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ABSTRACT

This paper describes a cross-agency model of training and technical assistance which prepares preschool teachers, therapists, social workers, drug treatment providers, parents, administrators, service coordinators, and bureaucrats to work with and understand children and families affected by alcohol and other drugs. Presented first is a brief background of the program, the Family Focused Early Intervention System (FFEIS). The program uses consultants to serve both as advisors and liaisons to regional and state authorities. Consultants who specialize in the areas of inclusion, developmentally appropriate practices, assistive technology for babies, toddlers, and preschoolers, and programs for children and families affected by alcohol and drugs. Additionally, data from various hospitals, agencies, and state and local health departments were analyzed with an eye toward social diagnosis, epidemiological diagnosis, educational and organizational diagnosis, and administrative and policy diagnosis. Data analysis revealed that the development of strong linkages between community early intervention providers, alcohol and drug treatment programs, health care providers, and public education activities was necessary to enable a seamless system of referral activity and services. It is also argued that pupil services personnel in schools can enhance these kinds of programs. Schools at both the building level and the district level must be more attuned to the needs of children and families affected by alcohol and other drugs. Contains three references. (RJM)

Developing a Seamless System for Meeting the Needs of Young Children Affected by Alcohol and Other Drugs through Training and Technical Assistance.

by
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Developing a seamless system for meeting the needs of young children affected by alcohol and other drugs through training and technical assistance

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On any given day, somewhere within the developmentally appropriate classrooms of the United States, you might see three, four, and five year old children affected by alcohol and other drugs starting their day in morning meeting circle time, hugging their neighboring peer, and letting them know, "Good morning. I'm so glad you're here today!"

On that same day, during one of the many the in-service trainings held by school districts around the country, you might hear a trainer address an audience of overworked and overburdened teachers about the terrible new problem they face by the coming of age of so-called "crack babies"[1] in their communities and the monumental challenges these children will exhibit as they enter their classrooms.

How can we assure the children of this nation, free and appropriate education environments where all children deserve to thrive? Free that is of myths, distortions of the truth, and failed beliefs, and appropriate, that is, educationally and developmentally appropriate to meet the needs of each individual child.

One answer is by providing continuous support through training and technical assistance to the teachers and providers who serve our children and their families.

OVERHEAD #1

My discussion with you today will present a cross-agency model of training and technical assistance that we have been using in the Commonwealth of Pennsylvania for the past three years which prepares preschool teachers, therapists, social workers, drug treatment providers, parents, administrators, service coordinators, and even bureaucrats to

[1] The term "crack babies" is being quoted as used by others. The term "crack babies" is an inappropriate term and only serves to perpetuate the stigma that children may face. A more appropriate term is "babies (or children) affected by alcohol and other drugs".

work with and to better understand children and families affected by alcohol and other drugs.

I'd like to begin with a brief background of our program, the Family Focused Early Intervention System (FFEIS) of Pennsylvania. This program, funded by federal and state dollars, is the result of interagency collaboration among the Pennsylvania Departments of Health, Education, and Public Welfare. When people ask me for whom do I work, and I begin to explain, most are amazed. "You mean all three actually talk to one another?" The answer, in Pennsylvania, is yes!

OVERHEAD #2

Consultants are assigned to specific counties, grouped by various colors you see on the map, where they serve as advisors and liaisons to regional and state authorities. The role of the consultant is strongly intertwined with the role of Local Interagency Coordinating Councils (LICCs) whose task it is to insure that early intervention services for children birth to school age are being provided appropriately in their own communities. These LICCs are represented by professionals in the early intervention community and by parents or consumers of service. FFEIS consultants work with the LICCs in their assigned counties, assisting them in prioritizing needs, identifying areas of technical assistance needs, securing training, facilitating local community collaboration, and helping with early intervention policy interpretations.

In addition to the county-specific consultants, there are consultants who specialize in the areas of inclusion, developmentally appropriate practices, assistive technology for babies, toddlers, and preschoolers, and programs for children and families affected by alcohol and other drugs. I am one of the specialized consultants in the latter group.

Initially, when a consultation service for children and families affected by alcohol and other drugs was created, two state consultants, Deb Daulton and myself, were charged with determining the numbers of "crack babies out there" to help prepare for what was to come in Pennsylvania schools. We turned that charge into a needs

assessment which encompassed a variety of investigatory issues. We undertook that statewide needs assessment at the request of the Pennsylvania Secretary of Health, Bureau Chiefs of Special Education and of Student and Community Services, and from the Deputy Secretary of Mental Retardation.

OVERHEAD #3

We held interviews with key informants, analyzed data from hospitals, agencies, and state and local health departments, conducted focus groups with recovering women and grandparent caregivers of affected children, mailed out a provider questionnaire survey, and held a stakeholders' meeting. Through these means of information gathering, we attempted to document the number of new cases of infants prenatally exposed to drugs, the needs of these children as they entered PA's early intervention programs, and the needs of the providers who were to serve them.

Components of PRECEDE, a model for health promotion and planning, were utilized in this needs assessment. PRECEDE is a framework which takes into account the multiple factors that "shape health status and helps the planner arrive at a highly focused subset of those factors as targets for intervention" (Green & Kreuter, 1991, p. 21). PRECEDE allows for comprehensive planning within a variety of situations.

OVERHEAD #4

For our purposes, we utilized four of the PRECEDE phases, the social diagnosis, epidemiological diagnosis, educational and organizational diagnosis, and the administrative and policy diagnosis.

OVERHEAD #5

(1) Social diagnosis - The social diagnosis measures quality of life factors affecting the population under study. In our case, we were targeting children and families affected by alcohol and other drugs. We learned a great deal about this by listening to those who participated in our focus groups.

OVERHEAD #6

The major issues raised by recovering women and family members dealt with lack of employment opportunities after drug rehabilitation, lack of availability of drug-free and safe housing, insensitive and inappropriate education for the survivors of addicted families, i.e., the children of addicts, re-unification of families torn apart by the disease of addiction and less dependency on the foster care system, discrimination - both as a person of color, and as a person in recovery - in a variety of settings, and recovery from partner abuse and violence. While this list is quite extensive to us as consultants within an early childhood technical assistance system, and also knowing that we are limited in scope to find solutions to these problems, it became clear that concerns for the education of preschool children affected by alcohol and other drugs extended well beyond the walls of the classroom. To these families, staying clear and sober by not having the stresses of unemployment, safe housing, physical or sexual abuse, or the fear that their children will develop a drug habit, was clearly their daily reality. We would be irresponsible as consultants in training and technical assistance if we did not acknowledge and respect the importance of these issues when planning training programs for our providers.

OVERHEAD #7

(2) Epidemiological diagnosis - This measures health problems contributing to the quality of life issues. For this, we considered indicators of morbidity, such as drug-related births and their sequelae, rate of women entering drug treatment programs, etc..

OVERHEAD #8

We were able to obtain data from the PA Center for Health Statistics and Research. They provided us with a state breakdown of admissions to drug treatment programs, so we were able to look for trends. This allowed us later to tailor our trainings to the trends of given communities. For example, while cocaine is the primary drug of choice in southeastern Pennsylvania, alcohol and marijuana are the most frequent drugs of choice in the northeastern areas of the state. Also, due to the changes made in birth certificates and the federal requirements to states for reporting information, we were also able to

obtain data on the number of drug-related births. While these figures are considered an underestimate, due to methodological problems of data collection, it nevertheless gave us valuable information which we could share with our constituents within the early intervention community. We considered enrollments in early intervention programs but our statewide database was not fully operational at the time. We also considered smoking rates of pregnant women, data which is considered rather reliable in our state. Smoking and its effects on child development and learning are often ignored. We chose to include tobacco in all trainings on the effects of substances of abuse.

OVERHEAD #9

(3) Educational and organizational diagnosis refers to an understanding of the predisposing, enabling, and reinforcing factors which, if modified, would bring about desired changes. For example, affective traits of providers, their knowledge and skill level, and the reinforcing factors which offer feedback, such as belief systems held by parents, foster parents, and the community at large regarding children prenatally exposed to alcohol and other drugs. Much of this information was gathered via survey questions.

OVERHEAD #10

Here is where we learned the most about the pervasiveness of the "crack baby" myth. However, here is where we also learned about the large void in knowledge among early childhood educators were expressing about prenatal effects of drugs and alcohol on children's development, and how families are affected.

OVERHEAD #11

Enabling factors refer to current skill level or new skills which facilitate providers' abilities to do their jobs with affected children and their families. We learned that management skills of children in classroom environments was lacking, and that providers were seeking to improve their abilities to network with one another. Providers also expressed a desire to access more training and to locate alternative financial resources to strengthen the services they were currently providing.

OVERHEAD #12

The reinforcing factors we found which influenced how providers were receiving information and feedback regarding affected children was largely through the media, popular magazines, made-for-TV movies. These served to create a general impression of doom and gloom for the child affected prenatally by alcohol and other drugs, a reinforcing attitude also expressed within the communities where these programs were located.

OVERHEAD #13

(4) Administrative and policy diagnosis - Here we attempted to determine whether current capabilities and resources available were adequately meeting the needs of children, families, and providers. We also considered the policies and regulations governing services to the early childhood population were able to support a perinatal substance abuse training and technical assistance program. We wanted to know what policy change would be required in order to provide this type of support, and what changes in policy and regulation would be necessary to change referral and treatment, or educational, practices.

OVERHEAD #14

For example, looking at current eligibility requirements for early intervention and determining whether they we excluding affected children; more control over licensing and regulation of specialized drug treatment providers serving women and children, and exploring other sources of funding for programs serving this population.

Based on the results of our needs assessment, which took us over a year to collect and analyze, we concluded that the development of strong linkages between community early intervention providers, alcohol and drug treatment programs, health care providers, and public education activities was necessary to set the stage for a well-rounded seamless system of referral activity and services. We were fortunate to team up with the state's Office of Drug and Alcohol Programs and begin the process of reaching out to drug

treatment providers who were operating over 50 specialized treatment programs for women and their children, both out-patient and residential, across the Commonwealth. Many of these programs did not have staff with the background in early childhood to establish state-of-the-art education practice.

Likewise, in our early intervention programs, many of the staff, some of whom had been working for 20 years as day care or preschool teachers, had little knowledge or experience working with children prenatally exposed to alcohol and other drugs, or with parents who were actively using these substances.

The first thing we needed to do was to begin linking the two systems together. This was not an easy task, and it is an on-going task to this day. Both communities, drug and alcohol and early childhood, come to the table speaking a different vernacular. For example, "enabling" a parent is considered to be a negative response among those in the drug treatment world, but a good and valued practice in family-focused early intervention programs. So we had to make sure that the word "enabling" either was not used in training, or was defined in context. Likewise the term "early intervention" conjures up different images in both groups. To drug treatment providers, early intervention means finding someone at risk for becoming addicted to drugs and intervening at that point. To early childhood providers, early intervention means working with young children who have disabilities, or are at risk, during their formative years, the first three years of life and prior to entering public school.

Both groups reflect different cultures, philosophies, and assumptions. The drug and alcohol community is blessed with an extraordinary number of recovering persons who work as counselors and administrators. The early childhood community does not share that same feature - most early intervention teachers were not preschoolers with disabilities. The unique features of each group brings on a different set of assumptions and values to the forefront. For example, drug treatment providers in specialized programs see the mother as the primary client. Early intervention educators see the child

as their primary responsibility. In linking the two, a new perspective must be considered - viewing the family as the client.

After the first year of implementation of the training and technical assistance program, we began to see evidence of the program's impact in several areas:

OVERHEAD #15

The first area of impact was seen by changes in attitudes and beliefs.

(1) Our needs assessment revealed that pregnant addicts were viewed by many of our early intervention providers as morally wrong. Using parents were stigmatized as uncaring parents. We countered these attitudes by the use of recovering parents as CO-trainers and thus helped toward the de-stigmatization of the pregnant & parenting addict. If you are not in a position to do this, using prepared materials, such as video, "Women of Substance" produced by Robin Smith and Ropy Kennedy of Video Action Fund, and "Treatment Issues for Women" produced by NADIR, can be very helpful.

OVERHEAD #16

We also saw improvement in provider and educator skills and resources through networking.

(1) Frequent joint training opportunities among early intervention and drug treatment providers allows networking to happen. We try to hold meetings every other month, inviting programs from both communities to share and learn together. Just recently we completed two regional workshops on issues of access to children's health care and early intervention regulations. Another forum for joint training comes once a year when we hold our annual April teleconference. Last year, through the co-sponsorship of the National Early Childhood Technical Assistance System, we were able to broadcast our teleconference to over 80 sites nationally and to 20 sites in Pennsylvania. We plan the same for next year.

OVERHEAD #17

We have also begun to see effects of our training and technical assistance program on administrative and policy at the state level. Some of these policy changes include:

(1) the creation of minimal state guidelines for serving young children who are admitted with their mothers in residential drug and alcohol treatment programs.

(2) the inclusion of a voting member to Pennsylvania's State Early Intervention Interagency Coordinating Council from the state Office of Drug and Alcohol Programs;

(3) developmental screening of children entering drug treatment programs.

In addition, our current policy work is focused on:

OVERHEAD #18

(1) identification of existing sources of funds to assist partial hospitalization and out-patient drug and alcohol treatment centers to serve young children who are at-risk but do not meet the state's criteria to receive early intervention services via Part H or Part B funds;

(2) the DAP education initiative is being disseminated to early intervention and early elementary school educators in Pennsylvania. This emphasis on creating learning environments based on children's developmental levels and individual learning styles is very appropriate for children affected by alcohol and other drugs, and

(3) fostering DAP practices for infants, toddlers, and preschoolers in drug and alcohol treatment settings through training and regulatory changes.

How do we know our training and technical assistance program is working? Over the past three years, we have collected extensive evaluation data. I would like to present some of our preliminary findings.

OVERHEAD #19

Our program undergoes a formative, or process evaluation, that is, an evaluation of all individual trainings. We do this by determining the type of training formats offered - live or teleconference, the number of participants, the satisfaction level of those

participants, and future training needs as indicated from our evaluation feedback. This happens each time a consultant delivers a training.

OVERHEAD #20, 21

Participants fill out a registration and evaluation form at the end of each training they receive. These data are entered into a database specifically designed to match evaluation results with individual consultant trainers and training topics.

OVERHEAD #22

At the back of the evaluation form, participants are asked to provide qualitative feedback. The individual consultant is then p[provided with this feedback and a summary of ratings obtained after each of their training sessions. This system also allows for quarterly reports which are summarized and provided to the FFEIS advisory board.

OVERHEAD #23

Here I have some summarized data to share with you. These figures are extracted from the overall FFEIS training evaluation database and are specific to the training and technical assistance program for AOD.

Our average response rate for completed evaluation forms was 68% for the years 1992-94. On a Likert scale of 1 to 5, with 5 being strongly agree, and 1 being strongly disagree, the average rating across all 10 items on the training evaluation was 4.4. The following ratings were obtained for selected items such as:

- overall the content of this training met my expectations - 4.2
- I learned something that I can use in my own situation - 4.3
- I learned something new today - 4.4

OVERHEAD #24

We are currently in the process of designing the next phase of our program evaluation, the impact study. Thus far, we designing a questionnaire which will be sent to participants of our trainings over the past years, randomly selected through the registration list on our database. We are also working with outside entities to assist us in

conducting a content analysis of our write-in comments, the qualitative data received on the evaluation forms, that we have been collecting over the past three years.

My discussion with you today has focused on the development and evaluation of a training and technical assistance program designed to assist providers from various disciplines who are working with children affected by alcohol and other drugs. I want to emphasize the success of this program is largely due to its support through inter-agency collaboration among state level departments, whose missions cross over each others' with regard to helping young children.

Now I'd like to shift gears a bit and share some of my thoughts with you on how pupil services personnel in schools can use the information I have presented today.

While school systems share a district name or community, individual school buildings within a district often develop autonomously from one another. This is often due to the transaction between a principal's leadership and vision for her or his school, and the skills and resources offered by the school's faculty and staff. It is important that individual schools within districts have opportunities for cross-training similar to the cross- training we provide in our early childhood AOD program. This would include opportunities for personnel across schools within a district to develop as teams and problem-solve those issues that are facing them and are most worrisome.

In addition, the introduction of family members in school in-service trainings might provide new insights and perspectives. I believe the key to establishing safe and drug-free schools is for schools to become more family-centered and community-centered. Often we hear schools say they are family or community-centered but really, they are not.

Becoming family and community centered can be accomplished in a number of ways: having parents as trainers, or co-trainers, or inviting parents to participate in in-service trainings is one way. This strategy would require some planning, similar to the planing process I described with the PRECEDE model. You would want to know for

example, what parents perceive as necessary elements for maintaining safe, disciplined and AOD-safe schools in their community. Planning should also include taxpayers who do not have children attending school, and influential community members who can act as change agents. These are the people who need to understand why they should be more supportive of their local schools....if their voices were included in planning for prevention programs, this would begin the process of the school becoming more community-based and community focused. Using focus groups, or conducting stakeholder meetings are two methods that we used in our needs assessment which school districts can use to include taxpayers and community members in their prevention planning.

Another important aspect in cross-training is to make the situation cross-disciplinary. Often times, those providing pupil services such as student assistance do not benefit from the knowledge and expertise of other professionals in the school building. For example, speech-language pathologists (SLPs) are trained in communication skill building but are viewed by others as only serving students with speech disorders. Their roles within schools have historically been limited and their skills under-utilized. One reason for this is the way that school districts are funded to hire SLPs. SLP positions are often tied to the number of special education students receiving SLP services. This is a regulation that needs to change.

The SLP can help the student assistance program (SAP) team members in the teaching of coping skills to students. The coping skills I am referring to are: (1) identification of feelings, (2) communication of feelings, (3) positive social interaction skills, (4) problem-solving skills, and (5) self-reliance or self-efficacy skills. These abilities are known to improve resiliency in at-risk students are usually incorporated in AOD prevention curricula.

SLPs have traditionally worked with students who present language and speech disorders. However, their preparation for master's level training and licensure includes

developing competencies in language development theory, cognitive approaches to language intervention, intervention for disorders of pragmatics, or social communication disorders.

SLPs can work to assist school teachers, health educators, and the SAP team in the creation of new curricula to meet the needs of students with language disorders, or to make modifications to existing curricula for students with special communication needs. SLPs can also be better utilized in the classroom at the early elementary levels. Through classroom collaboration, the SLP and teacher can design a whole language approach to prevention oriented lessons.

And finally, I would urge schools both at the building level and at the district level to be more attuned to the needs of AOD affected children and families. Families in addiction or crisis will rarely turn to the school to seek help or referral. Sometimes this is because we have developed adversarial relationships between school and home. Pupil service personnel need to gain a better understanding of how families can be empowered to help themselves - this will require school personnel to gain new knowledge and skills in dealing with families in denial or in crisis.

It is not easy to change...most of us would rather continue doing things the way we have always done them. After all,

OVERHEAD #25

the only person who likes change is a wet baby. I encourage you to take the risk....make that change.

READINGS

Antoniadis, A., and Daulton, D. (1993). Children and families affected by alcohol and other drugs: a study in Pennsylvania. Report of the Family Focused Early Intervention System of Pennsylvania. (Available through FFEIS, RR1, Box 70A, McVeytown, PA 17051)

Buckely, J. & Mank, D. (1994). New perspectives on training and technical assistance: moving from assumptions to a focus on quality. JASH, 19, 223-232.

Green, L. W. & Kreuter, M. W. (1991). Health promotion planning: an educational and environmental approach, second edition. Mountain View, CA: Mayfield Publishing Company.