training programs is crucial.

I appreciate what the House has done and urge you to continue your efforts.

I have with me as a part of this collaborative the Mayor of East Palo Alto, who is attempting to move a city whose infrastructure is deteriorating from the very weight of drug trafficking and drug activities.

Mr. Coats.

TESTIMONY OF MAYOR COATS

Mr. COATS. Thank you, Dr. Knight.

Chairman Rangel, and honorable members of the Select Committee on Narcotics Abuse and Control, ladies and gentlemen, I am Warnell Coats, Mayor of the City of East Palo Alto, California.

As a mayor of the city of East Palo Alto, I have daily direct experience with the impact of poverty on a small, underdeveloped community. Our police officers devote the vast majority of their time to controlling drug sales in our streets and dealing with the violent crimes which are the consequences of drugs.

We know that the best form of drug control is the elimination of the market by raising successful and productive children who will not abuse drugs.

Dr. Knight's program for drugs is an important example of the kinds of programs that impoverished communities need, one which is run by State and public entities with community control through school board representation.

We at the city level are proud of the leadership which the school community has demonstrated by serving the most at risk of other children. Because Ravenswood's intervention program is certainly based in the community and run by the school district, all public and private agencies' interest in promoting the welfare of our children are able to work together to meet their needs.

It is in this spirit of cooperation which I hope that this congressional committee will promote and repursue a better future for our children in the city of East Palo Alto and throughout the country.

Mr. RANGEL. Thank you, Mr. Mayor.

[The statements of Dr. Knight and Mayor Coats follow:]

Ravenswood City School District

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Prepared Statement of Dr. Charlie M. Knight
Superintendent, Ravenswood City School District, East Palo Alto, California

HEARING
before the
U.S. HOUSE OF REPRESENTATIVES
SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

July 30, 1991

"Educational Policy Implications for Serving Drug-Exposed Children"

Statement Prepared by:

Dr. Charlie M. Knight, Superintendent
Stephen J. Waterman, Assistant Superintendent
Magdalena R. Fittoria, Assistant to the Superintendent

Introduction

From your letter of invitation it is clear that this committee is painfully aware of the dangerous tidal wave of drug injured children approaching urban schools and threatening to drown the already struggling teachers and systems. (On March 8, 1990, the House Subcommittee on Children, Family, Drugs and Alcohol held a hearing titled, "Falling through the Crack: The impact of Drug-exposed children of the child welfare system.") The very name of this committee indicates that the House appreciates the difficulty of **eliminating** drugs and speaks instead of **controlling** them.

My small school district is already reeling from the first crest of the wave of children who enter with more than the usual disabilities resulting from growing up in poverty. At the same time we see funding eroding for even current programs. I cannot help but notice that our state legislature seems increasingly less willing to invest in public education now that the majority of students in California are not Caucasian.

Last fall, when the House of Representatives passed H.R. 1013 (Special Education re-authorization), it recognized the disproportionate numbers of black children, especially black male children who were being placed into Special Education Programs, and recommended research to find more effective ways to serve this group of traditionally underestimated young people. It also recognized that in utero drug exposure could result in increasing numbers of children in need of special services. The House bill contained a section calling for

demonstration grants to schools districts for intervention programs targeted to these children. The House bill contained no categorical funding for these programs. By the time the bill became P.L: 101-476 that language was gone and the only special funding was for coordinating existing services as part of the program evaluation.

The Throw-Away Children

On Friday, November 2, 1990, the Oakland Tribune reported on a study which found that "One in three young black men in California is either in jail, on probation or on parole." Today's eighteen-year-old black man was in second or third grade in 1980. He was more likely to have been identified as "Educationally Handicapped" than his Anglo or Hispanic peers. He was more likely to have been retained in a grade than other students. He was more likely to have been suspended. He was, in fact more likely to have found his public school days to be an experience which alienated and disenfranchised him from the mainstream culture.

It should not have been surprising that in the mid-1980's, when crack cocaine became easily available, it would have met with a large group of thirteen-year-old black boys whose teenage rebellion was intensified by the low self image they had gained from being told they were failures by their teachers and who had quite reasonably given up on the system for more immediate and tangible rewards. Enter the teenage black girls whose rebellion is made more isolating because their dysfunctional families cannot provide adequate support. As teenagers, these girls face the same pressures toward sex and drugs and away from school which are faced

by all girls. However, the boys they date are those who have found education to be futile; and the goals of steady job and small house seem vaporous at best when compared to the instant pleasures of sex and drugs.

The mixture has created a new generation of tragedy. The difference is that these least prepared mothers have infants who are extremely frustrating to raise.

If we as a country should have learned anything from the Japanese success, it would have been that our short-sighted view of reality and failure to invest in long-range goals, is crippling us today and threatens to destroy us in the future. California's spending on incarceration has increased by more than 500% in stable dollars over the past ten years, while its investment in avoiding incarceration has so eroded that spending in our students places us forty-eighth out of fifty states, and far behind other states with comparable costs of living.

Success Is Possible

I have not presented these facts out of bitterness, but out of concern for our future as a nation. We have enough research to be certain that children who are successful in school are unlikely to turn to drugs later, and that the most effective way to control drugs is to eliminate the market for them. It is a "Looking Glass" logic which places enforcement before prevention.

For the past 18 months, the Ravenswood City School District has been running a program for infants and young children born toxic positive, and their mothers. The program centers around therapeutic day care. Mothers are required to come to the center several times each week for drug and family counseling, parent training, preventive health care, and continuing education. The County's Child Protective Services and Health Departments provide a part-time nurse, a counselor and case management services. Our center serves 44 infants and children and their parents.

From our own early intervention program, funded in part by the Office for Substance Abuse Prevention (OSAP), we have learned that most children who come into this world affected by crack cocaine, can, after even as short a time as 24 months, behave so similarly to non-exposed children as to be indistinguishable. To achieve this level of progress, they need what all children need, a safe, stable, nurturing environment. Their problem is that they enter the world to the most unnurturing environment imaginable, and they would present a challenge to the most experienced and mature of parents. They are agitated and colicky, so they cry often and often fail to provide parents with hugs and smiles, cues which help parents bond with their children. And the parents...

The mothers of these difficult children are children themselves, undereducated, immature, without money, and usually without an available supportive family. The fathers are too often the black males who were called "disadvantaged," or "at risk," or "special ed" or any other names that made it acceptable for teachers to give up on them. The fathers are the boys whom

we pushed out onto the street, whom we told in a thousand ways that they were too stupid to make it in school. They are the inmates of California's alternative-to-school, its burgeoning prisons. Thus these young girls are left to their own inadequate resources as they raise some of the most difficult children. They have no job skills and little education. It is little wonder that we have found them cutting the ends of the nipples from baby bottles so that they can put broken-up hamburger and lettuce into the bottles. It is little wonder that after being cooped up in a dank apartment with a screaming baby for days at a time, they escape into drugs and loud tv. The result, of course, is the birth and raising of a new generation of American children, malnourished, sickly, and unprepared for an education system which is unable to meet their needs. Instead of leading the United States with their energy and productivity, instead of providing the support our generation will need as we retire, this new generation will become a drain on the country's shrinking resources.

Crack Children Can Succeed

The good news is that it is not impossible for us to change this picture. It is not even prohibitively expensive to do so. We have found, and our findings are supported by other programs in the state and around the country, that programs can be developed which will minimize the damage these children suffer and even produce school age youngsters better prepared to succeed in school than many non-drug exposed children. The service needs the following elements:

1. **The program should start at or near birth.** Our best success has been with infants. The effects of good nutrition, routines, good hygiene and health care, and carefully designed activities have immediate payoff for the children and society. The children suffer fewer health problems, they are more often left with their natural mothers - both savings for society. Support during their early development means they are less likely to be late identified as needing special education in school, or welfare/prison as adults; this saves both society and the child.

2. **A program needs to be developed around the child and child care.** In spite of their inadequacy as parents, the mothers love their children and want to keep them. But the mothers need respite, support and training. A program centered around long term day care provides the respite, and allows the mothers to keep their children, thus giving them the motivation to come for support and training.

3. **The program needs to be in the community and run by a credible, community-based organization, such as a public school district.** The public schools in a poor community are the last credible governmental institutions. In contrast to may other community based organizations, the school district can work easily in partnership with county departments of social services, public health departments, and child protective services departments. Centralizing service in the community takes away the problems the young mothers invariably face such as getting transportation, and gives them a local, peer support network.

4. **The program needs to be long term.** Many programs for postpartum infants and their mothers end within six months. Mothers who were unable to stop themselves from taking drugs while pregnant will be unable to turn their lives around within six months. They need support as they move from drugs, complete their education and get settled into work. Concurrently, the children need the stability that can be provided by a nurturing day care/education center.

5. **The program needs to require mothers to attend parenting counseling at least several times a week.** The goal of the intervention must be two-fold -- benefit to both mothers and children. The few reliable predictive scales for children's later success in school indicate that the mother's relationship of the child is critical. In cost-benefit terms, it is cheaper for society to have children stay with their parents than to pay for foster care when the children are young, and prison when they get older. If the mother can be helped to change along with the child not only will this child benefit, but also later children will be healthy; she will be a contributing member of society, and her children will be a benefit instead of a burden.

6. **The program needs the assistance and cooperation of county agencies.** We have seen that without the tremendous support we have received from Child Protective Services (CPS), our program could not survive. By working together, our program goes well beyond what CPS could do on its own, and provides a community center for CPS to effectively work with several clients.

7. **The staff needs thorough and on-going training.** While teachers in general can benefit from more training in cultural sensitivity, and the special needs of their students, it is clear that any program which directly aims at serving this special population needs more intense and practical training in the cultural strengths and differences of their clients.

8. **The program needs sufficient, long-term funding through direct grants.** Funding must include both basic child care costs of the special services the children need, and the costs of coordinating with a myriad of organizations and agencies. In our case, our OSAP grant provides the costs of some of the special services and some of the extended child care; the county's Public Health Department provides health screening and drug counseling; CPS provides basic child care for the first six months and some counseling. We still ran a deficit of over $100,000 this year, caused by providing basic child care and facilities costs.

Based on our experiences, I recommend that funds be set aside for grants to school districts from the federal government, perhaps through OSAP. We have found this young agency to be most cooperative and supportive. If funding is routed through the states, a portion must be set aside for programs such as ours, run by local educational agencies.

The total cost of such a program is approximately $12,000 per child per year. By using existing county agency resources, the total cost would be approximately $8,000

per child per year -- of which basic child care is about $5,000. At this time, I know of only one other program like ours in California, and as of June it had not begun to enroll children. According to our information, no other school district in the United States has received an OSAP grant - probably because the funding guidelines do not provide for grants which are large enough for the school district to run the program without using its own general funds.

Public School Instructional Programs Lack Essential Elements

The greatest weakness of school age programs is that clients have already fallen behind. They have been in an average of three foster care placements; have rotated between mothers and foster care; or have elderly grandparents who have been trying to cope with them. Children's routines have been disrupted, they haven't been able to bond with an adult. They have often suffered from poor nutrition and lack of medical care and have had few pre-education experiences. Identification of children is more difficult. The drug symptoms are now so mixed with the problems of lack of nurturing that the developmental problems require greater skill. This weakness is followed by the lack of a focused family service program which includes health services, counseling, job training and parenting along with the educational interventions for children.

When these vulnerable students arrive in school, they are greeted by teachers who have many children to serve and who often lack both the belief that these children can learn and the skills to effectively instruct them. Further, federal programs for public school children only look at the visible needs of the children. The Special Education Legislation referred to above

is an example of this fragmented approach to the problems of drug-exposed children. Likewise, ECIA, Chapter I and Title VII, bilingual programs focus on the children in isolation from their family and health needs. Schools lack the local resources to provide for the children in the context of their families - an essential component to successful intervention. Funding for school-age children must be broad enough to encompass staff development as well as the parenting, counseling and other services we have found to be successful in our Parent-Child Intervention Program (PCIP).

The federal government needs to lead the way in providing holistic programs for school age children, while concurrently supporting additional research.

Teacher Education Programs Ignore the Problem's Existence

There is little doubt that new teachers in our state are entering their profession unequipped to teach minority students, let alone drug affected students. Funding for teacher education programs must require direct experience in urban schools, and must require teacher candidates to participate in both cultural orientations and classwork in dealing with disabilities. These classes in turn must be taught by practitioners who are familiar with the manifestations of drugs and the dysfunctional environments of children.

[redacted]

The task we face is formidable. However, it is neither so expensive nor so difficult that we should abandon our efforts. Your leadership in assuring research and demonstration and training programs is critical. I appreciate what the House has done, and urge you to continue your efforts.

July 23, 1991

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Prepared Statement of Wannell Corto
Mayor of East Palo Alto, California

HEARING
before the
U.S. HOUSE OF REPRESENTATIVES
SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

July 30, 1991

Ladies and Gentlemen, as the Mayor of East Palo Alto, I have daily direct experience with the impact of poverty on a small, underdeveloped community. Our police officers devote the vast majority of their time to controlling drug sales in our streets, and dealing with the violent crimes which are a consequence of drugs. We know that the best form of drug control is the elimination of its market by raising successful and productive children who will not abuse drugs.

Dr. Knight's program for drug-affected infants is an important example of the kind of program that impoverished communities need — one which is run by a stable public entity with community control through school board representation.

We at the City level are proud of the leadership which the school community has demonstrated by serving the most at risk of all children.

Because Ravenswood's intervention program is centrally based in the community and run by the school district, all public and private agencies interested in promoting the welfare of our children are able to work together to meet their needs

It is this spirit of cooperation which I hope that this Congressional Committee will promote as we pursue a better future for our children. Thank you for your efforts.

Mr. RANGEL. We'll hear from Dr. Powell.

TESTIMONY OF DIANE POWELL

Dr. POWELL. Chairman Rangel and members of the Committee, I'd like to thank you for allowing me to come here today to talk to you a little bit about some of the aspects of educating these children in environments that are appropriate for them. And I'd like to really focus on the other 85 percent.

We know that 15 percent of these children may need special services, but I think that we really need to reflect upon the tremendous numbers of students who will enter into the schoolhouse doors in September and who are already there who may not need special education, but they will need other things. They'll need reasonable accommodations.

I'd like to talk to you a little bit about our project here in the District of Columbia, Project D.A.I.S.Y, that was brought together by a collaborative of agencies, including our school system, because we knew that here in the District we had 56 percent of the children that we were tracking on the birth to three tracking system that had been prenatally exposed, and we had to do something and we had to do it immediately.

And we also knew realistically, that all of these children would not be eligible for handicapping conditions, but we knew that they would have some different behavioral and learning characteristics. One of the things that we looked at was the whole concept of collaboration across agencies, and we noted that that is certainly something that has to be given credence.

We also looked at the types of supports we had to provide to families of these children, and we looked at the family here in the District in terms of an Afro-Centric approach, knowing that the mothers and fathers were often absent. And we had to look at foster care, and we had to look at children who were living in homes for children who have been identified as being boarder babies but to us it's just "children."

We also looked at the fact that sometimes there were good friends and neighbors who had these children, and so we instituted something that we called "Home-Based Intervention," which allowed us to take the supports out of the school into the home and into the community, or whatever that residence just happened to be.

Then we talked about providing parent training and support groups for our primary caregivers because sometimes our caregivers who love these children are tired. It is very difficult, when you've already raised your family, and you're 75 years old, and you have a 3- or a 4-year-old in your household who is extremely active. And the child has all of the cognitive abilities of any of your other children, but he won't stop moving. So we looked at that in terms of the types of supports that these people may need.

We also looked at what types of classrooms we needed. We needed to have classrooms that were developmentally appropriate, and we needed to reduce our class size, which we did.

We looked at having 15 children in our classroom. And of those 15 children, 5 of those children have been documented as being prenatally exposed, and 10 of them are non-exposed.

One of the things that we learned from our colleagues in Los Angeles is that children need to have role models that demonstrate pro-social behaviors. And what better way than to have children learn from each other?

Then we also talked about the whole concept of full inclusion. We all know how difficult it is to reintegrate children who are coming back from special education. As a special educator, having had many years of experience, I know how hard it is to move children back into the mainstream. So why take them out if they really don't need to leave?

Then we talked about where do supports really need to be? Do you need to pull children out? Or do you bring the supports to the children in their community? And we advocate and bring our supports to the community. We bring it to the local school.

So we have a clinical psychologist, and we have a clinical social worker, and we have a speech pathologist, and we have related medical support from our medical community that comes in and screens these children for risk factors such as lead.

We also look at maintaining children in classrooms in which we have adults that are consistent over a period of time, so we have multiaged settings in which 3-, 4-, and 5-year-old children can be integrated into the same classroom and they don't have to adjust to a new teacher every year because we know for many children who have had prenatal exposure, and for many children in general, changing environments and transitions are very difficult and they can have an impact on the learning process.

Then we looked at the fact that we needed to document what was going on, and we began our research efforts because we want to find out what really makes differences for children.

So we begin to look at very important elements such as structure, structure of the environment, structure of the relationships between adults in the environment, between children in the environment, between children and adults, and adults and children, structure of relationships between the home and the school.

Then we looked at the modifications of the environments. What do you need to make your environment nurturing? What type of a classroom do you need to have?

And then we began to look at, how do we train other educators to begin to look at these children as children first? I think first and foremost what we want people to recognize is that we're educating young children, and I think sometimes we begin to get so enmeshed in the statistics that we forget that these are little kids, and all of their noses run, and all of them get colds, and all of them have tummy aches, and all of them want somebody to hold and hug them and cuddle them.

So we talk about educating children and keeping in the forefront that that's how our population is. Young children, some of them who may have some very, very unique learning characteristics, but for whom if we intervene early enough, we feel that they can have a very successful school experience.

We're at the end of our first year of a pilot in which we've also had a summer program. And one of the things that we have found is that these children do not present as significantly different from their nonexposed peers.

What we do know is that these children can do well if we continue to put moneys into programs and we provide the types of resources that they need.

So I do urge you to think about what makes the program work and to put those types of things into buildings by providing the resources. And not only putting those resources into special ed, but looking right into regular ed classrooms where the 85 percent are waiting.

Thank you.

[The statement of Dr. Powell follows:]

CHAIRMAN RANGEL, AND MEMBERS OF THE HOUSE COMMITTEE,... I WOULD LIKE TO FORMALLY ENTER THE FOLLOWING TESTIMONY INTO THE RECORD.

THE NATIONAL ASSOCIATION FOR PERINATAL ADDICTION RESEARCH AND EDUCATION (NAPARE), HAS CITED FIGURES WHICH PROJECT THAT AS MANY AS 375,000 INFANTS ARE BORN ANNUALLY TO WOMEN WHO USED DRUGS DURING PREGNANCY. THIS FIGURE, APPROXIMATELY 11% OF ALL NEWBORNS ARE VIEWED BY SOME AS A CONSERVATIVE ESTIMATE. FURTHER , IT IS IMPORTANT TO NOTE THAT THERE ARE APPROXIMATELY 50 THOUSAND BABIES BORN IN THE UNITED STATES EACH YEAR WITH ALCOHOL RELATED DEFECTS SUCH AS FETAL ALCOHOL SYNDROME AND FETAL ALCOHOL EFFECT.

CONSEQUENTLY, WHEN WE BEGIN TO LOOK AT AGGREGATE FIGURES FROM PUBLIC HEALTH RECORDS AND ESTIMATE THE NUMBERS OF CASES WHICH REMAIN UNDOCUMENTED SOME STUDIES REPORT FIGURES WHICH REFLECT AS MANY AS 15% OF PREGNANT MOTHERS USING ILLEGAL DRUGS AND ALCOHOL.

THIS PROGRAM OCCURS IN ALL SEGMENTS OF OUR SOCIETY REGARDLESS OF RACE, ETHNICITY OR SOCIO ECONOMIC STATUS. DURING THE LAST FIVE YEARS WE HAVE SEEN A DRAMATIC SHIFT IN THE USE OF "CRACK COCAINE" BY MIDDLE CLASS WOMEN. UNFORTUNATELY, MEDIA TENDS TO FOCUS ON CRACK ABUSING WOMEN AS AFRICAN AMERICANS OR HISPANICS FROM ECONOMICALLY LIMITED SITUATIONS. IN REALITY, RESEARCH IS SHOWING THAT THE NUMBERS OF WHITE MIDDLE AND UPPER CLASS USERS MAY EQUAL THE TOTALS IN THE MINORITY COMMUNITIES. THE MOST DISTINCT DIFFERENCE IS THAT MANY OF THESE CASES REMAIN UNREPORTED.

THE CHILDREN, BORN TO THESE WOMEN IN THE MID 80's ARE NOW ENTERING THE SCHOOL HOUSE DOORS IN STAGGERING NUMBERS. ALL OF THESE

CHILDREN ARE "AT RISK" DUE TO SUBSTANCE EXPOSURE IN UTERO. AS A RESULT, MANY OF THESE CHILDREN WILL PRESENT WITH UNIQUE BEHAVIORAL AND LEARNING CHARACTERISTICS WHICH WILL REQUIRE EARLY INTERVENTION.

IN RESPONSE TO THIS TREMENDOUS CONCERN THERE ARE SOME PROGRAMS WHICH HAVE BEEN PUT IN PLACE IN SEVERAL OF OUR MAJOR URBAN CITIES. SOME OF THE PROGRAMS WHICH ARE IN THE FOREFRONT IN THIS EFFORT ARE:

.PROJECT DAISY..WASHINGTON D.C. SCHOOLS

.THE SALVIN PROJECT..L.A. SCHOOLS

.THE FLORIDA SUBSTANCE ABUSE PROJECT

.PROJECT WIN..BOSTON

.THE HARLEM PRIMARY PREVENTION PROJECT..NEW YORK

.NAPARE..CHICAGO

DUE TO THE KNOWLEDGE BASE WHICH HAS BEEN ESTABLISHED IN EARLY RESEARCH EFFORTS REGARDING MATERNAL BONDING AND EARLY LIFE EXPERIENCES OF MANY OF THESE CHILDREN, WE KNOW THAT EARLY INTERVENTION AND SUPPORT IS ESSENTIAL.

CONSEQUENTLY, IN DESIGNING PROGRAMS TO RESPOND TO THE UNIQUE NEEDS OF THESE YOUNG CHILDREN THERE ARE COMMON CHARACTERISTICS WHICH SHOULD BE FOUND IN EFFECTIVE EARLY INTERVENTION PROGRAMS. SOME OF THESE CHARACTERISTICS, ARE A PART OF PROJECT DAISY AND INCLUDE:

.COLLABORATIVE CONSULTATION ACROSS AGENCIES

.HOME BASED INTERVENTION

.PARENT TRAINING AND SUPPORT GROUPS FOR PRIMARY CARE GIVERS

.DEVELOPMENTALLY APPROPRIATE CLASSROOM PRACTICES

.EXPERIENTIAL LEARNING STRATEGIES

.FULL INCLUSION OF CHILDREN IN INTEGRATED SETTINGS

.MULTIDISCIPLINARY SUPPORTS INCLUDING:

.EDUCATORS

.SOCIAL WORKERS

.CLINICAL PSYCHOLOGISTS

.SPEECH PATHOLOGISTS

.MEDICAL SUPPORTS /SCREENING

.MAINTENANCE OF CHILDREN IN CLASSROOMS WHICH DO NOT EXCEED 15 CHILDREN TO 2 ADULTS

.MULTI AGE LEVEL CLASSROOMS

.RESEARCH TO DOCUMENT EFFICACY

.TRAINING TO GENERAL EDUCATORS

IN ORDER TO ACCOMMODATE AND EDUCATE THESE CHILDREN WE MUST PREPARE TEACHERS IN A MYRIAD OF WAYS. FIRST AND FOREMOST WE MUST STRESS THAT THESE " CHILDREN ARE CHILDREN FIRST". SECOND AS EDUCATORS WE MUST RETHINK THE WAY IN WHICH WE DELIVER EDUCATIONAL PROGRAMS. TO DATE THE JURY IS OUT AND THE VERDICT HAS NOT BEEN RENDERED RELATIVE TO THE NUMBERS OF THESE CHILDREN WHO WILL NEED SUPPORTS BEYOND THE REGULAR CLASSROOM. CONSEQUENTLY , WE NEED TO REFOCUS OUR THINKING ON THE CHILD'S STRENGTHS VERSUS Operating USING A PURE DEFICIT MODEL. IT IS CRITICAL THAT WE ATTEMPT TO SUPPORT AND MAINTAIN THESE CHILDREN IN SETTINGS WITH THEIR NON

EXPOSED PEERS TO THE DEGREE POSSIBLE. IT IS NOT APPROPRIATE.. NOR IS IT FINANCIALLY FEASIBLE TO SEGREGATE THESE CHILDREN FROM THEIR PEERS ...UNLESS THE DEGREE OF SEVERITY OF THEIR NEEDS WOULD MAKE ACCOMMODATIONS WITHIN THE REGULAR CLASSROOM SETTING UNREASONABLE.

INSTEAD WHAT WE NEED TO DO IS TO TRAIN TEACHERS TO WORK WITH THESE CHILDREN AS THEY WOULD ANY OTHER "AT RISK' CHILD IN THEIR CLASSROOM. KEEPING IN MIND THAT THIS IS THE ERA OF FULL INCLUSION... ONLY IF THE NEEDS OF THESE CHILDREN ARE SO SEVERE THAT THEY NEED ALTERNATIVE SETTINGS SHOULD WE ENTERTAIN SPECIAL EDUCATION PROGRAMMING. OTHERWISE IT IS OUR PROFESSIONAL RESPONSIBILITY AS EDUCATORS TO BRING THE SUPPORTS DIRECTLY TO THE CHILD WITHIN THE CONFINES OF THE REGULAR CLASSROOM.

THE SUPPORTS NEEDED FOR THESE CHILDREN MUST BE MULTIFACETED AND SHOULD INCLUDE SPECIFIC STRATEGIES AND REASONABLE EDUCATIONAL ACCOMMODATIONS . THESE MODIFICATIONS WILL FALL IN THE AREAS OF:

.STRUCTURE OF THE ENVIRONMENT
.STRUCTURE OF THE LEARNING MATERIALS
.STRUCTURE OF RELATIONSHIPS..CHILD -TEACHER, CHILD-CHILD, CHILD TO GROUP, AND TEACHER TO CHILD
.STRUCTURE OF THE CONFIGURATION AND USE OF SPACE

WE WILL NEED TO BOTH TRAIN PRE SERVICE EDUCATORS AND RETRAIN INSERVICE TEACHERS; ARMING THEM WITH A CADRE OF TECHNIQUES. IN SOME INSTANCES WE WILL NEED TO ASSIST TEACHERS IN REFORMULATING THEIR THINKING ABOUT WORKING WITH THESE YOUNG CHILDREN. IN ESSENCE THE ROLE OF THE REGULAR EDUCATION TEACHER WILL HAVE TO UNDERGO A DRAMATIC SHIFT.

AT THE PRE-SERVICE TEACHER TRAINING LEVEL UNIVERSITIES MUST EXPAND PERSONNEL PREPARATION PROGRAMS TO INCLUDE TRAINING OF TEACHERS TO:

.WORK COLLABORATIVELY ACROSS AGENCIES

.TO PARTICIPATE IN SHARED PROBLEM SOLVING AND DECISION MAKING

EMPHASIZE COMMUNITY BASED PROGRAMMING TO INCLUDE WORKING CLOSELY WITH FAMILIES

.PROVIDE TEACHERS WITH ALTERNATIVE CURRICULAR APPROACHES (DEVELOPMENTALLY APPROPRIATE) AND STRATEGIES

.FOCUS ON DATA COLLECTION AND DOCUMENTATION

IN ADDITION TO THE EFFORT MADE LOCALLY BY SCHOOL SYSTEMS AND THOSE RECOMMENDED FOR CONSIDERATION BY UNIVERSITIES: THE FEDERAL GOVERNMENT CONTRIBUTION SHOULD BE EXPANDED TO INCLUDED:

1. RESEARCH IN REGULAR EDUCATION PROGRAMS TO SUPPORT THE MAINTAINACE OF THESE CHILDREN IN SETTINGS WITH THEIR NON EXPOSED PEERS

2. SUPPORT OF EFFORTS TO DEVELOP CURRICULA AND CURRICULUM

ADAPTATIONS TO SUPPORT INNOVATIVE INSTRUCTIONAL PRACTICES

3. FUND INNOVATIVE PRESERVICE EDUCATOR PROGRAMS IN EARLY EDUCATIONAL INTERVENTION

4.BLOCK GRANTS TO SCHOOL SYSTEMS TO EXPAND , DEVELOP OR CONTINUE PROGRAMS DESIGNED TO ADDRESS THE EDUCATION OF THIS GROUP OF CHILDREN

MEMBERS OF THE COMMITTEE...

IN CLOSING, I URGE YOU TO APPROPRIATE FUNDS TO SUPPORT THESE CHILDREN NOW TO MAXIMIZE THE BENEFITS GAINED FROM EARLY INTERVENTION, VERSUS A DELAYED REMEDIAL OR CORRECTIVE APPROACH WHEN THESE CHILDREN REACH MIDDLE OR ADOLESCENT YEARS. LEAST WE WAIT THE COST.. WILL BE ASTRONOMICAL.. ONE THING THAT WE KNOW IS THAT EACH OF THESE CHILDREN IS UNIQUE. NO TWO CHILDREN PRESENT AT THE SAME TIME WITH ANY UNIFORM LEARNING OR BEHAVIORAL CHARACTERISTICS.

CONSEQUENTLY, WE MUST PROVIDE THESE CHILDREN WITH INTENSIVE INTERVENTION SUPPORTS IN ORDER TO WARD OFF A CRISIS IN THE FUTURE.

. FINALLY, WHAT WE CAN SAY IS THAT EARLY INTERVENTION DOES WORK AND FOR MANY, MANY OF THESE CHILDREN THE PROGNOSIS WITH EARLY INTERVENTION AND SUPPORT WILL BE OPTIMISTIC.

submitted by:
Dr. Diane E. Powell
Director,Project DAISY
District of Columbia Public Schools
July 30, 1991

Mr. RANGEL. Thank you.
Ms. Delapenha.

TESTIMONY OF LINDA DELAPENHA

Ms. DELAPENHA. Thank you, Mr. Chairman and members of the committee.

As you know, I'm from Hillsborough County, FL, and I work for the school system there in which I supervise a program that serves kindergarten and prekindergarten students who are considered at risk for potential school problems. I'm also a school psychologist, former teacher, and chairperson of the Drug Exposed Children's Committee in my school district.

I'm not going to talk about early intervention which I support, because I think enough has been said. I do want to talk about two things, and one of those is teacher training. Teachers want training. They are asking for training. They may not be asking in the ways that you would like them to ask, but they are asking in the ways that are most comfortable for them and in the way they perceive their situation.

A teacher isn't as interested in what goes on nationally or even in their State. What they're interested in is their classroom. The kinds of things they're asking is: Tell me what to do with the children in my class. I'm having difficulty. That's what they want to know. That's why you're not hearing this at the teacher union meeting. It just hasn't gotten that far.

They're calling me on the phone. Now that's kind of unusual because I am in Tampa, FL, in my little office. How do they find me? Well, NAPARE sends some of them to me, as well as the Los Angeles school district. In my county we began training our teachers last October. It took 9 months to put the course together, and we used the information that we got from Los Angeles. We have been working with them.

We started training our teachers in a very practical sense. We had them make things that they would take back and use in their classrooms. That's how you get teachers' attention. They come. They come at night. They come on their own time. They elect to come. They call now and say, "Can I get in in October when you do this again?"

We've had people from other districts drive over to attend the class. I say, "Yes, you can come if we have space, but our teachers come first."

I had a call just recently from a teacher in New York, not in the New York public school system, in a system just outside that, who is a first grade teacher, who wanted some help. And I said, "I don't know that I can help you because we're really dealing with early childhood, and we have not addressed primary grades yet. We have some difficulty with that because sometimes the curriculum is not what we feel is appropriate for young children, so we haven't tackled that."

She said, "I think I have 40 percent of my class that's prenatally exposed to drugs." I said, "Oh, well, that's interesting." She went on to describe her concern about a child who was having some

rather significant—what we call "perceptual problems" in the way he was dealing with his writing skills.

And I told her that it was a very interesting problem that she had, but I certainly didn't have an answer. And then she said to me, "I just need some help in getting through the day." And I said, "You know what? I think I can help you."

These are some of the things that you can probably adapt in your classroom that we're doing in our course with teachers, and I will mail you the suggestions that we have. I mentioned a couple on the phone, and she says, "Oh, that's great. I can't wait until I get it."

I've had calls from people in 23 different States. Some are actually teachers. Some are the people the teachers talk to and the ones that plan the in-service for teachers. And they say, "We need help."

I've given permission for our materials to be copied, used in other districts. I've gone out speaking, but I can't go around the country training teachers because I have a job in Hillsborough County, and I have a staff to supervise.

We have put together a course, and I have applied for a private grant to a private foundation because I couldn't find any other place to apply. There was no Federal source for dollars that would allow me to do teacher training in the area of drug-exposed children because I'm not reducing drug use in anybody. I'm just training teachers to work in their classroom.

We've done our course with about 75 teachers. It is six meetings, three hours, and a teacher comes one night a week. They come. They enjoy it. The evaluations are wonderful. They go back in their class, they report the next week about what they did, and how it worked. If it didn't work, what do you need to do? A regular education teacher is sitting in class beside a special ed teacher. They both come together.

The problem is we've got this training course and we'd love to share it with other districts, but we can't seem to get our materials put together because we need some funding to do that. So we're ready to share and we're sitting here not able to.

I have made some commitments that I'm probably sorry that I have, and I may not be able to fulfill, but I guess I feel sorry for people that are begging over the phone, and I say, "Yes, I'll help you, and we'll try to come in January." Connecticut asked us, and said, "We've identified our 30 people to be trained, and we want you to come."

And so that really leads me to the second point which is, we need some grants to help us expand teacher training and to do the kind of research and the kind of programs that Dr. Powell is doing so we can find out what it is that we need to do with the 85 percent that she's talking about that are going to be in the regular education program.

Thank you.

[The statement of Ms. Delapenha follows:]

STATEMENT

of

LINDA B. DELAPENHA

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HILLSBOROUGH COUNTY PUBLIC SCHOOLS
TAMPA, FLORIDA

Before the

HOUSE SELECT COMMITTEE ON
NARCOTICS ABUSE AND CONTROL

on

"DRUG EXPOSED CHILDREN
ENTERING THE SCHOOL SYSTEM"

July 30, 1991

I appreciate the opportunity to share with you some of the information and insights I've gained from working with educational support staff, teachers, administrators, and parents as we plan classroom strategies for young children who are prenatally exposed to drugs. Educators face a very serious and immediate question of how to prepare for or actually provide services to children prenatally exposed to drugs, with very little information upon which to draw.

Although longitudinal research is being carried on at the National Association for Perinatal Research and Education (NAPARE), in Chicago, and information is available for some infant and toddler interventions, there is no sound data base for making educational plans and predicting outcomes of children who are school age (five and over). Observational data exists from the Los Angeles Prenatally Exposed to Drugs (PED) project for a small number of identified children, and this information has been shared on a national basis. For school districts who desire to gather data about the educational needs of these children, I believe the Los Angeles School District document entitled, "Teaching Strategies for Working With Young Children Prenatally Exposed to Drugs/Alcohol" is the place to begin. Hillsborough County's Drug Exposed Children's Committee would not have been able to move as quickly into the area of teacher training without the information provided by this project.

Prenatal drug exposure is actually a community problem, not just a school district problem. School districts need to establish a multi-disciplinary committee or task force with community participation in order to become

educated and informed about all facets of prenatal substance abuse. If they want to positively impact these children, schools are going to have to cooperate with more agencies, community programs, etc., than ever before. In the short term, plans need to be made to provide accurate, unbiased information to counteract inaccurate information teachers have gained from the media. From my own observations, a teacher's perception of the problem is usually skewed in one of two ways: either the children are perceived as being unteachable, but really haven't arrived yet, or a majority of the children in the class are perceived as being prenatally exposed to drugs based on behavioral observation compared to a list of possible characteristics.

The first statement is the prevailing feeling of teachers who have not received informational inservice presentations, but have relied on the media for information. The latter statement is usually made by a teacher who has either gathered some information on her own or has attended some inservice program. I have observed an interesting phenomenon in myself and others as we begin to learn about the characteristics that children who have been prenatally exposed to drugs exhibit in the classroom. Examples of such characteristics include: behavioral extremes, difficulty handling routine or transition, language delays, difficulty focusing and maintaining attention, decreased response to verbal directions, to name just a few. In the four-, five-, and six-year-old child, these behaviors are not unique to prenatal drug use; they have existed within classrooms in the past. However, the teacher who begins to learn about the characteristics of children prenatally exposed to drugs may immediately begin to attribute these behaviors to drugs and label these children as "cocaine

or crack babies." If one then begins to validate these assumptions through retrospective interviews with the parent or caregiver, as Hillsborough County Schools did in a 1989 research project, one will find supportive evidence for only a few children. For the majority of children who have been labeled, one will find the following examples of information:

1) No information is available through foster parent, grandmother, or caregiver.
2) A serious pregnancy problem occurred for the mother, or a negative health history was present for the child.
3) The family is in crisis, or a trauma has occurred that is unrelated to drugs.
4) The family currently uses drugs, but no substantial data exists to suggest that this was the case six years ago when the mother was pregnant.
5) The mother may admit to using only alcohol, which is a legal drug.
6) The mother either refuses to answer questions about prenatal drug use or lies because she fears punishment.
7) A mother who is in a drug treatment program may choose to share information with the teacher that she used a number of drugs while she was pregnant, but her child is doing well in the classroom, and the teacher never would have suspected this child.

These are some of the answers you will find if you investigate the backgrounds of children in a regular education classroom that serves an "at risk" population. At this point in the learning process about prenatal

drug use, the educator revisits the role of the environment as a very important determiner of a child's behavior. Researchers currently debate the relationship between prenatal drug use and poor environment as to which causes more negative effects upon the child.

Appropriate teacher training programs can assist educators in progressing through the stages of discovery quickly so that they begin to focus their efforts on intervention strategies for "at risk" children, rather than dwelling on the need to identify prenatal drug exposure in school age children. At this time, the knowledge base in education is insufficient to indicate that teaching methods should be different for children prenatally exposed to drugs than for other "at risk" children. Assisting teachers to improve their teaching strategies with "at risk" children is an immediate, interim solution to helping children prenatally exposed to drugs. At the same time, we need to be conducting research that will enable us to learn more about these school age children and refine our teaching techniques, curriculum materials, programs, etc., if that becomes necessary.

How do we know that teachers are interested in receiving training and would elect to participate if given the choice? From our experience in the Hillsborough County School District, we are able to offer a course that is 18 hours in length, and meets one night a week for six weeks. By attending the course, teachers may receive recertification points to use toward the renewal of their teaching certificate. The Drug Exposed Children's Committee spent nine months developing a curriculum outline

for the course and finally submitted a syllabus to our Teacher Education Center in July, 1990, for approval, to be included in the fall offering of courses for teachers. The first course was actually 12 hours in length. It has been revised to 18 hours based upon the recommendation of the teachers in the class. In February, we offered the course at two different locations and had 27 participants in each class. In response to the questionnaire used at the conclusion of the class, the majority of the teachers told us that they took the class to obtain information to assist children in their classroom. All of them indicated after completion of the course that they felt more confident in meeting the needs of "at risk" children, and would recommend the class to a colleague. Some principals have expressed concern that as the word spreads about the usefulness of the course, we might have to turn teachers away. If we continue to train instructors and expand the teaching base, this problem will be minimized. Teachers and educators from 22 states have written to me or called to request assistance; I have usually mailed materials to them. The class instructors and I have presented a full day of training to groups within and outside of Florida. One year ago, I did a 3-hour presentation in the morning and repeated it in the afternoon for teachers in the Alexandria School District in Virginia on their professional study day.

Because we are willing to share information with other districts, Hillsborough County Schools has applied for a grant from a private foundation that initially contacted us about our program. The grant is to develop our own materials for training and then instruct individuals in other districts to train their own teachers. To the best of my knowledge, this

type of grant that focuses on teacher training, is not available currently from the federal government. Within our grant, we have included an evaluation component that will help us to assess the overall level of success of our inservice project as it affects a teacher's skills within the classroom. Some districts are so eager to work with us that they are willing to pay all of our expenses if we can assemble our material and train their instructors. Although we have set tentative dates, it is questionable whether we can honor them without monetary assistance to help assemble the teaching manual this fall; grant funds would not be available until December 1, 1991.

Because we may be observing behaviors that are unique to prenatal drug exposure, identifying an infant for early intervention strategies is a very different issue from identifying the school-age child. This opinion is based on the reports of very experienced caregivers who have worked in "at risk" environments for years and who now report subtle differences in the reactions and behaviors of infants. These differences are also suggested in some research that has been published.

In Hillsborough County, we have developed a checklist of behaviors for infants and toddlers that would lead to specific interventions within a day-care setting. We need funding to do the necessary research to validate the checklist. Preliminary intervention work with infants suggests a high rate of success; long term prognosis is not known. One of our priorities must be to find quality day-care programs for infants prenatally exposed to drugs or "at risk" from other conditions in order to be able

to provide early evaluation and services to them. The reimbursement allocation of $10.00 per child per day appropriated from the Title XX Child Care Block Grants to the subcontracted child care centers is not sufficient to provide the quality of care and environment necessary to make a difference for these children. In contrast, the pre-kindergarten units that provide quality care and staff for three-and-four-year-olds are reimbursed from state funds at a rate of $20.00 per child per day. Those in the Title XX child care programs are our most needy children.

Labeling a young child as a "crack or cocaine baby" has very negative connotations for the child in relation to the way adults view him: the expectations they have for his behavior and school achievement. I was invited to meet with a group of mothers who were recovering drug users living in a group situation. They had read about the teacher training that was going to begin in our school district and focused on my name in the newspaper. When I met with them, they expressed their concern about the labeling of children. After I explained that the focus of our program was interventions and good early childhood practice, they seemed accepting. One of the questions that they asked me that evening was whether or not they should share this information with their child's teacher when the child entered school in a few years. I responded that the decision would have to be theirs; I know of some very positive situations in which the teacher gained more insight into the children's problems and accommodated them more successfully in the classroom. However, I could anticipate situations that would be detrimental to the child. If we are able to offer early intervention services to a young child and we observe

remarkable progress, we would not want to jeopardize that progress with a negative label that would carry with it much lowered expectations. One of the reasons we attach labels to children is because dollars are generated by that practice. Documentation for prenatal drug exposure does not follow a uniform practice; even within a single state protocols can vary by hospital. For many children entering school this year, no testing was available at birth. Women who refrain from drug use for at least 48 hours prior to delivery may have clean records. Therefore, labeling these children to gain specific funding is not practical and may be discriminatory, based on some current testing practices.

Early intervention programs for young "at risk" children in the three to five-year-old age range are being provided through Special Education and Federal funds throughout the country. Individual states, community, and/or private resources, sometimes in collaborative efforts, are providing additional early intervention programs for these children. When children prenatally exposed to drugs enter our preschool classes, effective intervention strategies must attempt to counteract prenatal risk factors and stressful life events. The protective and facilitative factors that need to be built into each classroom, outlined by the Los Angeles City Schools PED program, are similar to those found in any good preschool program; however, these program elements are essential (not optional) for children that are more vulnerable due to their prenatal exposure to drugs. Teachers should be instructed to expect that children prenatally exposed to drugs <u>will</u> be present in their classrooms, even though they may not know who they are.

The most effective pre-school programs maintain a pupil-adult ratio of no more than 1:8 for children ages 3 and 4, and 1:10 for 5-year-olds; more adults are needed if the children are diagnosed to have more serious needs. Mainstreamed approaches for young handicapped children are highly desirable because of the positive role modeling and cooperative learning opportunities available, but not all school districts have the resources to provide these approaches. A developmentally appropriate curriculum, as outlined by the National Association for the Education of Young Children (NAEYC), is essential, and many good programs are available to schools. A strong parent involvement program, health services, and support services (school psychologist, school social work, guidance) need to be established. Some additional inservice training may be necessary for preschool teachers to maximize the effectiveness of the program.

There are two Federal Programs that currently provide effective services for young "at risk" children: Head Start, and Chapter One. This year the Hillsborough School District will have five (5) pilot Chapter One schools with kindergarten and primary class size reduced to 20 to 1 and extra support services offered to students; the following year there will be approximately 13 schools. Kindergarten and state funded pre-kindergarten classes will be included in the additional services that come from Chapter One. Federal programs, such as the two mentioned, are currently working with "at risk" children, and teachers are seeking help to be more effective with children who may be prenatally exposed to drugs.

Even though the State of Florida is funding excellent pre-kindergarten programs to serve a population similar to Head Start, and in many districts

these programs work together cooperatively, not all "at risk" three-to-five-year-olds who wish to enroll can be accommodated. Special education programs serving the same three-to-five-year-old age level will effectively address the needs of children who specifically meet criteria for handicapping conditions. Some children prenatally exposed to drugs will be served in this special education group, some in pre-kindergarten or Head Start classes, some in the private sector; however, some will not be served at all. We have insufficient data to determine the percentages of children who will qualify for special education services. Published estimates indicate that from 41 to 52 percent of children prenatally exposed to drugs require such services. Personally, I believe these estimates are grossly inflated, even when those children needing speech and language therapy are included. Although preschool special education programs appear to increase as the number of identified children increases, this is not so with programs that target the "at risk" population. Because of the availability of funds, it is reasonable to predict that school districts will want to place children prenatally exposed to drugs in these classes, but some of these children may not meet the criteria for a handicapping condition.

At the present time, school districts are designing their service delivery models for the Infant/Toddler population under the PL 99-457 mandates for services to children 0 - 2 years of age. In states that have elected to serve only a handicapped population, it is likely that only the most serious substance exposed newborns/children will be eligible for services. The potentially largest group of infants/children who are "at risk" from

prenatal drug exposure in the 0 - 2 years of age range may not have intervention services available to them, and this is the group with whom we can make a significant difference.

In summary, as children prenatally exposed to drugs enter school, the federal government needs to be interested in and responsive to the problems that school districts are facing. Holding hearings, such as today's, conveys that interest to school districts. Based on our own informal observations, early intervention services have the potential for being as successful with drug-exposed children as they have been with previous "at risk" populations. Therefore, special emphasis should be placed upon providing opportunities for these children to enroll in preschool settings, such as Head Start. Grants need to be made available through regular education sources for school districts to conduct research and expand teacher training efforts. Looking at existing school programs, adopting some new strategies or practices, and collecting data on these children is preferable to establishing new programs, other than for experimental purposes. I hope this committee will revisit this problem of school interventions for drug exposed children again in the near future as more research data becomes available.

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Mr. RANGEL. Thank you.

Mr. Owens.

Mr. OWENS. First, Mr. Chairman, let me congratulate the committee on inviting Dr. Charlie Knight, who is a very seasoned educator and superintendent in a very difficult school district out there. And I think Dr. Knight has attended education brain trusts for most of the last 8 years that I've been conducting each fall.

So welcome, Dr. Knight.

You say your proposed program would cost approximately $12,000 per child per year?

Dr. KNIGHT. Yes.

Mr. OWENS. After you utilize county agency resources, total costs would be approximately $8,000 per child per year? Are you saying that the total cost is $12,000, but if you got cooperation from the county, those in-kind services would reduce it to $8,000?

Dr. KNIGHT. Yes, Congressman. What we are simply saying is that we recognize the fact that there are limited resources, and we don't envision seeing additional new dollars. We are encouraging all agencies that have earmarked or targeted funds in their budgets to form collaboratives with other agencies to see if we can focus with some continuity and some unity on this problem.

And so what we have suggested is that—let's tap into child protective services which have earmarked funds in its budget. Let's tap into the health department which has funds in its budget. Let's also encourage or insist that the school district, with some of its title money, the ECIA chapter 1 moneys, the bilingual moneys—chapter 7. Somehow take all of these, as many of these funds as possible, pool them, and by forming these collaboratives we can reduce the high cost to a figure that we can live with.

After getting the involvement of both of those organizations and then going to the State Department, which has State and Federal child care funds, and tapping into that.

We have just about reduced that amount per child to approximately $2,000, and with the support of the district and foundations in our area, and the support of our Congressmen Lantos and Campbell who have interceded on our behalf to foundations, we have been able to put together a program that is very successful, been going on for some 2 years now, for 44 youngsters, and about 27 mothers who are actively involved in the program.

And with these supports, the program is implementable and it is certainly very, very helpful, particularly as we approach this and we're fortunate enough to get an OSAP grant of some $200,000.

Mr. OWENS. How does the cost per child in the program compare to the cost per child in the normal school setup?

Dr. KNIGHT. The revenue limit per child in California, the average is very low nationally. It's only $3,200 per child for our State. In my school district, it's close to about that amount—$3,200. So the comparison is about a third of the cost of what it costs for us to educate a regular child in a regular classroom.

Mr. OWENS. Dr. Powell, what kind of cost does a program like yours incur?

Dr. POWELL. Well, our entire project costs $425,000 to implement. But that is because we also budgeted in that cost all of the salaries for the multidisciplinary team, and we were hiring all new staff.

But our project is a regular education project, which is supported by having a multidisciplinary team.

So we don't incur the types of costs that you would by putting children in segregated programs. Our children are part of the regular program, and we just bring those supports to them so that these children have an opportunity to experience their educational programming within the confines of the mainstream or the regular environment.

Only if the child's—the degree of severity was such that they needed to be excluded would we refer our children out for special ed.

Now, that's a little different than some of the other projects. For example, in Los Angeles, the project at the Salvern School was initially designed to put eight children in a special education environment, and they had to code those children.

But when our associate superintendent went out to California and met with them, they indicated that if they could do it again, that they would not have these children in special ed; that they would try to look at full inclusion because that's what we're really—where we are really moving in terms of special education. We are now trying to fully include children with disabilities so that they can participate with their nondisabled peers.

So I think that if we look at models that will allow us to fully integrate children, we're going to find that it's more cost-effective. Otherwise, what's going to happen is that we're going to end up with two separate school systems. A completely special ed school system and a completely regular ed school system.

Or down the line when these children are reaching adolescence, we're going to have to deal with the costs for a lot of just remedial and compensatory education.

I think that what we're seeing with our children is that when you go in, and when our observers who were blind to who these children were, went in and began to code the behaviors on regular intervals, after a period of maturation—because, of course, when, you know, children get older and they learn based on what's in their environment, it is difficult to obviously identify which children were substance-exposed and which children were not. We're talking about 3-, 4-, and 5-year old children.

Mr. OWENS. How many children are there in your program?

Dr. POWELL. Right now, we have 30 children in our program, and we have just finished identifying 60. So we will have 60 when we go into next school year.

Mr. OWENS. The cost per year is how much?

Dr. POWELL. The initial cost was $425,000. We will actually be running at that cost for next year, yes.

We also provide transportation for our children who are exposed. We bring them to the schools. We have locations in each of the four quadrants of the district.

Mr. OWENS. So next year you will have 60 children at a cost of $425,000 for the overall program?

Dr. POWELL. Yes. And also, one of the things that we have been able to do is to get some in-kind support from other agencies, and that's been very, very helpful because I think that just as they have out in Palo Alto began to look at this as a collaborative proc-

ess, we have also looked at this as a collaborative issue in which we have to have shared vision and shared problem solving, and we have to all have equal ownership for the education of these children because they are going to pass through all of the system.

And if we can get these children when they first come into the schoolhouse doors, then as was stated by the superintendent, we won't have to look at these children in terms of supporting them perhaps in prison systems and in other types of agencies because we're getting them when they're young and when they're fresh and when they want to be there.

And we're also finding that parents, even though some of them are denying that they have used substances, we're finding that the parents are now becoming more and more attached to what's going on and are taking ownership and responsibility, and I think that that was a question that was raised in an earlier panel presentation in terms of responsibility.

Mr. OWENS. Thank you.

Thank you, Mr. Chairman.

Mr. RANGEL. Mr. Clinger.

Mr. CLINGER. Thank you, Mr. Chairman.

Just following up on that—what sort of emphasis do you think should be given to parent counseling? And I'm interested to hear you say that you're finding some of the parents were being more receptive to that kind of counseling. But isn't that the important part of this overall process?

Dr. POWELL. Yes, it is. We looked at parent training in a couple of ways. One, our clinical psychologist runs our parent groups, and our clinical social worker also assists in that process. And when we met with our parents, we asked them what they would like to do in the groups because we wanted them to take ownership. And they identified what their agenda would be, and they began to look at issues that centered on, how do we really work with our children?

We had some parents that had needs that were beyond just the needs of their children, and we're able to go out in our home-based intervention and to do consultation with them. But also because we work collaboratively with other agencies, we can refer them to mental health counseling here within the District, to the degree that that is necessary.

By having a clinical psychologist, we can also do play therapy with some of the children who have seen a lot of things in their early lifetime and have problems in dealing with that. So we do provide counseling. We provide peer-mediated counseling in which the parents can work with each other and problem solve together, and we're able to provide more of a lay counseling by having our educators be responsible for some of the groups that we run with our parents.

So we look at it as a totally collaborative effort in which a multiplicity of disciplines are sharing expertise. And one of those groups that's an expert are parents, and we try to recognize the parents as being experts because the bottom line in all of this is empowerment and you want to empower your parents to be able to be the advocates for their children and to not be just responsive to a system.

I think, you know, one of the problems when you look at the psychological research in terms of learned helplessness, you have a lot of people that are always in a receptive mode and never in a proactive mode, and we like it when our parents come in and say, "Well, I want this done for my child," or "I'd like to see something happen like this."

What we have seen in terms of the course of our project is not only have our children matured, but so have our parents. And I think a lot of that has to do with the fact that we're working with parents that not only are parents of children that have been exposed but parents who have not, so we have parents who work to support parents. And we talk about something that we all have in common, and that's our children.

Mr. CLINGER. Ms. Delapenha, I wish you could amplify a little bit on the need for teacher training. I mean, as I understand, we have 15 percent of children who have been affected by this problem who need to be in special education programs. But are they any different than other children who need to be in special education programs? If they are autistic, are they different from other autistic children?

And, likewise, the other 85 percent who presumably you're talking about mainstreaming, how are they different? In other words, why do we need to have special training for those particular people if they, in fact, are no different than their particular peer group?

Ms. DELAPENHA. I think sometimes perception becomes a reality for teachers. I agree with you. I don't know that the differences are that great, but if a teacher thinks that she cannot manage these children from everything she's read and that she is going to need some strategies to do it, then before she's going to feel that she's going to be successful, we need to provide that for her. In fact, a lot of our training is empowerment of the teacher.

We're saying, "You know, you've been a teacher for 10, 20 years. You've had a lot of successes. You're going to find that a lot of the techniques you use with difficult children are going to work with these children just as well.

"But let us give you some suggestions on structuring your classroom because it appears that some of these children may be a little more active and they may be coming from homes that are disorganized because they may be coming from homes that used drugs. So let's help you organize your class a little better than you've done, and let's talk about the schedule that you need to do that's good for all kids. But if you have some disorganized kids, and maybe you might have some drug-exposed children, these things will work for them too."

What happens is that you give the teacher some tools, and she goes back and she does it and she finds that it helps her control her entire class. It helps her feel that she's more effective, and we're basing this on feedback. A lot of this work is not research-based, typically on these children.

I agree that the differences are not that great from what we know now. But if the teachers think the differences are great, and they think they can't do it, then we need to help them along that process so that they feel they can. They get in and they see for

themselves, "Gee, there really isn't that much difference. I can do it."

Mr. COUGHLIN. Thank you.

Mr. RANGEL. Mr. Payne.

Mr. PAYNE. Thank you, Mr. Chairman.

It's in regard to the question of having all children now in the classroom. Many times people feel that to have children with special needs in the classroom with other children tends to bring down the overall quality of the education experience for all. In other words, brings the level down.

What has been your experience with having the integration of the children with special needs with other children? You were saying that people mature more when they help one another. Do you think that the level of learning is diluted at all with that situation?

Dr. POWELL. Well, one of the things that we do in our project is before we actually put any children in the classrooms, we talk at the schools where the projects are housed, and we say to them, "We're opening up a new classroom. And in this classroom we will have some children who have some risk factors. And some of these risk factors may include things like exposure to lead-based paint, perhaps a child who was born prematurely. Some of the children may have been prenatally exposed, and some of the children may have some developmental learning problems as well as children that may not have any of these problems because this is a regular program for children."

So we tell parents that we're going to have a program that will have some children with risk factors, but we also talk to them about the supports that will be placed in that classroom for every single child in that classroom.

What we're finding is that we have more parents who want their children in these classrooms once they visit the classrooms than we have space to accommodate. We have reconfigured our space so we have lofts in our classrooms. We have small study carrel areas. The classrooms are just absolutely beautifully child-centered. They are developmentally appropriate.

There are spaces where children can actually have some control over their environment and navigate in that environment and really explore. It's designed for hands-on learning.

We have a full-time aide in the classroom, along with the teacher. And because we have the related services—we have a speech language interventionist who can do whole language with all of the children. We have contracted with the Suzuki violin people to come in and give our children lessons in the Suzuki violin, and that involves using parents as well as children.

So when you think about all the wonderful things and all the wonderful resources that you get in this classroom, parents are dying to have their children there.

We in the District of Columbia have really embarked on a whole early childhood collaborative to develop model environments for young children. And a part of the model environment concept is to have multiage level settings.

So this is no different than any other type of classroom for young children that we have here. We have Montessori classrooms. We

have our multiage classrooms, and we have our model preschool demonstration sites.

So what we have done is to include these children in classrooms where other children might be, and I think by doing it this way there is no one who is singled out. And when you have a multilevel, multiage level classroom, you have an opportunity to stay with your teacher for more than 1 year. You have an opportunity to develop that nurturing relationship. And if you haven't had a mother, or your mother is there this week, and she's gone for the next 4, you have someone that you can depend on.

What I find when I go into the classroom, and I visit the classrooms quite regularly, is that the kids are really glad to see me because they know me. And not only do the 5 kids that are prenatally exposed jump on my back and want a piggyback ride, so do the other 10. Kids are kids. And some of them have different needs, but they're children first.

Dr. KNIGHT. Mr. Payne, our program isolates the youngsters but only for a small period of time. We start at birth with the youngsters, and then we assist those youngsters with varying instructional strategies so that those youngsters will be better prepared when they are integrated into the larger school setting.

We take our youngsters from birth, keep them in a regular child development center where they're integrated with the regular children. Then, we provide training for our kindergarten teachers so that they won't perceive these youngsters as being monsters and thus have that kind of concept direct their instruction.

We are working very carefully with the other agencies like the mental health development who could provide clinical psychologists because school districts can't afford that. Through these collaborations that we are using, we are able to get services that normally these children would not have. Having a clinical psychologist or a psychiatrist working with the youngsters, having a trained counselor and a drug counselor for the parents and particularly the mothers, having something to work with the grandparents who have a different kind of problem with these youngsters, and then having the school board of East Palo Alto and the city say that we are going to rally around this so that we can ensure that when these youngsters enter the public schools, they will enter school on par. We have enough data to ensure that through early intervention, that we will be able to produce the kind of youngster that will have a better chance of succeeding in the public schools.

Mr. PAYNE. Just one last kind of reality of the problem. You know, in special education in a lot of school districts, you get additional funds if a child is identified. For example, if you attempt to not identify the child or not label the child, the difficulty then of losing State aid, for example, becomes a factor in this.

The mayor, you know, sitting next to you and having to get a municipal budget, which I guess a portion of it has to go to the educational system.

You would integrate, but do you get the same dollars from the State because the child is a classified child, or not?

Dr. KNIGHT. Unfortunately, special education is not fully funded. It is already encroaching in my district on the general budget be-

cause it is not fully funded. What we are saying is that we can prevent the high cost of special ed through early intervention.

I must add also that 85 percent that we have been bantering around here will not have a smooth transition into public schools unless there is early intervention. The 85 percent will turn out to be youngsters that are hard to teach and teachers that are not prepared to do it. We do need staff development funds to train those teachers.

But on the other hand, we are saying that because special ed is currently encroaching on the general fund, that we need to limit the number of youngsters that we are identifying in special ed.

We feel, too, that these youngsters, not special ed kids—truly, there may be close to between 10 to 15 percent of it, but it's been my experience that most of these youngsters have normal or above average intelligence and that these youngsters, given an opportunity to receive good training and formal routines, that they will not be in special ed. And, therefore, there will be no need to be asking for additional special ed funds.

Dr. POWELL. I couldn't agree with you more. Years ago, I taught on a number of levels, but I took an experiment down in elementary school for 3 or 4 years, and used to take the so-called "hard to handle." You know, they were calling them special ed at that time. Of course, many, many, many years ago. I was young.

The youngsters, once they got in the classroom and the type of classroom that we had, tended actually to be really—there was really no difference in them, their ability to learn. We had no behavior problem.

We found that these labels that have followed youngsters, some of them were at the verge of being sent to, you know, placement in reformatory-type schools. Many of these youngsters just were as normal—I guess there was just a little tension or something, but they tended to move right along with the rest of the class, and that's all—unless there was something wrong with all the rest.

They did tend to perform, and so I couldn't agree with you more. The more you normalize the system, I think the more you'll find that there are less differences, and a lot of times we stigmatize the youngsters to make a big difference.

Thank you, Mr. Chairman.

Mr. RANGEL. I get the impression that the problem may not necessarily be the needs of the child but the needs of the teachers. I don't understand why, Ms. Delapenha, teachers have not collectively screamed out for help.

If doctors were losing patients like schools are losing students, they'd be charged with malpractice. If lawyers were practicing law the way they used to practice in the 1920's and 1930's and did not keep up with changing social and economic trends, they'd lose their licenses.

I get the impression that because students entering the classroom do not necessarily respond to the same type of training as the students of 10 or 20 years ago, that the teachers must now get special training in how to handle this problem.

Why is this not considered a part of regular teacher training, if indeed there are indications that the old training isn't working?

Ms. DELAPENHA. Why isn't it offered in actual teacher training?

Mr. RANGEL. No.

Ms. DELAPENHA. Is that the question? Which I think it should be.

Mr. RANGEL. No. No.

Ms. DELAPENHA. In the universities and——

Mr. RANGEL. That may be a simple way to put it. But employees normally know what they need.

Ms. DELAPENHA. Right. That's what we're doing in my district.

Mr. RANGEL. And this is what they would say, "I need this."

Ms. DELAPENHA. Right.

Mr. RANGEL. I mean a doctor would not walk into a hospital if he or she didn't have the supportive services that he or she needed in order to do the profession. They would say, "I'm violating my oath."

I assume there's a similar standard of professionalism in teaching (notwithstanding the fact that principals are reaching for early retirement based on contractual arrangements that have been made in order to cut costs).

I think it's the pride of teaching that would lead one to say, "It's not like it used to be, Mom, when you were teaching."

Ms. DELAPENHA. Right.

Mr. RANGEL. I don't hear that teacher training is keeping up with changes in students.

Ms. DELAPENHA. I think what I'm hearing from teachers who have been teaching 20 years is that they've been real successful. But they've noticed, let's say maybe over the last 5 years, and they'll tell me, "You know, it used to be when I taught, there were maybe only one or two children I thought I wasn't reaching in my classroom at the end of the year. Now I feel like maybe there are five that I'm not doing the best possible job that I feel I should do." And these are good teachers because they're very conscientious.

Mr. RANGEL. Well, in my district, those schools are called "highly effective," if only five kids were not reached. We would call that a "gifted and talented" school.

I'm talking about the schools where you know that half the students aren't going to graduate. The teachers know it. What's left of the parent structure knows it. And it seems like the mayors ought to know that these kids are coming out of the schools. You're going to have to pay more for them. They're inclined to get into trouble. They're inclined to go to jail, and the jail budget per capita is much higher than the school budget.

So someone gets in a room and brings in all of the forces they have—the judges, the prosecutors, the wardens, the police, and the teachers. And then someone should ask teachers, "Why are all these kids dropping out?" The teacher will say, "Because I don't have the tools to work with," and then some economist says, "That educational system is costing us a lot of money."

And then we don't have the special schools except as the communities have special needs. So if a kid comes in and the teacher finds out that the kid has been living in the street, that's a special need. That's one of those kids that's not going to be reached unless somebody comes up with some answer as to how the kid can get a meal, can wash, and have someone assist him or her with the work.

Dr. KNIGHT. Mr. Chairman, our problem in this area is twofold. First, the institutions that train teachers somehow or another have not recognized that there is a problem.

Second, the teachers who we would refer to as "experienced teachers" have not been trained to identify this new type student that we are having to train the student with special needs.

And so what we are attempting to do is, one, work with the college or university to be sure that if there is teacher training and practice teaching, that these teachers be assigned to some of the inner cities. There seems to be a reluctance for teacher training institutions to place a number of these teachers in inner cities.

Second, the seasoned teacher or the experienced teacher that we have to deal with needs staff development because they don't know the difference when they have 33 children who they've been told by test scores that they're all operating below the 50th percentile, and that they are most—90 percent of them are qualifying for special ed, or some form of special service from title 1 or chapter 1, or bilingual.

And when they get 33 in a classroom, and then exacerbate that situation with a youngster who comes in who is completely disoriented, or youngsters that no one has told to identify as a youngster with special needs except to put a global label on them and call them at risk.

And so what we are saying is that we have to prepare the teachers to, one, identify these youngsters early on, and for us then to develop some strategies that will be applied to the instructional program as opposed to doing what we have been doing. And that is, if they deviate from the norm, we put a label on them, have them tested for special ed, and then they become not only an at-risk child but also a high cost at-risk child.

Mr. RANGEL. Dr. Knight, I can't disagree with anything that you've said except I was trying to lean more toward what Dr. Powell was saying, that more and more of our kids don't need "special ed." They just need some "ed." And the problem is identifying how to transmit what you know to this child.

Now, if the child starts calling you a gang of names that may be endearing terms at his home that you may think is the height of profanity, one might be offended, hurt, or just get angry, but the kid was only communicating the best way he or she knew how.

Certainly kids I see in the supermarket that make their mothers angry—and I guess they assume their mothers love them—get called some names that I've yet to be called in the Army.

And the question really has to be, what does it take for a teacher to understand when he or she gets that assignment—it may not be a combat assignment—but it's not one of these Andy Hardy movies either. He or she should not fall apart but say, "This must have been what the child was talking about." And not just run off to the teachers' room and fall apart.

Now, some of these kids are extremely bright. At least when I see them in court, they pull their act together to avoid jail. I mean, they are extremely shrewd, some that fall out of school and get involved in drug selling.

As a matter of fact, this morning we were in Lorton Penitentiary, and there was no way in the world that these youngsters could

have gotten that articulate in 18 months. They went into the jail slick, and they conned the whole congressional committee this morning. [Laughter.]

Had my Republican friends crying with compassion because they found Jesus and everybody else. [Laughter.]

These are smart people in jail.

And I guess what I'm saying is that, knowing how everyone takes such deep-seated pride in their professions, teachers must learn how to bring out the intelligence of drug-exposed children.

You know, doctors go on strike now. At least in my community they strike for better resources. They're not going to let those people die on their watch unless they get more nurses and more people, and I'm with them, you know, as long as I'm certain that I've got another hospital to take care of those patients.

It makes sense that they would identify professionally with the needs of my community instead of closing their eyes to the blatant double standard that they have in the medical profession.

And I get awards from teachers. I talk with them. They get angry with me. But I would not tolerate to be taught how to teach in the manner in which our professional teachers are being taught. And then to send them to Newark. I mean, it's just not fair. And you can get your Ph.D. from Columbia and go to Newark, and you'd have a problem. Why can't teachers get together at conferences and say that things have changed and, "We demand to be trained to deal with those changes so that the kids could graduate and go."

Dr. Powell.

Dr. POWELL. I guess I'm chomping at the bit over here. I wanted to say to you because I do work in one of the universities here in terms of preservice, is that I find that many times the new teachers are so very naive.

And having had experiences working in corrections and with the emotionally disturbed in the LD population for a long period of time, I think that, you know, it is somewhat simplistic the way in which sometimes the institutions of higher education prepare young teachers.

And as Dr. Knight said, having a practicum placement in the urban area is a very unique opportunity.

Mr. RANGEL. What is that?

Dr. POWELL. Having a practicum placement. You very rarely find your institutions putting your student teachers in the urban areas where you really see a multiplicity of needs in children.

And oftentimes what happens is when you hire the teacher, they have been in a suburban community where everything has been available, and the children do sit quietly in their seats, and there are blinds, and there's no acoustical tile falling from the ceiling, and no parents are really irate.

I think that one of the things that we really have to look at in terms of funding is looking at our preservice teacher training, as well as in-service because you have to teach teachers. And one of the things I always tell the teachers that I work with is that, "You are not a teacher. You are a social worker. You may be a physician because you will be bandaging knees and skinned arms. You will be doing therapy with families. You will be doing intervention. You

may have to work sometimes as a police officer. You'll be educating, but you'll be doing all of these things."

You don't have one job anymore when you become an educator. You don't work from 9 to 3. You work for 24 hours, and you should welcome people calling your home.

I think that you have to teach new teachers about the resources that are out there in the community, and you have to teach them about different strategies, as Dr. Knight talked about, but you also have to teach them that they have to document and maintain records, and that teaching is a dynamic process. It's not static.

I think that you have a lot of people who went through formal educational training in which they learned a lot of good things, but the problem was in the practical application in the real world.

And I think now when my colleagues call me from Gaithersburg and way down in southern Maryland with the similar types of problems that we're having here in the District, is that it has changed dramatically, and you really have to be flexible enough to change with those times.

And I think that just in terms of the training institutions, they need a little shake here and there to look at the way in which they're delivering the programs because the children that we're educating now have very, very different needs.

The only thing that is the same is that they are—and I will always maintain this—children first. I think it's just the way that we go about it that has to be shifted.

Mr. RANGEL. Dr. Powell, I'm assuming that teachers are educated enough to know that they need special help. And so you can find the first group being naive.

I mean, this has been going on for a long, long time. And it would seem like those who evaluate the system—its successes, its failures in areas where teachers do need different types of training—that it shouldn't be politicians suggesting that they ought to spend more time in inner city schools and pretraining, or that maybe recruiting should be done from the very communities in which they need these types of informed teachers.

And I think that Ms. Delapenha really hit on it when she said, "Teachers don't know how to ask." It's almost like it's an omission that you don't know and that you're not supposed to say anything.

Ms. DELAPENHA. I didn't mean it in that way. I meant that they see themselves——

Mr. RANGEL. I know you didn't, but it came the closest to the way I see it.

Ms. DELAPENHA. OK. They see themselves as individuals——

Mr. RANGEL. Lawyers don't say, "I don't know anything about that kind of law." They say, "That's all I specialize in," and then they go and get some books and try to find out what the law is because lawyers can't say, "I haven't the slightest idea what the law is on that subject."

Ms. DELAPENHA. Well, the teachers are saying, "Give me some materials. Give me something I can read, something I can use." But they're not——

Mr. RANGEL. They say it to you?

Ms. DELAPENHA. They say it to me. And they say, "Please mail me things that I can use."

Mr. RANGEL. They don't say it to the dean of education at the universities.

Ms. DELAPENHA. No, they don't.

Mr. RANGEL. They don't say it to the presidents of the labor unions.

Ms. DELAPENHA. They don't.

Mr. RANGEL. They don't say it to the mayor, that I could do a better job if I was trained better.

Ms. DELAPENHA. No, they don't say that.

Mr. RANGEL. They're special people.

Dr. KNIGHT. Mr. Rangel, your point is well taken. However, you know, when you have—when you're in a situation like this, it's like having the flu. In defense of teachers, they hurt all over, and so sometimes they don't know to ask for special services for this youngster because they don't know how to identify this youngster.

Unfortunately, had it not been for the media, this problem of the drug-exposed youngsters would not have been illuminated. Because if you look at the programs, at the education conferences, if you look at programs that were for administrators—I go to a superintendent conference each year, I go to several other national administrative conferences—and I would defy anybody to find anything on that agenda addressing this child.

Now, it could be that those of us who are in inner cities, and those of us who are urban superintendents, are not illuminating this problem and providing the kind of leadership we need to provide in order to keep that before the public, keep that before the teacher training institution, and say to our teachers by our leadership that, "You are expected to meet the special needs of these children in the inner city. And we are going to provide those services."

I think that's the reason that we all are here to say, "Congress, could you—the policymakers—find some way of including in the directives that go out to these various funding sources, to say that you must have spent some of this money in the inner city," or that at least as you are addressing this problem, that—look at where the funds are going.

I defy anybody to say you're not providing enough money, and I would hate to, being the superintendent, to go on record as saying that. But as I look at where the money is being spent, the money is being spent on various programs, but very little services.

And so when we ask you for additional funds for staff development, we are saying, "We think that we can fix this situation with a new teacher. We think that we can do something about the seasoned teacher that is returning to school."

All we need are some additional resources so that, one, we can get them out of that classroom. And not try to provide this fix-all system after school, after 3. We're saying that let's get them fresh in the morning, and we cannot do this without resources. And I think that's what we are saying.

We're saying that we agree with you. Teachers ought to be able to say that they're empowered themselves. They see the problem, and they want to go and do something and prepare themselves to do a better job. Unfortunately, that is not reality, and so we are

just trying to stimulate that interest and that teacher improving her abilities to work with these special needs children.

Dr. POWELL. Mr. Chairman.

Mr. RANGEL. I knew I should have known better than to tangle with a teacher, much less a superintendent.

Dr. POWELL. Mr. Chairman.

If you have a second. You know, just looking at sports, you know, we see that there are sports teams in certain school districts that for the last 30 years have had winning teams.

Now, somehow the coaches are able to learn how to keep up with the new techniques. You know, you have shorter, smaller, quicker wide receivers than you used to. You don't use the old single wing like they used to use the T-formation.

What I'm saying is they would keep up in that area, but you don't seem to be able to keep up with the other—the other changes. I think that the chairman certainly is putting his finger right on it that the teacher training schools really need to take a look at what they're teaching.

You know, I heard a fellow say the other day that he had a good friend who was very sick. He had pneumonia. And he sent the fellow a get well card. The fellow was at home, you know, and the fellow appreciated the get well card but he said he needed a Blue Cross card so he could get into the hospital to get well. So, I mean, it's similar to that.

We need to really provide what's needed, you know. While he appreciated the get well card, that really wasn't the substance that he needed to get well.

So I think we need to really take a look at our teacher colleges. Fortunately, I did my practice teaching in the tough—so-called tough school, and, you know, it really worked out well. Of course, I went to one that was worse than that as a kid, so it wasn't, you know, tough.

But I just think that we need to really get more involved in the teacher training aspect, having exposure to like—not necessarily the Boyz in the Hood, but, you know, something in between perhaps where you could at least expect to know what you're going to encounter as an educator.

Dr. KNIGHT. In the meantime, while these institutions are catching up, we are going to utilize some of the strategies as used by the various teams because they use coaching. We use derogatory terms like "development." They don't develop players. They provide good coaching.

And so what we may have to do until such time that we receive the kind of product that we need to teach youngsters, is to employ some of those strategies that are used by the various teams. And just watching the Bulls play this year, I learned a great deal about strategy and how you assess, and you strategize, and you come up with another play.

And in order to be sure that these children are successful, we're going to have to employ some of those techniques.

Mr. RANGEL. Dr. Knight, I think we've reached each other. And if we can just use your talents to help us to articulate exactly what you've said—because this special challenge is not unique to the schools. It will relate even to the drug treatment center. You don't

take some ignorant person that's addicted to a drug, make them drug free, and then kick them out.

Dr. KNIGHT. That's right.

Mr. RANGEL. That person needs more. You would not condemn the doctor merely because the patient was discharged. The doctor would say, "There has to be an aftercare program."

And so while we are targeting this child that's been exposed to drugs, you and I and our entire panel know that these entire communities have such deep-seated problems that drugs are almost attracted to the problems.

If that teacher were in a position to demand of the mayors and the politicians all that he or she needs for the classroom, we wouldn't have the teenage pregnancy with the addiction to drugs in the first place.

And I just feel that we shouldn't ask a teacher to be a social worker, a drug counselor, a police person, a mother, and a father. We should have that person trained to identify what that school needs if it's going to function, and then we have to come in and make certain that we pay nearly as much attention to the school system as we're prepared to spend for maximum security prisons.

And this panel, I hope, will keep in touch with each other, and certainly with this committee, and with other things that Major Owens is doing, the Congressional Black Caucus on the legislative weekend is doing, because it's not going to help anyone to try to shift the blame.

What we have to really try to do is what the Attorney General has called "weed and seed," although I think he's done a lot more weeding than seeding.

But still, if you've appeared to clean out a community by putting the wrongdoers in jail, and then lockin programs that keep people out of trouble, this may be where we can start.

It means, not special schools, but schools to meet the needs of their communities. It means housing for the homeless. It means police that are sensitive as teachers would be to understand how respect runs two ways.

And if we can take our limited resources and target them, the formulas could easily be developed wherever you find the welfare, the pregnancy, the addiction, the crime, the homelessness, the poverty.

Thank you for the major contribution you made to this hearing, and most of all thank you for the patience that you've displayed at this hearing.

Dr. KNIGHT. Thank you.

Mr. RANGEL. The committee will stand adjourned subject to the call of the Chair.

[Whereupon, at 6:07 p.m., the committee was adjourned subject to the call of the Chair.]

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