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ABSTRACT

This report was developed to meet the staffing assessment requirements of the Vision 2000 program, an Arkansas effort to support a community-based service system to increase the independence, productivity, and integration of individuals with developmental disabilities. The staffing assessment portion of the program focused on three tasks: (1) determining the number and types of personnel currently providing services in the areas of developmental disabilities, mental health, education, and rehabilitation; (2) assessing the training needs of staff; and (3) assessing the training needs of families and other community members. The study utilized existing data sources, a structured interview questionnaire, and community focus groups to obtain its information. The report addresses these three questions with detailed information provided in both text and 37 tables. Major conclusions are that the lack of a collective vision of what comprises community based services obscures the focus of training; that, though training currently provided meets licensure requirements, there are several areas of concern; that training in reality receives little time or attention; and that the traditional workshop/conference approach may not be the most effective. (DB)

Vision 2000 Phase 1 Staffing Report

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Vision 2000 is a multi-year project coordinated by the Arkansas University Affiliated Program under contract with the Arkansas Governor's Developmental Disabilities Planning Council (DDPC) to develop recommendations for the optimal use of available funds, federal and state, to support a community-based service system that would increase the independence, productivity, and integration into the community of individuals with developmental disabilities.

VISION 2000
STAFFING REPORT FOR PHASE 1

Introduction

The Arkansas Governor's Developmental Disabilities Planning Council (DDPC) has funded Vision 2000, a multi-year grant ". . . to develop recommendations for the optimal use of available funds, federal and state, to support a community-based service system that would increase the independence, productivity, and integration into the community of individuals with developmental disabilities." These recommendations are to include a financial, needs (services), and staffing assessment that leads toward systems change. Specifically, the overall staffing assessment was to address the following:

1) a review of present executive, mid-management, and direct care staff in the existing service system and the need for staff development and training (including current curriculum and career development) necessary to support a community-based service system;

2) a review of how to strengthen community, family and other informal supports to meet the needs of people with developmental disabilities;

3) a projection of staffing and community and informal supports which would be needed to achieve a statewide community-based service system; and

4) recommendations for staff training and development as well as community and family education and training.

The concept of staffing when viewed in the context of inclusive communities requires significant changes in the traditional perception of human service systems toward the numbers and types of personnel needed as well as the training required. As persons with disabilities move from institutions to the community or from living in the community to becoming full ***participants*** in the community, training must be designed and implemented in significantly different ways. Both the formal and informal systems will need additional skills in order to support persons with disabilities in becoming active participants in community life, developing

relationships, determining what they want in their lives, having increasingly positive roles in community life, and developing the competencies necessary to accomplish these goals.

The concept of supports versus services and programs is also relevant to staffing issues. Taylor (1992) identifies three themes that articulate this construct. First, ". . . the central need and right of people to have a place of their own, free of discrimination based on disability, guided by personal and/or shared choices in all aspects, and separate from the provision of services. Second, ". . . the critical importance of supports, personal assistance services, and self-determination". Third, ". . . moving from the narrow view of community living-- to a broader definition of communities, community issues, and participation in all aspects of community life, which emphasizes the roles of ordinary citizens as well as the contributions made by persons with disabilities themselves."[1]

This interweaving of formal and informal supports necessitates a careful examination of what comprises "training", who are "staff", and what are the roles and responsibilities of both the formal system as well as the informal "system" of friends, neighbors, family and other community members. Traditional analysis of formal staff training needs have focused almost exclusively on the training competencies for staff in the specialized service system to enable them to fulfill specific program requirements. Training needs of staff in the generic system, as well as training needs of families, neighborhoods, community services and the general public were rarely considered or addressed. As "services" move to "individualized supports", and persons with disabilities become full community members, not only will specialized staff have significant changes in their roles and expectations, but the community itself must adopt active support roles.

[1]Taylor, S., Racino, J., & Walker, P. (1992). Inclusive community living. In W. Stainback (Eds.), *Controversial issues confronting special education: Divergent perspectives* (pp. 299-311). Boston, MA: Allyn and Bacon.

Approach

The staffing assessment portion of Vision 2000 has, in its first phase, accomplished an in-depth examination of targeted portions of both the formal and informal systems as part of meeting goals 1, 2 and 4 of the RFP. The first step in conducting this examination was convening a Staffing Subcommittee comprised of 26 members representing consumers, family members of persons with disabilities, human service agencies, health, education, higher education and direct service providers. (Appendix A contains a list of the members.)

The functions of the Staffing Subcommittee were two-fold: first, to determine which target groups might be assessed that would represent a broad array of both the formal and informal system, and second, to assist in the design of the strategies and instruments needed to assess the target groups.

Four meetings were held between December 1991 and May 1992. The focus of the initial meeting was to present an overview of Vision 2000 and engage the group in developing and fine-tuning an approach to identifying the training needs of the informal system. The second meeting examined the formal staffing approach and sampling strategies. The third and fourth meetings presented preliminary findings and allowed review and comment on various methods utilized to examine numbers and types of personnel currently employed as well as training needs.

The objectives that were essential in implementing the staffing assessment for Phase 1 included:

1) Determining the number and types of personnel currently providing services in each of the following areas: developmental disabilities, mental health, education, and rehabilitation.

2) assessing the training needs of staff; and

3) assessing the training needs of families and other community members.

For each of the three objectives, a description will be provided of the methodology employed and the findings. For Objectives 1 and 2, the methodology and findings will be presented by agency.

Methodology And Findings

Objective 1 **Numbers and Types of Personnel Employed: Division of Developmental Disabilities Services**

The number and types of personnel providing services to persons with developmental disabilities through the Division of Developmental Disabilities Services (DDS) includes two groups: first, those employed at the 6 Human Development Centers (HDCs), and second, those employed by Developmental Disabilities Services community programs who have contractual arrangements with the Division.

Information on the numbers and types of personnel employed by the HDCs was obtained through the Division of DDS. Arkansas Act 1129 of 1991 is the Appropriation Bill for personnel services and operating expenses for the Department of Human Services - Division of Developmental Disabilities Services for the biennial period ending June 30, 1993. This Act specifies 2598 positions by title and number to staff the six HDCs.

The Director of DDS and staff reviewed these positions and indicated those that would be considered "direct care" positions. These employees, by title and number are listed in Table 1.

The number of full time staff budgeted for FY '92 was 2293. The staff at the HDCs provided services to approximately 1270 individuals as of July 1, 1991 with 206 of this number, 17 years of age and under.

Information on the number and types of staff in the community programs was determined by DDS through a review of the FY 92 contracts. The data presented in Table 2 represents 96 of the 100 community programs.

The total staff employed, 1797, provide services to 1294 preschool children and 2892 adults for a total of 4168 served.

Table 1
Human Development Center Direct Care Staff Positions
Fiscal Year 1991-93

Position	Number Employed
Audiologist	2
Baker	22
Canteen Supervisor	2
Chaplain	1
Cook	27
Commissary Manager	1
Cottage Life Program Supervisor	21
Cottage Life Program Director	4
Dental Hygienist	1
DDS Counselor	15
DDS Language Development Supervisor	1
DDS Program Coordinator	27
DDS Team Leader	13
DDS Team Shift Coordinator	20
Dental Assistant	2
Dietitian	4
Equipment Operator	11
Food Service Worker	62
Habilitation/Rehab Instructor	132
Habilitation/Rehab Inst Supervisor	1
Grants Coordinator II	6
Institutional Beautician	3
Institutional Instructor II	10
Institutional Instructor I	19
Institutional Teacher Assistant	88
Institutional Instructor Supervisor	4
LPTN 1	3
LPN	135
Librarian	2
Librarian - Institution Assistant	2
Medical Technologist	3
MR Aide I	743

Table 1 (cont.)
Human Development Center Direct Care Staff Positions
Fiscal Year 1991-93

Position	Number Employed*
MR Aide I I	91
MR Aide Supervisor	64
MR Aide Trainee	292
Nurse	15
Nursing Services Unit Manager	6
Occupational Therapist	4
Occupational Therapy Assistant	1
Occupational Therapy Supervisor	1
Orthortist Aide	5
Pharmacy Assistant	2
Physical Therapy Aide	9
Physical Therapy Assistant	1
Psychological Examiner	25

*Not all positions are filled

Table 2
DDS Community Programs FY 92 Survey of Staff

Area	Administration	Direct Care
North Central Area	49	192
Northeast Area	46	157
Northwest Area	102	213
Southeast Area	85	382
Southwest Area	115	279
TOTAL	428	1369

Objective 1 (continued) **Numbers and types of personnel currently employed: Division of Mental Health**

The Division of Mental Health has a biennial appropriation for personnel services and operating expenses. In Arkansas Act 1082 of 1991, the legislature authorized 1555 employees by type and number for the Arkansas State Hospital in Little Rock, the George W. Jackson Mental Health Center in Jonesboro, the Benton Service Center and the Greater Little Rock Mental Health Center. The Division of Mental

Health reviewed these positions and determined which of these constitute "direct service" staff to individuals with mental illness. Table 3 summarizes these numbers.

Table 3
Division of Mental Health Services Direct Service Staff Positions

Position	Number Employed
Psychiatric Specialist Supervisor	4
Psychiatric Specialist	9
Psychiatrist	10
Mental Health General Physician	15
Mental Health Services Chief Psychologist	1
Psychologist Supervisor	4
DHS Nursing Services Administrator	4
Psychologist	7
Mental Health Psychologist Administrator	1
Psychology Resident	8
Senior Pharmacist	4
DHS Program Administrator	7
Mental Health Coordinator CMHC	1
Mental Health Social Work Administrator	1
Nursing Services Unit Manager	3
Nurse Supervisor	40
Pharmacist	5
Mental Health Director of Community Support Program	1
Psychological Examiner II	15
Nursing Services Specialist	7
Occupational Therapy Supervisor	2
Mental Health Director of Social Services	2
Social Worker II	16
DHS Program Coordinator	8
Nurse II	61
Occupational Therapist II	9
Social Worker I	28
Rehab Counselor III	2
Habilitation/Rehab Instructional Supervisor	7
Chaplain	1
Recreational Activity Leader Supervisor	4
Nurse I	3
Social Service Worker III	5
Rehab Counselor II	5
Social Service Worker II/Social Service Worker	14
Public Health Educator	2
LPTN Supervisor	32
Vocational Placement & Evaluation Program Coordinator	1

Table 3 (cont.)
Division of Mental Health Services Direct Service Staff Positions

Position	Number Employed
Habilitation/Rehab Instructor II	2
Psychological Intern	4
X-Ray Technician/Supervisor/X-Ray Tech II	1
Habilitation/Rehab Instructor I	16
Social Service Worker I	2
LPTN II	105
Recreational Activity Leader II	9
LPN II	33
LPTN II	105
Physical Therapy Aide	2
Mental Health Worker	163
TOTAL DIRECT SERVICE STAFF	900
TOTAL NON-DIRECT SERVICE STAFF	655
GRAND TOTAL	1555

Since not all persons receiving services from the Division of Mental Health would meet the federal definition of developmental disabilities[2], the 900 personnel noted in Table 5 would need to be prorated. Based on record review and professional judgment of the DMH, it was determined that approximately twenty-five (25) percent of the staff or 225 FTE would be providing services to persons with mental illness who meet the criteria for developmental disabilities.

The Division of Mental Health contracts with 15 Community Mental Health Centers (CMHC) to provide mental health services to children, youth and adults. Twelve CMHCs were surveyed to determine the number of staff employed providing direct services. Only 12 of the 15 were surveyed since personnel for the other centers were included in the Appropriation Bill (Act 1082) The numbers are reported in Table 4.

[2]*"A developmental disability is a severe, chronic disability which: is attributable to a mental or physical impairment or combination of mental and physical impairment, is manifested before the person attains age 22, and is likely to continue indefinitely, and results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, economic self-sufficiency, and reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of long or extended duration, and are individually planned and coordinated." (Public Law 101-496)*

Table 4
Community Mental Health Center Personnel Employed

Personnel	Full Time	Part Time
Psychiatrists	25	10
Psychologists	59	1
Masters Social Workers	88	5
Bachelors Social Workers	24	0
Registered Nurses	28	0
Licensed Psychiatric Technical Nurses	2	0
Licensed Practical Nurses	52	1
Case Managers	14	0
Habilitation/Rehabilitation Instructors	5	0
Speech/Language Pathologists	9	0
Licensed Professional Counselors	10	0
Licensed Associate Counselors	7	0
Psychological Examiners	30	1
Psychological Technicians	8	0
Youth Service Counselors	2	0
Clerical/Special Program/Administrative	60	0
TOTAL	423	18

The CMHC's also reported that approximately 25% of personnel time is spent with children, youth, and adults who meet the federal definition of developmental disabilities. Using the 25% figure, 120 staff in CMCHs provide services to persons with developmental disabilities. The estimate of 120 staff includes both full and part time employees. Any attempt to further prorate these numbers is not considered useful.

Objective 1 (continued) **Number and Types of Personnel Employed: Education**

The Arkansas Department of Education, Special Education Section annually collects information regarding the number and types of personnel providing services to students receiving special education services. These reports are submitted to the U.S. Department of Education, Office of Special Education and Rehabilitative Services. In 1990-91 2846.14 teachers provided special education services to approximately 44,337 students ages 3 - 21. Since the determination of eligibility for special education involves both an impairment and an effect on educational performance, the personnel data had to be analyzed using the numbers of special

education students who would meet the narrower federal definition of developmental disabilities. To accomplish this, the Coordinator for the Comprehensive System of Personnel Development (CSPD) and the Administrator for Compliance/State Program Development reviewed the supporting data collected and maintained at the state level and estimated the number of students served by placement that would meet the developmental disabilities criteria. Based on the numbers served by placement, the current teacher-pupil ratios were applied to provide an estimated number of teachers and the results reported in Table 5.

Table 5
Number and Types of Special Educational Personnel Currently Employed to Provide Services to Students with Developmental Disabilities

Placement		Total No. Served	No. with DD	P - T Ratio	No. Teachers Serving DD
3 - 5 Year-olds:					
Varied:	Ed.	3825	1323	1:15	88
	DDS	749	749	1:7	107
6 - 21 Year Olds:					
Regular Class		17,002	1400	1:25	35
Separate Class /Regular School		17,810	4465	1:25	179
Segregated School		5088	5088	1:8	609
Public Residential		78	78	1:8	10
Private Separate School		0	0	1:8	0
Homebound/Hospital		266	266	1:8	33
Private Residential		95	95	1:10	10
Private Residential		173	173	1:8	22
TOTAL					1093

Part III, Table 3, Part B, Education of the Handicapped Act Implementation of FAPE Requirement 1990 - 91 School Year. Section A: Educational Placement of Handicapped Children

The total number of personnel in full time equivalents (FTE) that provide services to students who meet the developmental disability criteria is approximately 38 percent of the total number of special education education teachers employed.

An analysis of types of certification required by these teachers presents a more complex issue. Arkansas Teacher Certification requirements for the provision of

special education falls into these categories: mildly handicapped, moderate, severe and profoundly handicapped, seriously emotionally disturbed, hearing impaired, visually impaired and speech pathology.

All personnel in these categories must have at least a Bachelor's degree as well as meeting specific certification requirements established by the state. Of the projected 1093 teachers (FTE) who provide services to students with developmental disabilities, the Department of Education estimates that at least 80% would have certification in the area of mildly handicapped.

In addition to special education teachers, the Arkansas Department of Education indicates the following numbers for "Other Special Education and Related Service Personnel" (see Table 6).

Table 6
Other Special Education and Related Service Personnel

Other Special Education and Related Service Personnel	FTE Employed ages 3-21
Vocational Education Teachers	21.00
Physical Education	17.40
Work Study Coordinators	6.50
Psychologists	7.59
School Social Workers	7.04
Occupational Therapists	21.20
Audiologists	3.25
Teacher Aides	936.30
Recreation Therapists	1.00
Other Diagnostic Staff	89.99
Physical Therapists	25.01
Counselors	10.14
Supervisors/Administrators	171.47
Supervisors/Administrators (SEA)	20.00
Other Professional Staff	80.51
Non-professional Staff	191.73
TOTAL	1610.49

It is assumed that the other special education and related service personnel spend a significant portion of their time providing services to students with developmental

disabilities, especially psychologists, occupational and physical therapists and teacher aides.

Objective 1 (continued) **Numbers and Types of Personnel Employed: Rehabilitative Services**

The Division of Rehabilitative Services (DRS) provides significant services to persons with developmental disabilities. DRS estimated that they served approximately 950 individuals with developmental disabilities on an annual basis. In terms of staff, DRS employs 70 rehabilitative counselors for 2591 clients. Based on this data, approximately 26 (FTE) counselors provide services to individuals with developmental disabilities.

Summary. The total numbers of personnel (FTE) that provide direct services to child, youth, and adults with developmental disabilities within the major service systems include:

Developmental Disabilities Services	
• HDCs	2019
• Community Programs	1797
Division of Mental Health	
• ASH	900
• CMHC	120
Department of Education	1093
Division of Rehabilitation Services	26
Total	**5955**

Since many of the numbers were reported in less than 1.0 FTEs, there are over 6000 personnel providing a variety of services to individuals with disabilities across the State of Arkansas.

Objective 2 **Assessing the Training Needs of Staff**

The Staffing Subcommittee assisted with the development of a questionnaire designed to assess the following elements: (a) community-based training received,

(b) community-based training needed, (c) attitude toward community-based services, (d) knowledge of what community-based means, (e) current job responsibilities (skills) that are considered community-based, (f) training needed to provide services to persons with dual diagnosis, and (g) role in provision of services to persons with dual diagnosis.

Additionally, basic descriptor data was identified including: position, number of years in the field of developmental disabilities or human services, and recruitment into the field of developmental disabilities. Questions were generally open-ended allowing the respondents freedom to include relevant details. A copy of the interview form is in Appendix B.

The structured interview questionnaire included perceived training needs, as well as questions that elicited knowledge of the community-based services, and the skills utilized to provide community-based activities. Since the community-based system is still being conceptualized, perceived training needs can be utilized to identify elements that will coincide with training requirements within the proposed system. This common point of reference is important because it builds on perceived needs rather than introducing training that the staff does not view as necessary.

The Staffing Subcommittee also recommended sampling each of the identified groups: DDS community programs, CMHC, rehabilitation counselors, HDC, and a private and public mental health residential facility. Structured interviews were conducted by UAP staff or under the direction of UAP staff. In some instances, the questionnaire was mailed to the sites, completed by the community staff and then used as a basis for a clarification interview. Preliminary data was reported at the June 9, 1992 DDPC meeting and in the Interim Report. Additional data has been collected and all data is reported in the following sections.

Objective 2 (continued) **Assessing the training needs of staff: Division of Developmental Disabilities Services**

Thirty-eight DDS community program sites were sampled. Table 7 provides an overview of the 181 respondents interviewed in DDS community programs statewide. Surveys were coded according to the following categories: administrators

and mid-management comprised the management category and the direct care category was composed of professional staff (licensed, degreed, or certificated) and paraprofessionals. Since community programs reflect a diversity of management structures, services, and job titles and functions, some variance within and among group designations may occur.

Table 7
Descriptive Information for Community Programs Respondents

Group	No. Staff	Percentage (%)	Mean Yrs. Experience	Range
Management	61	34	12	1-28
Administrators	29	16	14	1-28
Mid-Management	32	18	10	1-24
Direct Care	120	66	12	1-28
Professional Staff	52	29	9	1-25
Paraprofessionals	68	37	7	1-39
ALL STAFF	181			

One third of the staff were in management positions and two-thirds in direct care. The numbers interviewed represent over 10 percent of the total employed. A sampling of 10 percent is considered to be statistically adequate for purposes of this study. The ratio of management to direct care interviewed (33%) is also consistent with the overall employment structure (34%). It should be noted that administrators have a mean of 12 years of experience and direct care 8 years. Both of these figures suggest that many persons working in the field of developmental disabilities tend to remain in the field over an extended period of time even though frequent staff turn over in some positions was reported. This core of dedicated staff are critical in implementing a community-based system.

In response to the question, "How did you first become involved in working in the field of developmental disabilities?" those factors most frequently noted by the respondents are contained in Table 8.

Table 8
How DDS Community Program Staff Became Interested in Working in the Field of Developmental Disabilities

Group	N**	Category* AP	CC	FF	FM	HS	UN	OT
Management	58	9	10	3	5	6	14	11
Administrator	28	4	5	1	3	2	7	6
Mid-Mgmnt.	30	5	5	2	2	4	7	5
Direct Care	118	22	26	11	12	4	17	26
Professional Staff	52	9	13	1	6	4	9	10
Paraprofessionals	66	13	13	10	6	0	8	16

*Variable Key: AP-Advertised position; CC-Community contact; FF-Friend of family; FM-Family member with a disability; HS- High school experience; UN-University experience; OT-Other
**Includes only personnel responding

For administrative staff and direct care professional staff, community contacts and university experience were powerful recruiters. For direct care paraprofessionals, advertisements and community contacts were major recruitment strategies. It has been reported that contacts with persons with disabilities lead people to the field of developmental disabilities, as evidenced in reported comments (e.g., babysitting a child with special needs, neighbor had a child with Down Syndrome, my own child has a disability.)

Table 9 identifies the training in community-based services received in the last two years and the mean length in hours.

Table 9
Reported Training in Community-Based Services Received in Last 2 Years

Group	N	N Receiving Training YES (%)	NO (%)	Mean Hrs.
Management	61	79	21	39
Administrators	29	76	24	46
Mid-Mgmnt.	32	81	19	33
Direct Care	120	63	37	31
Professional Staff	52	77	23	36
Paraprofessionals	68	53	47	25

* Includes only personnel responding

Both groups reported considerable participation in community-based training. The mean hours spent (over a 2-year period) exceeds the mandatory training requirements of 12 hours per year by DDS Licensure. However, *47% of the paraprofessionals reported that they had not received community-based training* and those that had received training reported the least amount of training. This may reflect either a lack of awareness of what constitutes community-based training or the fact that the training received covered multiple topics including agency policies and procedures and center orientation as well as community-based issues.
Of those who reported receiving community-based training, the location of the training for management was local (39%) and state (49%). Direct care staff reported 37% local and 43% state. With both groups, the state level training - presumably the DDPC, CPA, Special Show Conferences, DEC, AAMR - comprised nearly half of the training received in community-based services.

Table 10
Sponsors of Community-Based Training Reported by DDS Community Program Staff in Last 2 Years (1990-92)

		Groups Providing Training*				
Group	N**	OA (%)	OC (%)	CO (%)	SA (%)	UN (%)
Management	48	11	13	20	19	1
Administrators	22	5	8	11	8	1
Mid-Mgmnt.	26	6	5	9	11	0
	76	32	19	26	19	8
Direct Care						
Professional Staff	40	15	9	11	12	5
Paraprofessionals	36	17	10	15	7	3

*Variable Key: OA-Own agency; OC-Other community agency; CO-State conference/other state entity SA-State agency; UN-University

** Includes only personnel who reported to have received community-based training.

Training conducted at state conferences or by a state agency was important for management and for direct care. Training was also sponsored locally and was conducted by the respondent's own agency personnel or another community agency. Although the immediate topics and content are pertinent, responses showed wide variance in both the location and sponsor of the training. It is probable that ongoing systematic training with on-site follow-up may not have occurred.

The respondents indicated a variety of community-based topics in which they had received training. Table 11 describes these topics.

Major topics of training for management included case management (29%), individualized plans (25%), and community integration. The most frequently reported training for direct care staff was behavior management (40%), educational and disability specific information (33%), and health issues, CPR and safety (24%). It may be relevant to note that several of the topics reported by the respondents to be community-based training may not have immediate applicability to the skills needed by staff in a community-based support network. Since *all* training may have

been reported, rather than only the community-based training, the amount of training provided specifically designed to enhance the community-based system is probably less than the total. The "Other" category was significant (40% and 30%) and contained such topics as legislation, center orientation, funding, fund raising, etc.

The *attitudes* of the DDS community program staff toward community-based services was assessed through the question, "How do you feel about the need for community-based services?" The *attitude* toward community-based services was positive. Ninety-three percent of management and 89% of direct care staff felt that community-based services were essential with less than 1% of the total opposed. Responses to this topic were diverse including statements such as "need more to prevent individual from being isolated"; "tremendous need"; "some cannot be provided services by the community"; "more and bigger facilities (workshops) are needed", "it has to be done in the community" and "persons have to be instructed in the setting where they will use the skill". It is not clear if the strongly positive attitude reflects the attitude toward present community-based services or the system of individualized supports and services based on person-centered planning that brings persons with disabilities into full citizenship in the community. A review of the actual responses tends to support the former view.

Table 11
Topics of Training Received in Last 2 Years (1990-92) by DDS Community Program Personnel

		Topics of Training Received*										
Group	N*	BM (%)	CI (%)	CM (%)	ED (%)	FM (%)	HI (%)	IP (%)	MW (%)	SC (%)	SE (%)	OT (%)
Management	48	8 (17)	11 (23)	14 (29)	9 (19)	8 (17)	6 (13)	12 (25)	7 (15)	10 (21)	1 (2)	19 (40)
Administrators	22	3 (17)	6 (29)	9 (18)	5 (23)	3 (14)	4 (18)	6 (29)	3 (14)	4 (18)	6 (29)	9 (41)
Mid-Mgmnt.	26	5 (19)	5 (19)	5 (19)	4 (15)	5 (19)	2 (8)	6 (23)	4 (15)	6 (23)	5 (19)	10 (39)
Direct Care	76	30 (40)	15 (20)	11 (14)	25 (33)	8 (11)	18 (24)	14 (18)	6 (8)	10 (13)	5 (7)	23 (30)
Professional Staff	40	11 (28)	8 (20)	5 (13)	15 (38)	5 (13)	9 (23)	7 (18)	2 (5)	10 (25)	4 (10)	11 (28)
Paraprofessionals	36	19 (53)	7 (19)	6 (17)	10 (28)	3 (8)	9 (25)	7 (19)	4 (11)	0 (0)	1 (3)	12 (33)

*Includes only personnel who reported receiving community-based training.

* BM - Behavior management
CI - Community integration/normalization
CM - Case management
ED - Educational/Age appropriate practices/Disability Specific
FM - Working with family members
HI - Health issues/CPR/Safety
IP - Individualized plans
MW - Medicaid/Medicaid waiver/Funding sources
SC - Identifying, developing, & coordinating community resources
SE - Supported employment
OT - Other (e.g., Center orientation, funding, legislation, fund raising)

Assessing the *knowledge* of staff toward community-based services was determined through the structured interview by requesting the respondents to describe community-based services in an open-ended format and then comparing these descriptions to the descriptions used by DDPC in the RFP for the community-based system*. Table 12 presents this comparison.

Of those elements indicated in the DDPC description, both management and direct care staff identified two elements most often: (1) promotes integration, and (2) meets individual needs.

The DDS community program staff consistently identified "in own community" as the major element of their description. Management also identified equal access to community resources as "an important element" while direct care staff indicated that "promotes independence" was significant. The description of community-based services was somewhat narrow and it was clear from the responses that staff did not necessarily differentiate between *community presence* and *community participation*. "Preparing for independent living", "assist clients to live in home setting", "work with corporations" and "supervise client outings" are examples of responses that illustrate that community-based descriptors do not necessarily equate with individualized supports in the community. The move from community presence to supporting participation may present a significant training need.

***DDPC - RFP Description:**

A community-based services system is one that: promotes independence, productivity, and integration into the community; is flexible and developed to meet individual needs; enables the independence of individuals by providing individualized skill development, client-centered support systems, integrated services, and equal access to community resources; develops comprehensive and coordinated services which create an environment that supports and encourages access to those services; enhances rather than inhibits the lives of persons with developmental disabilities; provides quality of life, and is cost effective.

Table 12
Description of Community-Based Services Reported by DDS Respondents Compared to Elements of DDPC Description

Group	N of Respondents Identifying Elements of DDPC Description*														
	IO	CC	CS	EA	EE	EL	FL	ID	IN	IS	IT	MI	PR	QE	QL
Management	34	1	1	7	0	0	0	2	6	2	10	9	1	0	0
Administrators	20	0	1	5	0	0	0	1	2	2	6	3	1	0	0
Mid-mgmnt.	14	1	0	2	0	0	0	1	4	0	4	6	0	0	0
Direct care	52	1	2	4	2	2	0	6	13	2	20	20	6	0	0
Professional staff	22	1	1	1	2	0	0	3	7	2	9	11	3	0	0
Paraprofessionals	30	0	1	3	0	2	0	3	6	0	11	9	3	0	0

*Variable Key:

IO - In own community
CC - Comprehensive and coordinated services
CS - Client-centered support services
EA - Equal access to community resources
EE - Environment that encourages access to services; convenient
EL - Enhances, not inhibits, lives
FL - Flexible
ID - Individualized skill development
IN - Promotes independence
IS - Integrated services
IT - Promotes integration
MI - Meets individual needs
PR - Promotes productivity (job placement; contracts)
QE - Cost-effective
QL - Quality of life

Table 13 presents the type of training staff perceived that would be useful to them to help implement a community-based system.

The consistent element of perceived training needs across both management and direct care staff was developing community support/resources. The staff recognized that both support and resources had to be available in the community and that additional skills/competencies would be required for implementation. An examination of the "Other" category revealed relevant topics such as "direct experience", "funding", "visiting other sites", and "assistive technology".

It is interesting to compare the training received (see Table 11) with the training needed (Table 13). The following comparisons are made:

	Training Received		Training Needed	
	Mgmnt.	Direct Care	Mgmnt.	Direct Care
Case Mgmnt.	29%	14%	2%	0%
Behav. Mgmnt.	17%	40%	7%	4%
S. Employment	23%	7%	4%	6%
Indiv. Plans	25%	18%	5%	4%
Service Coord.	21%	13%	28%	25%

DDS community program staff do not perceive a need for "more of the same" training, but rather are requesting training in the core area of identifying, developing, and coordinating community resources and supports. This addresses the skills needed to support individuals in becoming active participants in the community.

Staff were asked, "In your job, what types of interactions and/or responsibilities do you have with persons with disabilities served by your program and which of these activities do you consider to be community-based?" Table 14 presents the responses to this question.

Table 13
Reported Types of Training Perceived to be Needed to Implement Community-Based System by DDS Community Program Staff

		Topics of Training Received*											
Group	N*	BM (%)	CI (%)	CM (%)	ED (%)	FM (%)	HI (%)	IP (%)	MW (%)	SC (%)	SE (%)	RL (%)	OT (%)
Management	57	4 (7)	7 (12)	1 (2)	2 (4)	3 (5)	1 (2)	3 (5)	3 (5)	16 (28)	2 (4)	2 (4)	14 (25)
Administrators	26	3 (12)	4 (15)	0 (0)	0 (0)	1 (4)	1 (4)	2 (8)	3 12	5 (19)	2 (8)	1 (4)	5 (19)
Mid-Mgmnt.	31	1 (3)	3 (10)	1 (3)	2 (6)	2 (6)	0 (0)	1 (3)	0 (0)	11 (35)	0 (0)	1 (3)	9 (30)
Direct Care	114	4 (4)	12 (11)	0 (0)	8 (7)	9 (8)	3 (3)	5 (4)	2 (2)	28 (25)	6 (5)	2 (2)	18 (20)
Professional Staff	48	3 (6)	5 (10)	0 (0)	3 (6)	7 (15)	0 (0)	2 (4)	2 (4)	14 (29)	3 (6)	1 (2)	7 (15)
Paraprofessionals	65	1 (2)	7 (11)	0 (0)	5 (8)	2 (3)	3 (5)	3 (5)	0 (0)	14 (22)	3 (5)	1 (2)	13 (20)

*Includes only personnel who reported receiving community-based training.

BM - Behavior management
CI - Community integration/normalization
CM - Case management
ED - Educational/Age appropriate practices/Disability Specific
FM - Working with family members
HI - Health issues/CPR/Safety
IP - Individualized plans
MW - Medicaid/Medicaid waiver/Funding sources
SC - Identifying, developing, & coordinating community resources
SE - Supported employment
OT - Other (e.g., Center orientation, funding, legislation, fund raising)

Table 14
Responsibilities of DDS Community Program Personnel Considered to Be Community-Based

Type of Interactions	Mgmnt.* N	Admin. N	Mid-Mgmnt. N	Direct Care** N	Prof. Staff N	Paraprof. N
Coordinating Client Services	13	7	6	6	5	1
Taking People into Community	6	3	3	19	2	17
Direct Training	9	2	7	29	7	22
Health training	0	0	0	1	0	1
Facilitating Independence	1	0	1	4	3	1
Facilitating Integration	2	0	2	5	2	3
Managing Staff	4	3	1	1	1	0
Planning Activities	2	2	0	1	0	1
Individual Plan Development	5	1	4	4	1	3
Individual Plan Implementation	8	3	5	12	4	8
Working with Parents	0	0	0	3	2	1
Training Staff	4	2	2	3	3	0
Facilitating Work Skill Development	4	2	2	13	6	7
Working with Outside Groups	3	2	1	1	1	0
Helping Clients Access Community Resource	6	2	2	8	4	4
Evaluation	5	0	5	2	0	2
Other	7	5	2	12	(5	7
Unsure	0	0	0	9	2	7

Note: Numbers reflect responses

Primary community-based interactions were described by management as coordinating client services, direct training, individualized plan implementation, facilitating socialization and providing support services. Direct care staff indicated direct training, taking people into the community, providing support services and facilitating work skill development. Within the direct care staff, paraprofessionals indicated a higher number of direct support activities (i.e., taking people into the community, direct training, recreation/leisure activities, and providing support services). It is apparent that a number of the skills needed to support persons with disabilities in the community are currently being utilized by DDS community program staff. However, the utilization of many skills is within the community program/residence in terms of preparing persons for the community and/or

involves relatively time-limited experiences in the community (e.g. outings, leisure activities). Management and direct care described only 12% of their interactions as helping clients access community resources. When this is considered in the context of the training needs, it is evident that full community participation with individualized supports is still not available for all persons.

With the increasing number of persons with mental retardation also identified as having mental illness and/or significant behavioral challenges, staff were asked to indicate the type of training needed to provide supports for these individuals. Table 15 indicates the areas of training needed.

Table 15
Reported Types of Dual Diagnosis Training Needed by DDS Community Program

	Personnel*					
	MG	AD	MM	DC	PS	PP
Type of Training	N	N	N	N	N	N
Anything	4	3	1	17	6	11
Behavior Management	7	7	0	11	5	6
Characteristics Dual Diag,	8	0	8	21	13	8
Community Involvement	2	2	0	3	1	2
Communication	1	0	1	5	3	2
Coping/Stress	1	0	1	7	3	4
Activities of Daily Living	0	0	0	1	0	1
Family Involvement	2	0	2	1	0	1
Interdisciplinary Collabor.	5	2	3	1	1	0
IHP Devel/Implementation	1	1	0	2	0	2
Integration Strategies	2	1	1	2	1	1
Mental Health	10	6	4	17	4	13
None	0	0	0	4	3	1
Other	11	8	3	21	10	11
Recreation/Leisure	1	1	0	1	0	1
Referral Sources	3	1	2	4	4	0
Safety	0	0	0	1	0	1
Supported Employment	3	1	2	0	0	0
Supported Employment	3	1	2	0	0	0
Socialization	1	1	0	0	0	0
Training to Facilitate Success	0	0	0	2	1	1
Unsure	0	0	0	2	2	0
Independent Living	1	1	0	1	1	0

*MG - Management; AD - Administrators; MM - Middle Management; DC - Direct Care; PS - Professional Staff; PP - Paraprofessionals

Management and direct care staff noted the following as primary training needs: (1) behavior management (2) characteristics of dual diagnosis, and (3) mental health services. Other topics included civil commitment, cultural competency, housing, and communication skills.

The diversity of the responses including the number who indicated that "anything would be helpful" probably describes the lack of consistent appropriate training as well as the scarcity of approaches/services/supports available to persons with dual diagnosis. It is also interesting to note that behavior management was indicated as a major topic of training received by the DDS community program staff but was not indicated as a type of training needed for a community-based system. The respondents seem to be indicating that the training they had received was not readily applicable with persons with dual diagnosis/challenging behavior or that a different type of training was needed.

A limited number of personnel in HDCs were interviewed (18 in 4 HDCs). These findings will be reported when additional data being gathered as part of the Personal Description Form process is completed.

Objective 2 (continued) **Assessing Training Needs: Mental Health**

Nine CMHC sites were sampled. Table 16 provides a descriptive overview of the 37 staff interviewed.

Table 16
Descriptive Information for CMHC Respondents

Group	N	Percentage	Mean Yrs. Experience	Range
Management	9	24	20	6-36
Direct Service	28	76	10	2-25

The staff interviewed in the CMHCs are reported as management and direct services staff. The mean for years of experience of management staff was 20 years and for direct service 10 years. It should be noted that direct service staff includes 26 professional staff and 2 paraprofessional staff. The extended time spent in the field by many of the respondents indicates that a relatively solid core is available for training purposes.

In analyzing how persons became involved in the field of human services, Table 17 reflects those indicators identified by respondents.

Table 17
How CMHC Personnel Became Interested in Working in the Field of Human Services

Group	N	Category* AP	CC	FF	FM	HS	UN	OT
Management	9	1	1	1	0	0	5	1
Direct Care	28	4	3	2	2	1	8	6

*Variable Key: AP - Advertised position; CC - Community contact; FF - Friend of family; FM - Family member with a disability; HS - High school experience; UN - University experience; OT - Other

Since most persons interviewed were professionals, (both management and direct service) it is not unexpected that university experience was the most significant factor in recruitment to the field.

Table 18 identifies the number who reported receiving training about community-based services in the last two years and the amount of training received.

Table 18
Reported Training in Community-Based Services Received in Last 2 Years by CMHC Personnel

Group	N	N Receiving Training YES (%)	NO (%)	Mean Hrs.
Management	8	7 (88)	1 (12)	42
Direct Service	28	22 (79)	5 (18)	32

* Includes only personnel responding

Eighty-eight percent of the management and seventy-nine percent of direct service reported receiving community-based training. CMHC management personnel have had a mean of 42 hours of training over the past two years that was reported as community-based and direct care staff have had a mean of 36 hours. This exceeds the DMH program standard requirements (40 hours initially for paraprofessionals) and is reflective of the continuing education requirements for social workers and psychologists.

Table 19 indicates the source of the training in community-based services. It is apparent that the state agency (DMH) was responsible for a significant portion of the training offered for both groups with their own agency being a secondary provider.

Table 19
Sponsors of Community-Based Training Reported by CMHC Personnel in Last 2 Years (1990-92)

Group**	Groups Providing Training* OA	OC	SC	SA	UN
Management	3	1	0	4	0
Direct Service	8	5	3	11	1

*Variable Key: OA - Own agency; OC - Other community agency; SC- State conference/other state entity; SA - State agency; UN - University

**Includes only personnel responding.

Table 20 identifies the site of the training with management receiving training primarily at the local level and direct service staff receiving training at both the local and state level.

Table 20
Sites Where Community-Based Training was Received by CMHC Personnel in Last 2 Years (1990-92)

	Training Site		
Group	Local	State	Regional
Management	6	2	1
Direct Service	14	13	2

Table 21 describes the topics of the community-based training in which CMHC staff participated.

Table 21
Topics of Training Received in Last 2 Years (1990-92) by CMHC Personnel

	Topics of Training Received*							
Group	BM	CM	ED	FM	HI	MW	SC	OT
Management	2	3	2	0	2	0	2	7
Direct Service	9	3	6	4	2	1	10	18

*Variables
- BM - Behavior management
- CI - Community integration/normalization
- CM - Case management
- ED - Educational/Developmentally appropriate practices/Disability specific
- FM - Working with family members
- HI - Health issues/CPR/Safety
- IP - Individualized plans
- MW - Medicaid/Medicaid waiver
- SC - Identifying, developing, & coordinating community resources
- SE - Supportive employment
- OT - Other

Major training topics included training in behavior management for direct service staff as well as educational and health /safety issues. Case management was a major training piece for management. The "Other" category included stress management, drug/alcohol treatment, center orientation, and group therapy. This may indicate that *all* training was reported or that the respondents perceived that because their services were offered at a site located in the community, all training would be considered "community-based".

In all 36 interviews (one person did not respond), CMHC personnel considered community-based services essential. This is a strong affirmation of the need for these services and the commitment of CMHC to provide them. Responses included: "More important than anything if properly staffed and supported"; "Services should be provided by a professional"; "Very important as we move sicker and sicker people into the community"; and "It's important for the family to receive services where they live. Again, the specifics of the responses indicated that many of the staff felt that community-based services meant in their program or office rather than in every day settings throughout the community.

Assessing the knowledge of staff regarding community-based services was determined by comparing responses to the open-ended question "How would you describe community-based services?" to the description used by DDPC in the RFP of what elements constitute community-based services. Table 22 presents this comparison.

Table 22
Description of Community-Based Services Reported by CMHC Respondents vs. Elements of DDPC Definition

	N of Respondents Identifying Elements of Definition*								
Group	IO**	CC	CS	EA	EE	EL	IN	IT	MI
Management	8	0	1	0	0	0	0	0	1
Direct Care	19	1	1	1	2	2	1	1	4

*Variable Key:
IO - In own community
CC - Comprehensive and coordinated services
CS - Client-centered support services
EA - Equal access to community resources
EE - Environment that encourages access to services; convenient
EL - Enhances, not inhibits, lives
IN - Promotes independence
IT - Promotes integration
MI - Meets individual needs

**IO - In own community (included due to high number of responses)

Of those elements indicated in the DDPC definition/description, the element of "in own community" was the most frequently noted. Five respondents indicated "meets individual needs." The CMHC responses were narrower than the responses of the DDS community programs, probably indicating that the mental health system had less formal exposure to the various elements explicit in this concept within developmental disabilities.

Table 23 presents the type of training CMHC staff perceived that would be needed to implement a community-based system.

Table 23
Reported Types of Training Needed to Implement Community-Based Training by CMHC Personnel

Types of Training Needed	Management N = 9	Management (%)	Professional Staff N = 28	Professional Staff (%)
Behavior Management	0	0	1	3
Community-Based Instruction	0	0	3	10
Developing Community Support/Resources	4	44	8	32
Disability Specific	0	0	1	3
Working with Families	1	11	0	0
Health/Medical Issues	0	0	3	10
Supportive Employment	0	0	1	3
Supervision/Management	2	22	2	7
None	0	0	2	7
Uncertain	0	0	3	10

The major element of perceived training needed was "developing community support/resources". CMHC staff recognized the importance of both support and resources in order to have a community-based system. This parallels the responses of the DDS community programs and reinforces the need for generic as well as informal supports.

Staff were asked to describe which of their interactions/responsibilities they considered to be community-based. Table 24 reports the results of this question.

Table 24
Interactions of CMHC Personnel Reported to Be Community-Based Services

Types of Interactions	Management N = 9	%	Professional Staff N = 28	%
Coordinating Client Services	2	13	8	29
Taking People into Community	0	0	1	4
Direct Training	2	13	2	7
Facilitating Integration	1	11	0	0
Managing Staff	2	13	1	4
Individual Plan Development	1	11	1	4
Individual Plan Implementation	1	11	0	0
Working with Parents	0	0	6	24
School/Center-Based Activities	0	0	3	11
Facilitating Socialization	0	0	2	7
Providing Support Services	5	56	14	50
Supervising Clients	1	11	1	4
Training Staff	0	0	3	11
Facilitating Work Skill Development	0	0	1	4
Helping Clients Access Community Resources	0	0	10	36
Evaluation	2	13	4	14
Other	0	0	5	18

For both groups, the type of interaction described as "providing support services" comprised the majority of the responses; "coordinating client services" was the second most common type of interaction. However, from the responses, it was evident that the staff were not necessarily in the community with the individuals, but rather coordinating their mental health program with other programs.

When asked to identify the types of training required to provide support to persons with a dual diagnosis, the primary responses were a better understanding of the characteristics of dual diagnosis and referral resources. Table 25 summarized these responses.

Table 25
Reported Types of Dual Diagnosis Training
Needed by CMHC Personnel

Types of Training Needed	Management N = 9	%	Professional Staff N = 28	%
Characteristics of Dual Diagnosis	4	44	2	7
Family Involvement	0	0	1	4
Interdisciplinary Collaboration	0	0	5	18
Integration Strategies	1	11	0	0
Mental Health	1	11	0	0
Referral Sources	2	22	3	11
None	0	0	1	4
Other	4	44	8	29

It should be noted that the respondents either did not routinely provide services to persons with dual diagnosis or did not have a strong sense of what training they needed. The "Other" category included such responses as "utilize Medical Center grand rounds as inservice for MI/MR topics", "more MR specific information", "don't know", and "drug/alcohol programs and information".

Arkansas State Hospital (ASH)

A respondent pool of 7 ASH personnel participated in the structured interview activity, of which all were classified as professional staff (requiring licensure or certification). The ASH respondents had an average of 14 years experience in service delivery to persons having mental illness, with a range of 8 to 19 years.

When asked how they first became interested in working in the field of developmental disabilities, 2 reported an advertised position for employment, 3 as a result of university experiences, and 2 through some other type of experience.

The descriptions of community-based services provided by these respondents diverged from the respondents of other groups participating in the structured interview activity. Whereas most respondents in other groups identified "in own community" as a component of their definition, only 1 individual of the ASH pool identified this characteristic. "Integrated services", however, was identified by 2

respondents and 3 respondents reported that they were uncertain what the term "community-based services" meant. However, 5 respondents agreed that community-based services were essential within the service delivery system, and 6 respondents reported that they primarily functioned in a support role when interacting with adults having disabilities in their facility.

The training experiences and needs of participating ASH personnel indicated that little training had been provided in the area of community-based services. Only 2 respondents (29%) reported such training, and this had been provided by the agency or some other community agency at the local and state levels. Similarly, most respondents (71%) reported that *no training* was needed in the area of community-based services.

When asked to identify training necessary to serve persons with dual diagnosis, 3 respondents (43%) reported needs in the category of "community involvement", and 2 respondents (29%) identified "referral sources". Several respondents (29%) reported that they had no training needs in this area.

Private Mental Health (PMH) Facilities

Of the group of PMH employees (n =5) participating in the structured interview activity, *all* respondents reported roles which were classified as professional staff. The PMH respondents exhibited an average of 19 years experience in service delivery to persons having disabilities, with a range of 15 to 25 years.

When asked how they first became interested in working in the field of developmental disabilities, 1 (20%) reported an advertised position for employment, 1 (20%) as a result of family members having disabilities, 1 (20%) as a result of university experiences, and 2 (20%) through some other type of experience.

The descriptions of community-based services provided by these respondents were generally brief with most individuals (60%) reporting that these services are provided "in the community" where adults with disabilities reside. Other responces provided included more global descriptions including "formal and informal

networks" and "range of services". Community-based services were reported to be essential by *all* respondents.

The training experiences and needs of participating PMH personnel indicated that training typically was provided by the agency or some other community agency at the local level. Training in community-based services as reported by the respondents typically included areas relevant to the performance of professional duties within the facility, including crises intervention, respite care, legal issues, emotional/psychological disorders, therapy techniques, mental health issues, psychological evaluation, and civil commitment.

When asked to identify community-based services training needs that would be helpful to provide services to their clients, the PMH respondents generally expressed a need for training to facilitate team building, funding for needed services, and the development of problem solving skills. When asked to identify training necessary to serve persons with dual diagnosis, respondents again reported needs in the category of problem-solving, as well as program coordination and alcohol/drug treatment strategies. The reported perceived role of PMH employees was to provide individualized services and to offer service coordination assistance.

Objective 2 (continued) **Assessing Training Needs: Education**

The Arkansas Department of Education, Special Education Section, annually conducts a broad based training needs assessment of school personnel and parents. This assessment identifies the training needs of various groups by topic. Training needs surveys are sent to all school district superintendents (approximately 311) and to LEA Special Education Supervisors (approximately 110). In turn the administrators and supervisors, utilizing multi-source data and local needs sensing activities, complete surveys for the following groups: administrators, regular and special education teachers, support personnel, paraprofessionals and parents.

The results of this extensive survey are reported by group in Tables 26 through 30 with the results prioritized by number of responses.

Table 26
Number of Special Education Teachers Requesting Inservice Training in Specific Subject Areas

Topic	No.
Developing program goals and objectives	834
Applying behavior management techniques	722
Monitoring student progress, grading, and collecting data	549
Interpreting assessment results and developing instructional programs	519
Integrating students with disabilities into regular class	507
Federal, state, and local regulations, laws, and due process procedures	496
Transition of students from school to post-secondary environments and services	444
Utilizing effective conference skills	359
Utilizing consulting teacher model	341
Developing curricula for secondary special education students	220
Transition of preschool students to school programs	191
Developing and implementing programs for preschool students with disabilities	170
Using paraprofessionals, peer tutors, and volunteers	124
Strategies for returning students from restrictive settings to local schools	84

Table 27
Number of Regular Classroom Teachers Requesting Inservice Training in Specific Subject Areas

Topic	No.
Integrating students with disabilities into regular classes	9,448
Applying behavior management techniques	6,406
Federal, state, and local regulations, laws and due process procedures	4,037
Utilizing consulting teacher model	2,960
Monitoring student progress, grading, and collecting data	2,217
Using paraprofessionals, peer tutors, and volunteers	1,672
Utilizing effective conference skills	1,107
Strategies for returning students from restrictive settings to local schools	951
Transition of preschool students to school programs	890
Interpreting assessment results and developing instructional programs	656
Transition of students from school to postsecondary environments	587
Developing curricula for secondary special education students	584
Developing and implementing programs for preschool students with disabilities	52[illegible]

Table 28
Number of Administrators Requesting Inservice Training in Specific Subject Areas

Topic	No.
Federal, state, and local regulations, laws and due process procedures	1,163
Integrating students with disabilities into regular classes	910
Developing and implementing programs for preschool students with disabilities	364
Transition of preschool students to school programs	329
Utilizing consultant teacher model	284
Transition of students from school to postsecondary environments and services	268
Applying behavior management techniques	201
Using paraprofessionals, peer tutors, and volunteers	198
Utilizing effective conference skills	177
Strategies for returning students from restrictive settings to local schools	149
Interpreting assessment results and developing instructional programs	135
Developing curricula for secondary special education students	92
Monitoring student progress, grading, and collecting data	64
Developing program goals and objectives	29

Table 29
Number of Parents Requesting Inservice Training in Specific Subject Areas

Topic	No.
Federal, state, and local regulations, laws and due process procedures	1,393
Integrating students with disabilities into regular classes	1,135
Transition of students from school to postsecondary environments and services	1,042
Utilizing consulting teacher model	828
Applying behavior management techniques	790
Utilizing effective conference skills	639
Developing program goals and objectives	567
Transition of preschool students to school programs	510
Monitoring student progress, grading, and collecting data	364
Strategies for returning students from restrictive settings to local schools	363
Interpreting assessment results and developing instructional programs	261
Using paraprofessionals, peer tutors, and volunteers	133
Developing and implementing programs for preschool students with disabilities	111
Developing curricula for secondary special education students	57

Table 30
Number of Support Personnel Requesting Inservice Training in Specific Subject Areas

Topic	No.
Federal, state, and local regulations, laws and due process procedures	315
Integrating students with disabilities into regular classes (classroom modifications, learning styles, placement options)	221
Applying behavior management techniques	220
Utilizing effective conference skills	127
Monitoring student progress, grading, and collecting data	96
Strategies for returning students from restrictive settings to local schools	88
Developing and implementing programs for preschool students with disabilities	82
Interpreting assessment results and developing instructional programs	59
Transition of students from school to postsecondary environments and services	56
Developing program goals and objectives	51
Utilizing effective conference skills	26
Transition of preschool students to school programs	25
Utilizing consulting teacher model	24
Developing curricula for secondary special education students	12

The results of the survey indicate that for all groups, two common priorities (of the top 5) were: (1) integrating students with disabilities into regular classrooms, and (2) federal, state and local regulations, laws and due process procedures.

All direct instruction, support personnel, and parents indicated that behavior management techniques were also a priority. Only special education teachers indicated developing program goals and objectives as a "top 5 priority" and for special education teachers it was the top rated training need. The rating by all five groups as a major training need of integrating students with disabilities into regular classrooms indicates the importance of full inclusion in all aspects of the community.

Interviews were also conducted with the staff at the Arkansas School for the Blind and the Arkansas School for the Deaf. Table 31 summarizes these findings.

Table 31
Training Needs of Regular Classroom Teachers who Teach Students with Visual or Hearing Impairments as Reported by Personnel at the Schools for the Deaf and Blind

Hearing Impairments	Visual Impairments
Effective Use of Interpreters	Awareness About the Differences in Learning Styles of Students Using Braille
Effective Use of Auditory Trainers and Other Equipment	Specific Information About Visual Impairments
Awareness of Environmental Modifications Useful with These Students	Mobility Instruction and Use of Sighted Guide Techniques
Minimal Knowledge of Sign Language	Knowledge About the Social Aspects of Visual Impairments
	How to Teach Independent Living Skills

The training needs identified emphasize the necessity for specialized training to ensure full inclusion of students with sensory disabilities.

Objective 2 (continued) **Assessing Training Needs: Division of Rehabilitation Services (DRS)**

Of the group of DRS employees (n = 7) participating in the structured interview activity, 2 (29%) reported administrative roles within the DRS service system while the remaining 5 employees (71%) reported roles which were classified as professional staff. The DRS respondents exhibited an average of 14 years experience in service delivery to persons having disabilities, with a range of 5 to 27 years.

When asked how they first became interested in working in the field of developmental disabilities, responses were distributed across 4 categories: 2 (29%) through community contact with individuals having disabilities; 2 (29%) as a result of family members having disabilities; 2 (29%) as a result of university experiences; and 1 (13%) through some other type of experience.

In examining the descriptions of community-based services provided by these respondents, few responses were provided (with the exception that 4 individuals (57%) reported that these services are provided "in the community") where adults

with disabilities reside. Such services were also reported to be essential by all respondents. This finding was consistent with the reports of other groups included in the structured interview activity. Training which had been received in the area of community-based services as reported by the respondents included: new futures planning, regulations, quality control, counseling techniques, community placements, and accessibility.

An examination of the training experiences and needs of participating DRS personnel indicated that training typically was provided by the agency at the local level. When asked to identify community-based services training needs that would be helpful to provide services to their clients, the DRS respondents generally expressed a need for training to develop and refine evaluation, assessment, and counseling strategies. When asked to identify training necessary to serve persons with dual diagnosis, most respondents (59%) again reported needs in the categories of assessment, evaluation, and counseling strategies. These expressed needs for training in both community-based services and dual diagnosis are interesting in light of the perceived roles of the DRS employees that were reported: most respondents (59%) identified *services coordination* as their principle role.

Informal Supports

Objective 3 **Assessing the Training Needs of Families and Other Community Members**

Overview

In an effort to clarify the training needs of as diverse a range of organizations and individuals as possible, a series of smaller inquiries were utilized to supplement the formal training needs studies previously described. Numerous groups participated in this endeavor, and the approaches used to obtain information, while varying across participating groups, yielded a wealth of information that support findings obtained in the formal studies as well as providing information useful for generating recommendations for the design future training activities. Findings from these various groups are presented in the following section. Whenever possible, information will be presented by region (see Figure 1) and by age groupings.

Focus Group Approach

With the parent groups included in the informal studies, a structured group format was employed to obtain information. This included a 4-step process. First, an explanation of the overall intent of Vision 2000 was provided to the participants. Second, an overview of the Staffing Assessment process, along with a clarification of

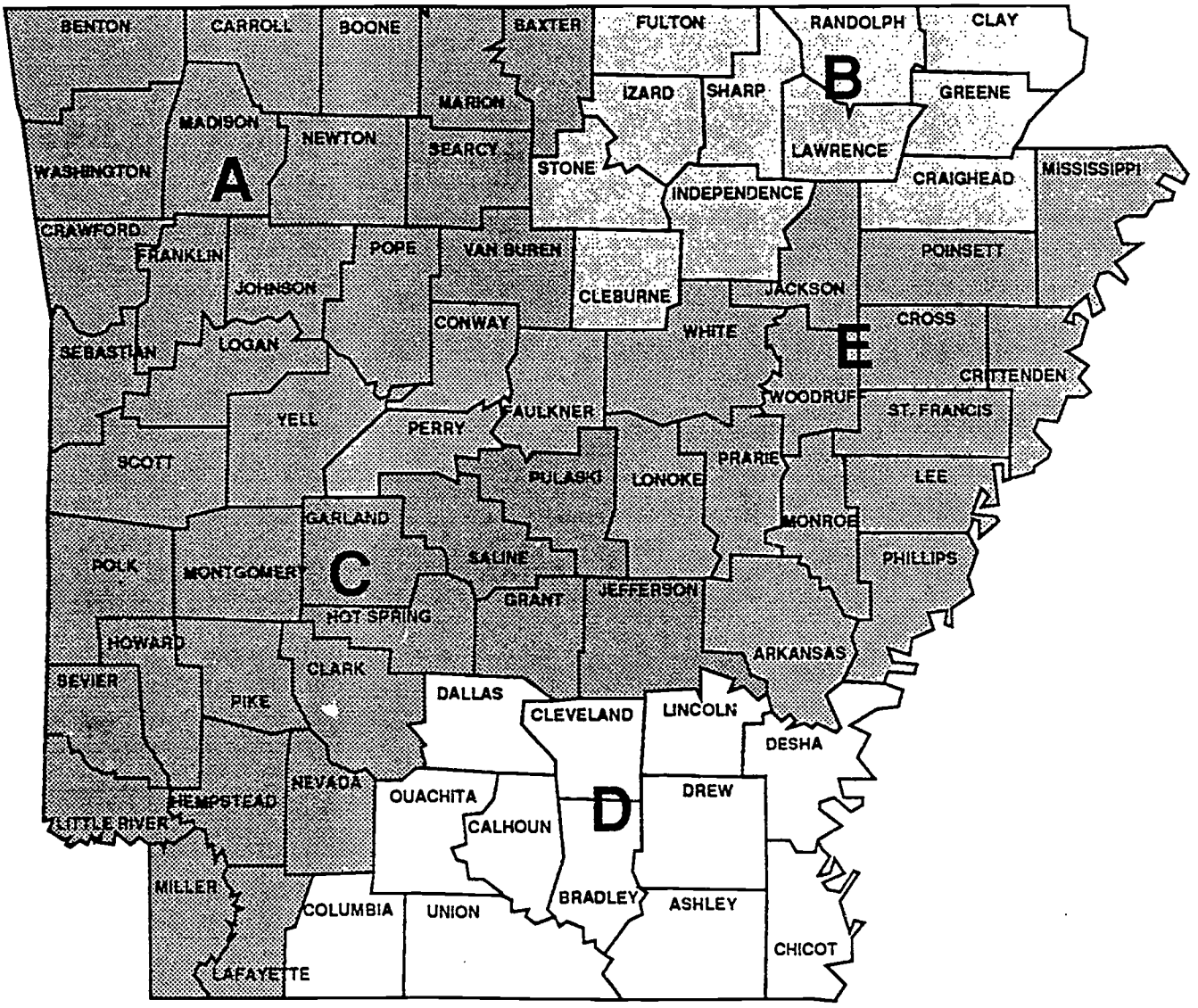

Figure 1. Regions of State from which parent groups were selected.

the purpose of Focus Groups. Third, a discussion by the group, facilitated by a Focus Group leader, covered the following topics: (a) identification of the informal supports currently being used with an emphasis on the variety and individuality of each person's support system; (b) perceptions of the need for improved staff training with an emphasis on specific areas of training; and (c) information that should be provided to members of the local community regarding persons with disabilities (with an emphasis on information beneficial to all persons). Finally, the

Focus Group prioritized the listing of formal and informal supports and training identified by the participants. All references to *priority areas* in the following narrative should be viewed as evolving from use of Focus Groups.

Objective 3 (continued) **Assessing Informal Supports: Parent Groups**

Parents of children with disabilities throughout the state participated in the informal studies using the Focus Group approach. During meetings with parent group members, a facilitator elicited responses of training needs for their areas, followed by a prioritized ranking of the needs by group members. Ranked statements were grouped into the following categories: *community, family, medical/health, teacher-specific, general education, paraprofessionals, administrators,* and *support personnel* (i.e., therapists, psychologists, etc.). Summary findings of the parent group meetings are presented by Region. Within each of the regional discussions that follow, tables are included that reflect the overall importance of a priority area (*family, community,* etc.) as it was ranked by the groups. In order to present this information, a weighted value was assigned to each ranking (i.e., ranking of 1 = 8 points; ranking of 2 = 7 points, etc.) and these values were summed by the priority area.

Region A. Parent group participants in Region A (*n* of participants = 62; *n* of groups = 8) tended to rank *family and community* needs as being the most important areas for training. *Family* issues, such as parental rights and disability information available at birth, were ranked by 3 of the parent groups as the top priority, while *community* issues, such as training church workers and information regarding trauma issues, were ranked as the first priority by 2 groups. Other areas that received this ranking included *medical* training (physicians listening to patients), *support personnel* training (therapists needing training in pediatrics), and *teacher specific* issues (augmentative device information and training).

The second priority rankings also focused on *family and community* issues. Parents wanted to be taught how to advocate for the rights of their children, receive positive information about developmental disabilities, and have readily available materials

for new parents. *Community* issues that ranked as a second priority included training in increasing community awareness of disability legislation, training recreation workers to work with children with disabilities, and making more services available to families.

Family and community issues were also indicated as a third priority. Parents noted that the availability of truthful information about disabilities, immediate availability of services, and parental training for early intervention participation were important. *Community* issues included training for Boy Scout leaders to meet the needs of participating children in this organization and increased knowledge of DHS workers regarding availability of services and resources.

Less frequently ranked issues included for *medical/health* were the need for physicians to listen to parents and to assist in the parental grieving process, and teacher *specific* needs for training such as mobility awareness, dyslexia training, and improving communications skills with parents. Table 32 provides an overview of the priority rankings.

Table 32
Region A Parent Group Priority Rankings of Needs

Issue Areas	Weighted Ranking
Family	81
Community	104
Medical/Health	42
Teacher Specific	19
General Education	17
Administration	0
Support Personnel	18
Paraprofessionals	0

Region B. Parent group participants in Region B (*n* of participants = 14; *n* of groups = 4) ranked the following as the top priority: *Families* (need for information on grief stages and parental rights); *medical/health* (training pediatricians in

developmental disabilities); and *teacher specific* (helping teachers work with parents).

Teacher specific and *administration* issues were identified as being a second priority area. Teachers needed training in accommodating the needs of children with disabilities and information pertaining to normalization principles and practices. School *administrators* had training needs in the areas of parental rights and information regarding disability legislation.

Third priority areas for training included assisting teachers to recognize signs of developmental disabilities, information regarding parental rights, information provided to parents at the birth of a child with a disability, and training of church workers.

Issues with lower rankings included *community* awareness via public media, information regarding disabilities available to church members, and teaching children in schools how to recognize disabilities. Table 33 presents these rankings for this region.

Table 33

Region B Parent Group Priority Rankings of Needs

Issue Areas	Weighted Ranking
Family	28
Community	16
Medical/Health	8
Teacher Specific	38
General Education	8
Administration	14
Support Personnel	3
Paraprofessionals	0

Region C. Parent groups in Region C (*n* of participants = 21; *n* of groups = 5) ranked *family* needs as being the highest area for training . *Family* issues included information about IEP team participation strategies, dealing with frustration, and strategies for working within the system. Two groups identified *general education* issues, including vocational training for high school students and the need for disability specific information.

Second priority rankings included *community* needs (information/training for employers and community awareness through the media); *family* needs (teaching parents to communicate with professionals and teaching parents to deal with difficult behaviors); and *medical/health* (providing more developmental disabilities information to nursing personnel).

Third priority rankings focused on *community* needs (automatic referrals and training local church workers), *teacher specific* needs (training teachers to reteach skills and providing head injury information to teachers), and *general education* (behavior management training).

Medical/health needs (sensitivity training and general information regarding disabilities) were identified as a lower priority, as were other *family* and *community*. Table 34 indicates these rankings by region.

Table 34
Region C Parent Group Priority Rankings of Needs

Issue Areas	Weighted Ranking
Family	59
Community	47
Medical/Health	16
Teacher Specific	12
General Education	30
Administration	0
Support Personnel	0
Paraprofessionals	0

Region D. Parent group participants in Region D (*n* of participants = 14; *n* of groups = 4) ranked *family* and school-related issues as the first priority. *Family* issues, identified by 2 groups, focused on teaching parents to apply for benefits. *General education* (making the school aware of parental rights) and *teacher specific* (teaching teachers how to identify and access grant resources) were also important.

Second priority area issues included *family* (training to make parents aware of rights and how to work with teachers during IEP processes), and *teacher specific* (facilitating and understanding of the assessment process).

Two groups identified the need for parents to be aware of community resources and two other groups identified *teacher specific* issues (knowledge of student rights and adapting classroom materials/availability of resources).

Community issues, ranked lower, included public awareness, training religious workers, and community support through public service announcements. Region D group priorities are presented in Table 35.

Table 35
Region D Parent Group Priority Rankings of Needs

Issue Areas	Weighted Ranking
Family	59
Community	30
Medical/Health	0
Teacher Specific	23
General Education	25
Administration	0
Support Personnel	0
Paraprofessionals	0

Region E. Parent group participants in Region E (*n* of participants = 47; *n* of groups = 8) most frequently ranked *family, community,* and *teacher specific* needs as being the most important areas for training. Three groups identified *family* issues including disability specific information for parents, and training on the availability of resources as being the top priority. Two groups ranked *community* needs that included increased awareness of mental disabilities and normalization training as important areas. Two groups also targeted *teacher specific* issues, including specific disability inservices for teachers and the provision of disability information, as high priority training areas. Only one group identified *medical/health* issues (sensitivity of medical personnel) as a high priority area for training.

Secondary priority areas included: *community* (training for regular day care workers, the need for DHS resource personnel to be more respectful of the rights of families, and the importance of public service announcements from respected community leaders); *support personnel* (integrated therapy and therapists having realistic expectations of families), *teacher specific* (regular teacher training in learning disability issues/strategies and training in interpersonal skills, rights of families, and legislation), and *medical/health* (physician sensitivity).

Issue areas that received a ranking of 3 were primarily *community* and *general education* issues. *Community* issues (positive portrayal of people with disabilities in the media, community awareness of specific needs of persons with disabilities, city awareness in rural areas, and training hospital chaplains in grief support) and *general education* (increased awareness of individual rights and transitional planning in schools). *Family* issues, third priority, focused on providing information regarding the nature of their children's disabilities and the availability of local business support. The only *teacher specific* issue ranked as a third priority was teaching regular classroom teachers to detect learning disabilities.

Community issues were ranked in each of the subsequent rankings, and were more frequently reported than any other issue area. *Medical/health* needs (increased physician education) and *support personnel* (therapists trained to work with families) were reported. Table 36 presents these rankings.

Table 36
Region E Parent Group Priority Rankings of Needs

Issue Areas	Weighted Ranking
Family	49
Community	101
Medical/Health	27
Teacher Specific	38
General Education	3
Administration	6
Support Personnel	21
Paraprofessionals	0

A summary table for all five Regions is presented in Table 37.

Table 37
Summary Rankings of Needs by Region

	Weighted Rankings *							
Region	FAM	COM	M/H	TS	GE	AD	SP	PAR
Region A	81	104	42	19	17	0	18	0
Region B	28	16	8	38	8	14	3	0
Region C	59	47	16	12	30	0	0	0
Region D	59	30	0	23	25	0	0	0
Region E	49	101	27	38	3	6	21	0
TOTALS	276	298	93	130	83	20	42	0

Variables: FM- Family; COM-Community; M/H-Medical/Health; TS-Teacher Specific; GE-General Education ; AD-Administration; SP-Support Personnel; PAR-Paraprofessionals

When the weighted rankings are compared across regions, it is evident that parents view the community and families as the primary audiences for training. This view strongly supports the perceived training needs of DDS community programs and CMHCs in learning to identify, develop, and coordinate community resources.

Objective 3 **Assessing Informal Supports: Arkansas Alliance for the Mentally Ill-Children and Adolescent Network (AAMI-CAN)**

The training needs of persons involved in providing services to children and youth with serious emotional disturbance/mental illness were identified through surveying four AAMI-CAN groups (n = 41) from various parts of the State including Heber Springs, Little Rock, El Dorado, and Clinton. Rankings of training needs are reported by AAMI-CAN parent group. These rankings were elicited through the Focus Group approach described earlier.

Little Rock AAMI-CAN (n = 4). Four areas of needs were identified: (1) training to heighten teacher awareness, such as the development of skills enabling teachers to recognize signs of depression in children, (2) parent training in behavior management and aggression control strategies, (3) respite training that would enable professionals and parents to deal with all aspects of mental illness, and (4) teacher training in the management of behavior.

El Dorado AAMI-CAN (n = 5). Five areas of needs were prioritized: (1) inservices for teachers encouraging the recognition of mental illness' early warning signs, (2) public outreach through the use of videotape technologies, (3) training for day treatment center staff in strategies for facilitating socialization, (4) job coach training, and (5) increased disability awareness using the news media.

Heber Springs AAMI-CAN (n = 7). This group prioritized and ranked seven areas of needs. The identified needs for this group all tended to focus on public awareness and media issues. The needs, in priority order, were: (1) information regarding less serious forms of mental illness to be used in public service announcements, (2) newspapers to feature regular articles (e.g., personal stories) on mental illness to heighten public awareness, (3) for information to be presented in late night media formats, (4) for promoting AAMI membership and activities by local community health centers through personal contacts made by AAMI members, (5) facilitate awareness in the psychiatric community of the existence of AAMI support groups, who in turn could disseminate information to clients and families, (6) enhance family empowerment through training and treatment

involvement, and (7) the need for mandatory involvement of families with children under 18 years of age who have mental illness.

Clinton AAMI-CAN (n = 23). This group prioritized and ranked six areas of training needs: (1) training within the judicial system regarding the needs of persons with mental illness, (2) strategies pertaining to school transitioning, (3) the development of more "friends of the court" within the judicial system, (4) increasing civic awareness of mental illness, (5) greater awareness of the public regarding signs of mental illness in children and youth, and (6) consumer information on housing alternatives in the local community.

In analyzing the priority training needs identified by the AAMI-CAN groups and utilizing the same weighting procedure for the ranking, it is evident that the community was the primary training audience (46 points), followed by teachers (28 points), family (16) and mental health professionals (8). The findings are consistent with the other parent group reports.

Objective 3 (continued) **Assessing Informal Supports: Consumer Groups: Consumer Groups**

A small group of consumers representing Garland County Community College (n = 6) and the University of Arkansas at Monticello (n = 4) were interviewed. These participants had a mean age of 22 years (Range = 19-37). Disability categories included physical, sensory, and learning disabilities.

Examination of the overall rankings of the Consumer Focus Groups included activities for *education, community awareness, individual specific,* and *family specific.* Identified priority areas are presented by consumer group.

Garland County Community College. Areas of need identified by this group tended to focus on barrier awareness activities. Priority areas identified by this group by ranked importance included (a) remediated coursework; (b) career counseling; (c) early registration (including the need for receipt of books early for taping); (d) availability of transition specialist counselors; (e) sign language training for faculty and staff; (f) availability of adaptive equipment in laboratories; and (g)

training for faculty and staff on the provision of educational/academic accommodations for people with disabilities.

University of Arkansas at Monticello. Areas of need identified by this consumer group focused on the need for teacher and faculty inservice. Training needed by teachers and faculty which was identified included (a) information on specific disabilities; (b) information on human sexuality and persons with disabilities; (c) strategies to encourage openness when talking with children about disabilities; (d) barrier awareness for sensitivity; and (e) strategies for the development of social skills and facilitating positive self-concepts among students with disabilities.

The Division of Rehabilitation Services Consumer Advisory Board. This consumer group was also surveyed to determine training needs that they considered important. This Board represents a number of diverse constituencies and provided a variety of responses to potential training needs. Needs were ranked in the following order:

- Training for persons with disabilities on housing strategies (e.g., owning, renting).
- Training on self-advocacy and self-determination.
- Training health personnel in disability issues.
- ADA training for businesses, consumers, and colleges.
- Training for persons providing supports and services to children with HIV/AIDS.

Other major topics of interest were developing supports for aging persons with disabilities as well as families who have adult sons or daughters with disabilities, and training for persons providing supported employment and employment opportunities.

Objective 3 (continued) **Assessing Informal Supports: Foster Families**

A group of foster family participants were also included in the informal studies to examine the training needs of this population throughout the State. A Foster

Parent Survey Form was designed to obtain demographic information and related training needs information. A total of 518 survey instruments were mailed to individuals identified by the Division of Children and Family Services requesting their participation in the study. Of this group, 104 survey forms (20%) were returned, representing 55 families and 101 children. Descriptive data generated for the total pool of completed surveys are presented.

Sample characteristics. The mean age of children placed in participating foster care homes was 7 years (Range = 1-18 years). Of this group of foster families, 53 children (51%) were 1-5 years of age; 30 children (23%) were 6-12 years of age; and 21 children (20%) were 13-18 years of age. The mean length of stay in foster care settings for the entire group of children was 14 months (Range = 1-72 months). Disability characteristics of the group as a whole indicated that children with multiple disabilities (62%) were more frequently reported by the foster parents, followed by children with emotional disturbance (7%), mental retardation (7%), learning disability (4%), attention deficit disorder (2%), and autism (1%).

Regarding the gender of the children placed in foster care settings, males represented 60% of the sample. By age group, males were more frequently represented in the 1-5 age group (n = 37) than were females (n = 15). In the 6-12 year group, males (n = 19) outnumbered females (n = 9) by more than 2 to 1. In the 13-18 age range, however, females (n = 15) exceeded the number of males (n = 6) who were placed in foster home settings.

African American children characterized approximately one fourth (n = 25; 24%) of the entire sample, with a disproportionate number of these children in the 1-5 year range (n = 19). Relatively few African American children were in the 6-12 (n = 4) and 13-18 (n = 2) ranges.

Training needs. Foster family members were asked to identify training that had been received to prepare them to care for their children. Of those who responded to this survey item (n = 85), *no training* was reported by the majority of respondents (n = 52; 62%). This finding was consistent across all age categories of children who were placed in foster care settings. Approximately 25% (n = 21) of

foster family members reported the receipt of training specific to meet the individual needs of their children. General foster parent orientation training was reported by a surprisingly small number of the respondents (n = 12), with most training being received by family members having children ages 6-12 years (n = 8) and 1-5 years (n = 4) respectively.

Foster family members were also asked to identify information *not provided* during the course of their training experiences that would have been beneficial. Of those individuals who responded to this survey item (n = 38), most individuals (n = 31; 82%) reported needs for individual and/or family specific training. Examples of needed training that was reported included such responses as disciplinary measures, expectations/setting limits, specific information on children, strategies for coping with disabilities, and recognition of behavior problems and disabilities. For the entire sample (n = 38), relatively few family members reported medical training needs (n = 4; 7%) and these families served children solely 1-5 years of age.

Foster family members were also asked to identify other areas of training that they felt would be helpful for all foster families. Of those responding (n = 58), 49 individuals identified training areas that could be categorized as family and/or individual specific. Most respondents (n = 27) reporting these needs had children 1-5 years of age. Needed medical training was reported by only 9 respondents for the entire group, with these family members serving children 1-5 years of age and 6-12 years of age.

Objective 3 (continued) **Assessing Informal Supports: Transition Project**

In 1991, local Transition Team meetings were conducted by the Arkansas Transition Project in Greenwood (Region A), Malvern (Region C), and Crossett (Region D). At these transition group meetings, needs for *communities* were identified. Employing the same type of categorization approach that was described previously, 21 needs were identified for the city of Malvern. Of these needs, 14 could be categorized as *community needs* (e.g., respite, accessibility, social roles valued, recreation options, peer tutoring, counseling/moral support, and information

transfer between school and vocational services). Several *family* needs were identified, including the need for assistance to help teenage mothers complete high school, advocacy and support networking within families. *General education* needs included higher education needs being addressed, mandated curriculum questions at both the local and state levels, and functional curricula utilization at the local level.

In Greenwood, two needs were identified which focused on *public education* or *community issues*. It was noted that the public needed to be aware of the number of children with developmental disabilities as well as to be knowledgeable about disabilities in a general sense.

In Crossett, the transition team identified 15 needs of which 14 tended to be categorized as *community issues*. Such needs included on-the-job training, public education, leisure time activities, transportation, affordable housing, community accessibility, insurance liability issues, and other community relevant needs. In follow-up meetings with parent groups at these sites, these training needs were reaffirmed.

Objective 3 Assessing Informal Supports: Respite Care

Camp Aldersgate developed a survey instrument in 1991 as a designated activity of a DDPC Networking Grant. The instrument was designed to examine the respite needs of parents throughout the State. The survey was completed in 1991-92, with data being reported on 224 returned instruments. The particular survey question that was of particular relevance for this report asked parents, "What special skills would the respite care provider need?" Parents were given a menu of skills from which to choose. There were G-Tube, positioning, seizure control, updraft, track care, sign language, suctioning, CPR, and other - specify. Characteristics that were reported were coded as falling into three categories: *educational, medical,* and *positive social/emotional interaction.*

In examining the total set of responses (n = 224), most participants in the survey (n = 110; 49%) reported that *medical* characteristics were most important for respite

caregivers. Another 62 individuals (28%) identified *educational* characteristics as important traits for respite caregivers, and 17 respondents (8%) identified *positive social/emotional interaction* characteristics. No training needs were identified by 35 respondents (16%)

Region A. Examination of responses provided by participants from this Region (n = 63) paralleled the response trends exhibited for the entire pool of respondents. Most individuals reported *medical* characteristics (n = 32; 51%), which included specific strategies such as seizure control, positioning, G-tube needs, CPR, tube feeding, cleft palates, and suctioning. Of secondary importance were characteristics categorized as *educational* traits that were identified by the respondents (n = 15). Such characteristics included basic child care, positive behavior management, developmentally appropriate practices, sign language, use of augmentative communication devices, and spoon feeding. This was followed by responses categorized as *positive social/emotional interaction* traits (n = 7, which included characteristics such as love, patience, caring attitudes, having fun with children, and Christian morals and values. No training needs were reported by 9 respondents (14%).

Region B. Responses provided by participants from this Region (n = 10) were similar to those reported in Region A. Most individuals reported *medical* characteristics (n = 6), which included specific strategies such as seizure control, positioning, G-tube needs, CPR, suctioning., nutritional needs of child, ostomies, catheters, and choking interventions. Characteristics categorized as *educational* traits that were identified by the respondents (n = 3) included basic child care, developmentally appropriate practices, sign language, working with adults, and dealing with behavior problems. This was followed by responses categorized as *positive social/emotional interaction* traits (n = 1), which included being understanding and firm.

Region C. Persons responding from this Region (n = 76) again reflected the response patterns of Regions A and B by reporting (n = 34; 43%) the importance of *medical* characteristics for respite caregivers. Traits which were identified included seizure control, CPR, machine usage (suction and updraft), G-tube feeding, positioning,

equipment for asthma, track care, and catheters. *Educational* characteristics were viewed as being more important in this Region with 22 persons (29%) identifying such traits as child specific needs, autism, basic child development, sign language, mental retardation information, and communication skills as being important. *Positive social/emotional interaction* traits were viewed as being important with less frequency (n = 4), and included characteristics such as love, patience, needs direction, Christian morals and values, and caring. No training needs were reported by 16 persons (21%).

Region D. As with Region B, there was a small group of respondents representing Region D (n = 18), and most of these individuals (n = 14; 78%) reported *medical* characteristics as being most important for respite caregivers. Typical responses were similar to those expressed by respondents in other Regions, and also included severe allergies, lifting and non-ambulatory techniques. *Education* characteristics were reported as being important by 3 respondents and did not differ from the needs reported in other Regions. There were no *positive social/emotional interaction* traits that were reported as being important. No training needs were reported by 1 respondent.

Region E. Respondents in this Region (n = 38) identified *medical* characteristics as being most important (n = 16; 42%), with responses analogous to those reported by persons in other regions. *Educational* characteristics were identified as being important by 10 respondents (26%), and did not differ from previously expressed traits with the exception of toileting skills, dressing, and Down syndrome characteristics being reported. *Positive social/emotional interaction* traits were identified by only 4 respondents, with comparable characteristics previously identified in other Regions being reported. A total of 8 individuals reported that specific skills were necessary.

Giving the limited number of selections, parents could choose from, it is important to note that parents added a significant number of comments that reflected social/emotional qualities as well as educational characteristics of the respite caregivers .

Objective 3 (continued) **Assessing Informal Supports: Personal Description Surveys**

Two questions focusing on training needs were included in a comprehensive *Personal Description Form* developed by Conroy and Feinstein Associates for the Arkansas Vision 2000 Project. Survey forms were completed by case managers affiliated with ICM, Inc. who had direct contact with consumers with disabilities statewide. The questions included (a) Tell me about the best staff person you've ever had; and (b) What characteristics/qualifications/training do you want staff to have? Responses to each of the two questions were coded according to pre-designated categories that included (a) attitude, (b) educational, (c) medical, (d) or other.

Tell me about the best staff person you've ever had. Responses provided by the participants to this question (n = 79) fell overwhelmingly into the attitude category (n = 71; 76%). Other responses included educational (n = 2), medical (n = 2), and other (n = 3). Examples of typical responses included "firm, but caring and sensitive", "concerned, interested, respectful", and "empathy, honest, enthusiastic".

What characteristics/qualifications/training do you want staff to have? Responses provided by participants (n = 93) to this question fell primarily into the attitude category (n = 55; 59%). Typical responses included such statements as "loving, patient, sincere, understanding", "listen, not talk down to people", "good heart, treat child like their own, supportive", and "build self-esteem, kind, caring".

More than one-third of the participants' responses' were categorized as educational (n = 33; 36%), with typical responses such as "knowledge of disabilities", "degree of experience", "well-trained", and "education degree" being reported. Medical related responses were provide by only 5 participants , and included responses such as "give medication", "medical training", and "physical therapy exercises".

SUMMARY OF INFORMAL FINDINGS

A variety of activities were used to obtain information to identify training needs for targeted populations in Arkansas. Information compiled from these diverse groups tend to aggregate around three specific themes.

First, the importance of *community* involvement in the lives of persons with disabilities, families, and professionals is very clearly articulated across the range of groups who participated in information gathering processes relative to this report. Parents, perhaps more so than any other group, cogently identified a wide range of issue areas regarding how services should be provided to their children that they deemed to be of particular importance. The sheer diversity of the issues identified, while on the surface providing specificity of topical areas relevant to training needs, could be grouped more generically into community issues. While many parents identified the need for training of agency personnel with whom they interacted to secure needed services in their communities, there was also a consistently expressed need for training of individuals who have, to date, *not been included* in the traditional training schemata of existing service delivery systems. For example, the need to provide training and information to employers, church workers, Boy Scout leaders, day care providers, hospital chaplains, and recreational workers that was reported by many parents, coupled with the oft-cited need for "greater community awareness" clearly supports the need for community-oriented training that is more generic than has historically been provided.

Second, on examining the qualitative information generated from parents, respite care givers, and personnel participating in the studies, it appears that there is an underlying concern for service providers to have a caring, concerned attitude in their interactions with persons with disabilities. Such needs were succinctly identified in the Personal Description Surveys previously described. In this study, characteristics such as "caring", "listening", and "understanding" were frequently cited as important traits. Such findings were supported by parent reports that workers in DHS should "listen to" and "respect" families and their needs. Support for greater emphasis being placed on affective qualities is also found in parent group

rankings of the need for sensitivity training with physicians as well as other community members.

Third, the information compiled succinctly indicates a need for specialized training for particular target audiences. Regardless of the population that was examined in the series of studies conducted, there were both *individual-specific* as well as *group-specific* special needs for both training and information. This was especially true for respite care providers, who generally had very little, if any training to prepare them for providing services to children with disabilities having chronic and acute health problems (e.g., children with multiple disabilities). Specialized skills (such as use of G-tubes, employing positioning techniques, augmentative communication devices, programming, and adaptive equipment maintenance) were identified by families as skills that service providers need to adequately support children with disabilities. Similarly, highly trained personnel, such as physicians, were consistently identified as needing specialized training in family interaction/sensitivity issues.

CONCLUSIONS AND RECOMMENDATIONS

Central to the staff training issues, as well as the broader systemic issues critical to a community-based system, is the need for a clear concept of what a community-based system really is. The principles and values on which it is based as well as the infrastructure designed to support such a system must be articulated. The fundamental challenge in this, is that the nature of systems, programs, and services as they have been established and funded must be redesigned to ensure that individualized supports and resources are available for full community inclusion for all persons with disabilities. At the present time in Arkansas, the following conclusions regarding training needs within the formal and informal systems are presented based on the needs-sensing activities reported previously.

Conclusion 1:
The lack of a collective vision of what comprises community-based services obscures the focus of training. Without a careful and thoughtful presentation of the system, training primarily responds to funding streams (i.e., case management,

HCBS Waiver), to broad topics (behavior management, activities of daily living) or to licensure requirements (12 hours per year) with no framework in which these skills should be utilized. Since most persons with disabilities already live, work and receive services in the community, the difference between community *presence* and community *participation* must be addressed. Also, within the context of this collective vision, is the primacy of consumer choice, preference and self-determination. Not only must the programs and services be reconfigured to individual supports, but they must be guided by the valued outcomes of the individuals, not the system. In assisting persons with disabilities to construct their own lives, the specialized service providers, the generic service system, and neighbors, family, friends, and community members will all have pivotal roles.

Recommendation

> DDPC, in conjunction with families, individuals with disabilities, legislators, and state and community agencies and providers, and utilizing information from Vision 2000, should adopt and disseminate an operative description of the community-based system. This operative description should then become part of appropriate statues and regulations as well as guiding the development of policies and procedures.

Conclusion 2:

Training currently provided to staff meets licensure requirements and addresses a variety of current topics. The training, when viewed from a statewide perspective, presents significant areas of concern:

- The applicable divisions under DHS do not have a state-wide training plan that includes competencies and skills needed for a community-based system for persons with developmental disabilities. There is no assurance of equitable training across the state.
- Community agencies have markedly different training plans and the content and topics of the training are not consistent.

- Neither standards nor curricula have been developed and disseminated for community-based training that reflect both internal coherency and best practice.
- Training in community-based issues is not available routinely at a local/regional level (i.e., community colleges, technical colleges, etc.).
- Community programs establish their own job titles, functions, and pay scales, so career opportunities and career ladders for direct care staff are not uniform across the community system.
- Many of the training needs identified by various groups were similar if not identical.

Recommendation

Training must have a higher priority and funding to support it if a community-based system is to be implemented. A comprehensive training plan for personnel development should be developed by relevant divisions within the Department of Human Services. Consideration should also be given to coordinating major training initiatives across Department of Human Services, Health and Education. This comprehensive personnel training plan should be developed in active collaboration with families, individuals with disabilities, providing agencies, and community members. The plan should require ongoing input and updating and would identify and designate the major content areas and training priorities for various constituencies.

Curricula and competencies must be established and mechanisms for providing the training identified and utilized. As part of the Vision 2000 activities, outlines for training modules and associated competencies will be developed in the following areas:

- Values Training
- Positive Behavioral Supports
- Person-Centered Planning Techniques

- Technology
- Environmental Modifications/Adaptations
- Mobility
- Employment (job development/analysis, job coaching)
- Functional Programming
- Civil Rights
- Personal Health (family planning, sexuality, catheterization. . .)
- Quality Assurance
- Specialized Financing (Tefra, Medicaid, Medicaid Waiver. . .)

Consideration should be given to working with local technical schools as well as community colleges to incorporate the curricula as an integral part of their course work. Consideration should also be given to utilizing collaborative groups in local areas as training audiences (e.g. CMHC staff, DDS community programs, rehabilitative counselors, education personnel, etc.) The Transition Project could serve as a prototype for collaborating efforts in developing and defining person - centered visions, identifying needed supports and resources and providing training across agency and constituency boundaries.

Conclusion 3:

During the needs-sensing activities that were undertaken by this project, it became evident that training of staff, although regarded as important, in reality received limited time and attention. The constraints on training are real and should not be minimized. Funding for services remains precarious. Local community providers often can not compete with the education system or private consultant's salaries. Since many providers have services for young children and their families, as well as adults, the training must cover a wide variety of topics, roles, and functions. Many staff have a strong commitment to the field as demonstrated through the years they worked. This solid care brings experience and dedication that must be maximized.

Recommendation

It is imperative that the impact of well designed and coordinated training, which is continuous and ongoing in nature, on quality of services be recognized. Since it is common for funds dedicated to training activities to be the first ones cut when budgets are tight, this must be avoided through specific legislative language. Consideration should be given to adding language to agency appropriation bills which requires a certain percentage of funds be utilized for ongoing staff development. Without such a rigid commitment, the training necessary to support a comprehensive move toward individualized support and full inclusion of persons with disabilities will likely not occur.

Conclusion 4:

Results of the formal and informal surveys indicated that the model for staff training most often utilized was the traditional workshop/conference approach. This is frequently the case in situations where training is approached in a non-sequential way rather than emanating from a coordinated statewide training plan. This approach does not utilize information about how adults learn best and does not provide for varying levels of intensity in training (such as awareness training versus competency-based skill development training).

Recommendation

As the curricula and competencies are designed, it will be imperative to consider how adults learn. Research about training practices has shown that the most effective training has immediate application, is ongoing, and has built in feedback loops between the instructor, the staff, and the job. Adult learners do not always transfer general training to specific situation unless the training, application, feedback loop is designed to enable this to occur. Training design and implementation must be based on these considerations.

It is also recommended that assisting families/consumers in establishing networks provides another forum for training. The Family Leadership Training Project, currently supported by DDPC, is an excellent example of this approach and should be continued and expanded as much as possible. These activities allow families to share information, experience different models of service and work through shared concerns most effectively.

Conclusion 5:

In reporting and discussing the training needed both from the staff's view point as well as the family's and consumer's, it was evident that several themes emerged:

(a) Personal characteristics and attitudes of staff as well as community members were crucial. Parents and consumers asked for persons who would listen, who valued the individual with the disability, would support the individual in obtaining their valued outcomes and could provide the knowledge and skills to ensure full community inclusion

(b) Staff, community members, and parents may require specialized training to ensure that an individual is fully supported. For instance, if an individual uses an augmentative communication device, then not only staff should understand its use and purpose, but an employer, landlord, and friends should also.

(c) Training must be conceptualized at different levels of intensity. Public awareness is crucial, as is bringing the community infrastructure into the training arena.

Recommendation

In designing the curricula and competencies, attention must be given to ensuring that:

(a) strategies for developing a strong value base are incorporated. A commitment to person-centered planning, self-determination, and individualized supports is essential.

(b) training is available for certain specialized services and supports.

(c) training emphasizes how to provide supports rather than just single topic issues since staff and community members will have varying supports and roles.

(d) complex issues are addressed including respecting consumer preference and choice, dignity of risk, sexuality, AIDS/HIV, use of alcohol and drugs.

(e) staff providing support will need to be trained to "train" other members in the community. (e.g. assisting employers, landlords, co-workers, pastors, neighbors in effectively communicating with and providing support to an individual with a disability.

(f) community and infrastructure training is critical.