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Evaluating the Implementation of the Kentucky Drug Endangered Children Training Network

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Evaluating the Implementation of the Kentucky Drug
Endangered Children Training Network

Ramona Gabbard
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Executive Summary

In late 2004 the Kentucky Drug Endangered Children Alliance was created to bring attention to the methamphetamine problem in Kentucky and coordinate the efforts of many different agencies. The Training Network is part of the Alliance and seeks to educate the various service providers that may come into contact with the child victims of caregiver meth abuse and production. The Training Network estimates it has provided training to almost ten thousand individuals in the three years it has been at work.

My evaluation of the implementation of this training effort focused on the type and number of participants and whether the goals and intentions of the network were achieved. Because the founders of this program did not intend for it to be long-term, the structure and goals of the program were not planned beyond holding a few trainings on the subject of methamphetamine in Kentucky. They expected another well-established agency to incorporate the need for training on the subject of drug endangered children and methamphetamine. Even now, three years after they began, the program had no logic model or consistent evaluation methods. By using a coverage analysis, reviewing program records, and conducting a component analysis I determined that the Alliance Training Network has room for improvement, particularly in the areas of built-in evaluation and consistent record-keeping. If the Training Network works to improve planning and evaluation they could use their knowledge to not only improve their current trainings but improve the likelihood of successful programs in other states that are dealing with similar problems.

-Kentucky Drug Endangered Children Training Network-

In December 2004, the Kentucky Alliance for Drug Endangered Children was formed. The inspiration for the program is a National DEC Alliance with which Kentucky's Alliance is loosely associated. The founders of Kentucky's DEC Alliance acted because they saw the significant impact of methamphetamine in our state. Kentucky's resources, especially in rural communities, were being drained by methamphetamine in the community. Kentucky's DEC Alliance is a far reaching collaboration that includes the UK College of Agriculture Cooperative Extension Service's Health Education through Extension Leadership (HEEL), College of Medicine, College of Social Work, College of Public Health, College of Law, College of Pharmacy, and College of Dentistry in partnership with many agencies across the state.

The Drug Endangered Child Training Network (DECTN) is one part of the Kentucky DEC Alliance. Its function is to train community service providers that are likely to become involved in the lives of children who are the victims of caregiver methamphetamine manufacture or abuse. The purpose of the training is to disseminate accurate information regarding the risks for children in drug endangered environments, particularly involving meth, and to encourage a collaborative response among these service providers to bring about positive outcomes for the children involved. Collaboration is further encouraged by the Training Network through advocating the formation of local "DEC teams" in each county.

While the coordination of community services is beneficial to protecting children in any drug abuse environment, DEC programs have gained acceptance and momentum because of the serious strain that children's meth exposure and its' aftermath has placed on a community's resources.

Research Question

Since it began in 2005, the Drug Endangered Child Training Network estimates it has provided 500 trainings to nearly 10,000 people. Is the training reaching the target audience? Do the activities of the DECTN match their theoretical intentions for the program?

Literature Review

The term “drug endangered child” is a relatively new term and the state alliances that have formed are often very new. For this reason, there is virtually no research done on these specific programs. In the limited literature concerning drug endangered children, there is a great deal of information overlap because the concept is relatively new. Most work on the topic is descriptive or anecdotal and there is a definite lack of empirically based research. But training people, even from multiple disciplines, is nothing new. Evaluations of programs with a similar collaborative intent to the DECTN are mostly generated from the fields of social work and public health. Relevant studies and evaluations measured training outcomes and attempted to gauge the success of collaboration among service providers.

“Drug Endangered Children Need a Collaborative Community Response” presented research and findings from an evaluation of the first year of the Drug-Endangered Children Project in Spokane Washington. This is the *only* implementation evaluation of any DEC related activity that I found in the literature. The “DEC Project” in this article was essentially what Kentucky’s Drug Endangered Children Training Network refers to as a “DEC team”— a local level of collaboration among service providers that meets regularly.

In this study, the evaluators sought to gauge success by evaluating the outcome of Child Protective Service (CPS) case files on children identified by law enforcement as having been found in a

drug endangered residence. Of the 22 children identified, only 11 had files with the local CPS office. The inconsistency between law enforcement and CPS records demonstrated the need for interdisciplinary understanding and cooperation because it meant there were 11 children who never received the services that social work can provide. Within the CPS files, there was a marked lack of information and case resolution as all of the 11 children were still in protective custody and there was sparse information on mental health history. Some children were still “falling through the cracks” and for others it was too early to say that some children were positively affected by the DEC Project’s existence.

The second question that the research tried to answer was how well the DEC team collaborated in its first year. There are no assessments that have been established in the literature as effective measurements of multidisciplinary collaboration, so the evaluators chose two common assessments called the Team Fitness Test and the Team Observational Tool as indicators of group cohesiveness and measurements of communication, leadership, role clarity and goals. These instruments were given to team members at every meeting as well as to student assistants that observed the meeting. In the Spokane research, team members ranked collaboration high throughout the first year with no significant differences between the first meeting and last meeting of the year. However, the student observers ranked collaboration lower.

The researchers felt this implied that team members feel good about working with other disciplines but may not represent an objective view of real cooperation and collaboration. Because the participants had a vested interest in the study, they may have ranked collaboration higher than it really was. This should be taken into consideration when choosing tools to evaluate collaboration among DEC teams. The evaluators never gained a clear understanding of why there was no follow up from CPS regarding the law enforcement-identified drug endangered children, but the study indicates that despite the efforts of this “DEC project”, the communication between disciplines was perhaps not very good.

Feelings of collaboration among DEC teams, while important, should not be weighted more heavily than objective successes. (Altshuler, 2005)

Partly due to the Homeland Security mandate for emergency preparedness, there are many recent studies regarding programs to train service providers. Studies like these are especially useful because like the DEC training, these trainings seek to bridge the gaps among a diverse collection of service providers in preparation for intense, serious events. A 2005 study in the *Journal of Public Health Management & Practice* reported results from a 6 day training program to increase emergency preparedness among public health staff and community service providers. The training forced the formation of multidisciplinary teams, required outside team homework and employed a team-based tabletop exercise. The evaluators used participant surveys, observation and developed several other instruments to gauge success of the training.

They acknowledged the challenges of assembling full-time workers for long training and of making the content useful for such a diverse audience of disciplines. But they argue that the intensity and the group-learning are well worth it. For example, the evaluators found a “significant increase in networking, communication, and coordination between individuals from different agencies/departments”. The evaluators also suggest making any team exercises as “real world” as possible by providing realistic circumstances and encouraging problem-solving. (Livet, 2005)

Another study from the same *Journal of Public Health Management & Practice* points out some other effective tools for measuring the success of training—pre- and post-tests and the follow-up survey to determine if appropriate implementation has occurred. The training program, which targeted public health employees and their community partners, focused on a series of concrete steps to utilize a new method of strategic community health improvement. The pre- and post-tests and follow-up survey yielded helpful information such as what tools training participants found most useful and how many were implementing what they learned six months later. Gathering feedback is sometimes viewed as a waste of time and money by trainers, but if the information requested is relevant, it is well worth the

time and effort to develop the tests and surveys. Done properly, tests and surveys provide evidence of the effectiveness of training and point out ways to improve the program. (Lesneski, 2005)

Finally, an evaluation from the *Journal of Environmental Health* analyzed a bioterrorism preparedness training program that recruited volunteers from three subsets of the program's target population of "first responders"—police departments, rescue squads, and fire companies. The evaluators argued that programs which "train-the-trainers" are often more efficient when the target population is dispersed. In this way, the training participants can go among their own profession and relay what they have learned to their co-workers in a time-efficient and convenient way. (Abatemarco, 2005)

A uniting thread of all of these training programs (or any social program) is their goal of creating a positive change and persuasively linking that change to the work of their program. To do this, the program must provide rigorous documentation so that appropriate evaluation methods can be used. Many of these programs, knowing that ongoing evaluation can add to their credibility, build it into their program by doing pre- and post-tests and gathering consistent records on participants from the beginning. Another common evaluation tool is following up with training participants to see what is working and to identify reasons for any failure of the program.

Research Design

Program evaluations have grown increasingly important in the past several years because of the demand for proof of effective programs by policymakers and the public and the need to monitor and improve ongoing programs. The program itself should guide the decision of which evaluative tools to use. Evaluation at each of the following stages is possible and necessary to create the most effective programs. The chronological model of program development developed by Berk and Rossi provides a useful method for matching appropriate evaluation methods to each progressive stage of a program. The stages Berk and Rossi identify are:

- 1- Assessing Needs and Feasibility
- 2- Planning and Design of the Program
- 3- Delivering the program
- 4- Improving the program

In the case of the DECTN, the program has been training individuals for two and a half years and reports that it has trained nearly 10,000 people. From my initial interaction and introduction to the program, it appeared beyond any brainstorming/ design phase and was well into delivering the program. Because of this, I chose to use three tools identified by Berk and Rossi as effective evaluative tools of a program's success when in the delivery stage. (Berk and Rossi, 1999) The evaluation methods that I used to use to evaluate the program are: reviewing existing program records, coverage analysis, and component analysis. I later added a logic model to my list of evaluation methods. Logic models are useful evaluation tools at any stage of a program and the Training Network certainly needed an established logic model.

The Essential Evaluation Tool: The Logic Model

A logic model explains to outsiders how the program will work to solve a problem and can serve as an internal guide to program administrators. Programs may become complex very quickly but the bare-bones structure of the logic model returns administrators to the original understanding and reasoning of how the program is to work. Logic models typically identify the resources the program will rely on, such as specialized human knowledge or financial support. It identifies the necessary activities that will be undertaken to achieve their desired outcome. The outputs are the services or products that are made available to the targeted population of the program as a result of the program activities. The *outputs* are important to define separately from the *outcomes*.

While the development of a logic model is most beneficial at earlier stages of program development, the reality is that many programs do not have clear logic models before program delivery. The Training Network was no exception to this common pitfall. Logic models clarify the intended cause and effect relationship from a program's activities to its expected outcomes. To make effective use of further evaluation tools, the logic model should be firmly established.

Component Analysis

Many aspects of program evaluation require an established logic model. A careful understanding of the logic model is considered especially crucial to the component analysis. A component analysis maps the relationship between program operations and outcomes for each major component of a program. By attending DEC meetings and working with the staff of the Alliance, I was able to develop the logic model and use it to develop a flow chart that defines the relationship between the training network's program operations and the short term and intermediate outcomes they expect from the training. It is also useful to identify potential political and economic factors that could impact

program implementation. With the stakeholder input and the logic model, I separated each major component of the Training Network and linked it to its expected outcomes to compare with the planned program and provide feedback. Using this analysis in conjunction with the logic model will allow the Training Network to more accurately revise and improve their program by targeting the areas that do not meet expectations.

Program Records

Program records should be generated on the basis of usefulness. For this reason, I initially worked with the staff of the DEC Alliance to identify key questions and concerns about the program. Then I reviewed the program's current records to assess their adequacy in answering those key questions. Any program can generate mountains of paper and data, but linking program records to necessary and important information needs will make a program much more efficient by eliminating needless data and identifying new types of program records and evaluation tools that can answer the questions that current records do not meet.

Coverage Analysis

Coverage analysis is useful for evaluation because it provides information regarding the acceptance of and extent of participation by the target group and examines the different levels of participation by subgroups of the target population. Without realizing it, many programs exclude people they claim to serve or give priority to those with less need. Coverage analysis can uncover these inconsistencies and help program administrators evaluate their current methods of attaining participants.

Data Collection

The Training Network made training participant data gathered from training sign-ins available to me to measure participation by the various community service providers in the target audience. Also a web-based survey was performed by the Training Network using Survey Monkey. The resulting feedback from this survey was also made available.

Data Analysis

Those individuals that received the web-based survey and those present in the training participant database overlap. I only used the participant database to measure participation among various groups. I will use the survey to gauge effectiveness of training as it asks respondents about how prepared they felt to create a DEC team in their county because of their DEC training experience. The survey also asks how effective they think DEC teams will be for creating positive outcomes for drug endangered children in their county. This information speaks to the level of acceptance of the program by training participants.

Both databases are made up of open responses. For instance, training participants and survey respondents wrote out the name of the agency they represented. To make use of these databases I coded the open responses so that I could identify which target group the person is representing.

Findings

Developing the Logic Model

During initial meetings and conversations with leaders in the organization, I was informed that there was a logic model and I was welcome to use it. This was important because several program evaluation tools require a clear logic model of a program before proceeding into further evaluation. Unfortunately, when I received this logic model I found it was actually a flow chart of how they wanted different community service providers to work together. (This original document can be found in Appendix A.) Because of the lack of a previously established logic model, I spent a considerable amount of time gleaning information through informal interviewing, discussion at meetings, and feedback on several drafts, to create the DECTN logic model.

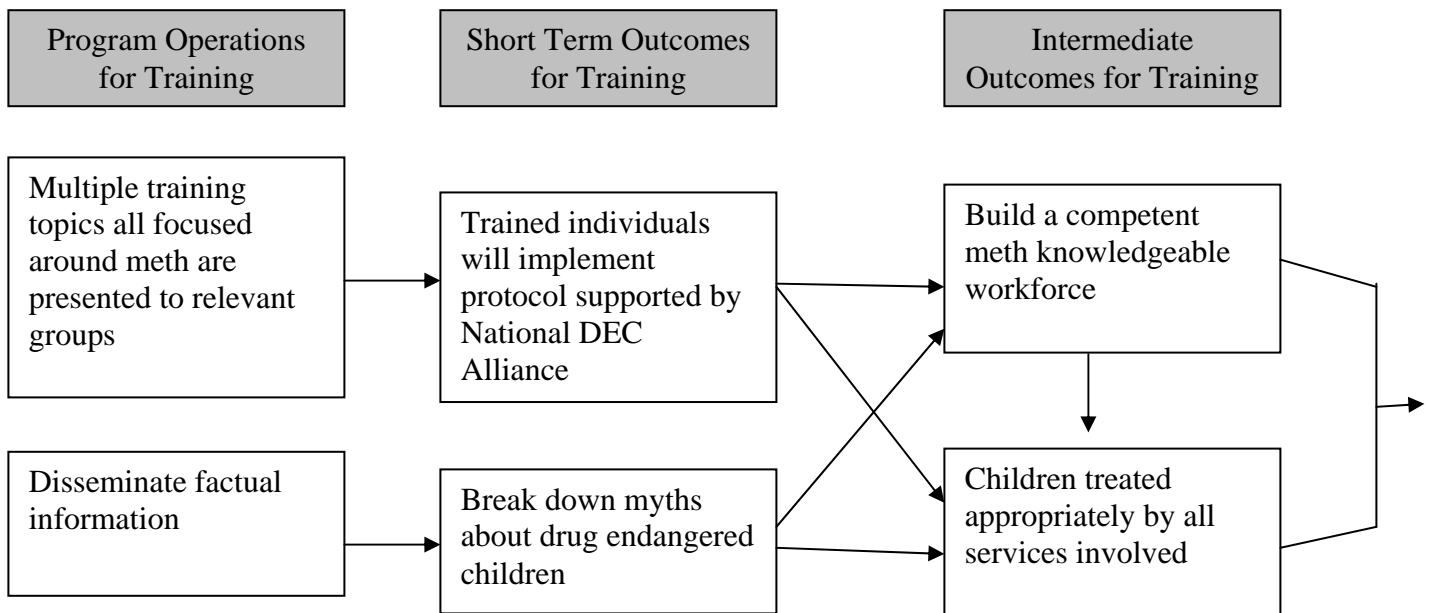
Delving back into the history of Kentucky's DEC Alliance, the program's chair, Holly Hopper, explained to me that it started in a very ad-hoc fashion. The founders felt there were many organizations in Kentucky that could have easily filled the need for training and education regarding the myths surrounding methamphetamine. These founders believed the need for training would be realized and quickly integrated by another organization capable of providing the training. Instead, requests for training poured in and the program has done continuous training all over the state to small and large groups. They did not formalize a strategy or a program logic model when they began. After two and half years of training they are beginning to see the need for a logic model to effectively evaluate and improve their program. Not only does the lack of a logic model impede program evaluation, but it also impedes clear success and understanding among program participants. In the case of the DECTN model, the inputs are trainers and their specialized knowledge and financial support from several relevant regional agencies. The activities are to build presentations with meth as the central topic and to bring together people who are concerned about meth and other drugs in the community who may not already know each other. Their output is providing trainings, but that is not

their end goal. Their end goal, or desired *outcome*, is to build knowledge and break myths regarding meth in order to have a positive effect on the lives of drug endangered children. The component analysis will make further use of the logic model.

Component Analysis

Components are generally defined as the largest building blocks or features of a service. In the case of the DECTN these blocks are the trainings and providing support for DEC teams. I developed separate flow charts of these two components that link them to program theory.

The first flow chart shows how program operations for training lead to the expected short-term and intermediate outcomes.

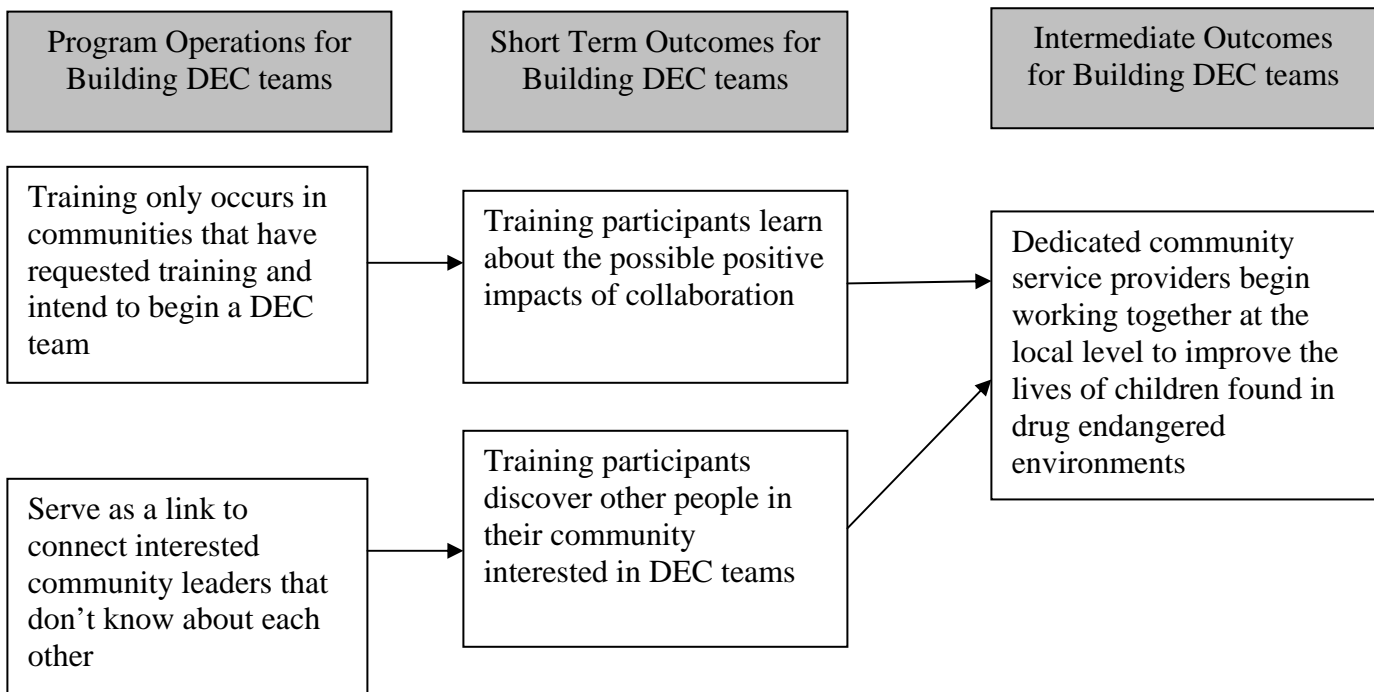


Because the DECTN has not investigated the outcomes of any specific child protection cases, they cannot link their training with any specific successful outcome. However they have trained many (almost 10,000) people and intentionally identified and combated false information that gets circulated about children exposed to meth. They have likely influenced the way many people have interacted with

children found in meth-producing homes, but there is no way to really know that because of their lack of records. We really only know that they are completing their program operations, but not whether that translates to their desired outcomes. They will improve the likelihood of children being treated appropriately by all community-based services if they make evaluation and record-keeping a priority and demonstrate the link between training and successful outcomes.

Included in the figure of 10,000 training participants are several groups that do not fit their intended audience. This could be a sign of political influence causing them to train individuals in order to please powerful people. Another potential political and economic impact comes from the statistics surrounding methamphetamine. The number of drug busts or people in treatment going up or down will have an impact on funding from politicians and agencies. Less community problems with meth and other drugs should mean less of a need for training but there are rumors that some poor rural law enforcement are telling known meth producers to get out of their county so they won't incur the high cost associated with a drug bust.

The second flow chart shows how program operations regarding DEC teams are to lead to short term and intermediate outcomes for successful DEC teams.



The component analysis, when used in conjunction with the coverage analysis and stakeholder input, revealed that although building DEC teams is considered an important component of the program, there are significant gaps in bringing them to fruition. Trainings are often given in a profession-exclusive, not collaborative, setting and participants are missing the opportunity to meet a diverse group of interested individuals. This could be a potential political influence. There is a history of contentious relations between some service providers such as law enforcement and social workers and by having profession-exclusive trainings they are avoiding interaction. But coming together and understanding the motivations of each service provider would improve relations and lead toward effective DEC teams.

The program administrators confide that despite numerous trainings and several dozen DEC teams starting, there are only a handful of viable DEC teams. The Training Network is essentially not fulfilling its intended operation of connecting interested community leaders. Also, there is a gap between the short and long term expected outcomes of building a DEC team. While the survey in the coverage analysis gave indication that program activities are getting training participants to realize the potential impact of a DEC team, the program is doing little to show people how to start one. A general reluctance to be proactive in this role of starting DEC teams has inadvertently come to mean that there is actually not even a consensual explanation of what a DEC team is or what it should do.

Program Records

Before I assessed the program records, I discussed some of the most pressing research questions and data needs of the network with the stakeholders of the organization through time allotted at meetings and through questionnaires sent by e-mail as a follow-up from meetings. The Training Network members identified the following as important data needs.

- Assessing what subgroups in the target audience have been reached and identifying groups that are underrepresented
- being able to link the training efforts to any positive outcomes in child protection cases
- evaluating the success of DEC teams that have developed as a result of the DECTN

As stated previously, the Training Network members initially believed their existence to be short-lived and did not arrange for much data collection. As a result, I found that their data regarding program participants is not comprehensive. The data on 2005 trainings included individual level information, such as what organization participants represent, their occupation, title, and what county they represent. The four trainings that occurred in February and March of 2005 were sponsored by the National DEC Alliance. Since the 2005 trainings, Training Network has recorded data only in an aggregate form. The 2006 and 2007 training databases listed the type of participants at each training but no individual level detail is given. This is less of a problem if training is specifically for teachers or law enforcement and they are the only type of participant at a certain training. But it becomes an issue when there are several different groups at a single training and they simply record that 65 people were in attendance. Because data was collected in aggregate, the detail and accuracy of the information regarding participants suffers. The DECTN has no way of utilizing this information to know whether a training that was offered to a range of disciplines was only attended by one group. Unfortunately, the 2006 and 2007 data also are incomplete, as there are several items missing.

Another complication for the program with determining the numbers of training participants and their background is that the few trainers utilized by the DECTN are volunteering their own time and are encouraged, but not required, to record attendance data and training evaluations. The trainers come from the professions the DECTN is trying to reach and trainers who can communicate effectively within their own profession are a valuable resource. However, the program administrators have had problems getting the trainers to consistently record information on participants. The reason for this complication, they cite, is they feel they can only request that the trainers keep track of participation but they do not have the authority to demand it. But it hinders evaluating how well target groups have been reached if large numbers of trainees in specific target groups have been trained with no way to track them. Certainly this is an issue that must be addressed if the program is to gain validity and be useful to

Kentucky as a weapon against drug use. Despite these limitations, it was possible to use DECTN records to get an idea of what subgroups in their target population had been reached and which ones had not. The findings from the coverage analysis follow.

Another information need, which is to link the training to positive child protection outcomes in real cases, is hypothetically possible but not with the Training Network's current records. One possible way to do this is by using their access to the records of child protective services. The CPS has recently agreed to make a significant amount of their records open to the DECTN to review cases flagged for children removed from homes due to caregiver drug abuse. While the process would be time consuming, they may be able to identify and interview the community workers who were involved. They could survey them and determine if there is a difference in outcome for the children between those who had received training and those who had not. One potential complication is that the state child protection records to which they have been promised access are in the TWIST (The Worker's Information SysTem) database, which is notorious for frequently crashing and being poorly constructed. Unfortunately, using this path to determine success could end similarly to the incomplete child protective records found in the Spokane, Washington DEC study discussed in the literature review, which found large gaps in data and inconclusive results.

A more likely intermediate step to this larger goal of determining positive outcomes for the children is to do pre- and post-tests of training participants and maybe even a 6 month follow up regarding knowledge of drug endangered children and the retention of this knowledge. Using this information would be a steady base to build more detailed research. It may also help to define success (and failure) for drug endangered children because often their lives are in turmoil for years after caregiver drug use. Success must be clearly defined before it can be measured.

Finally, the DECTN also wants to evaluate the success of DEC teams. The formation of local DEC teams is encouraged by the DECTN but they have been reluctant to be prescriptive regarding the membership or actions of the teams. Currently, the DECTN members make themselves informally

available to offer advice or material support for DEC teams but do not initiate the contact or evaluate team performance. Of the more than 40 DEC teams that claimed to have formed the DECTN leaders considered only ten or so are viable groups today. Contact with each of these DEC team is possible but an in depth analysis of each team may be beyond the limited financial resources of the DECTN. At the very least the Training Network should establish objective behavioral indicators of what makes a DEC team viable. These behavioral indicators will not only help evaluate current groups and provide them with ways to improve but will also serve as guidelines for future DEC teams.

Coverage analysis

~Target Group Participation~

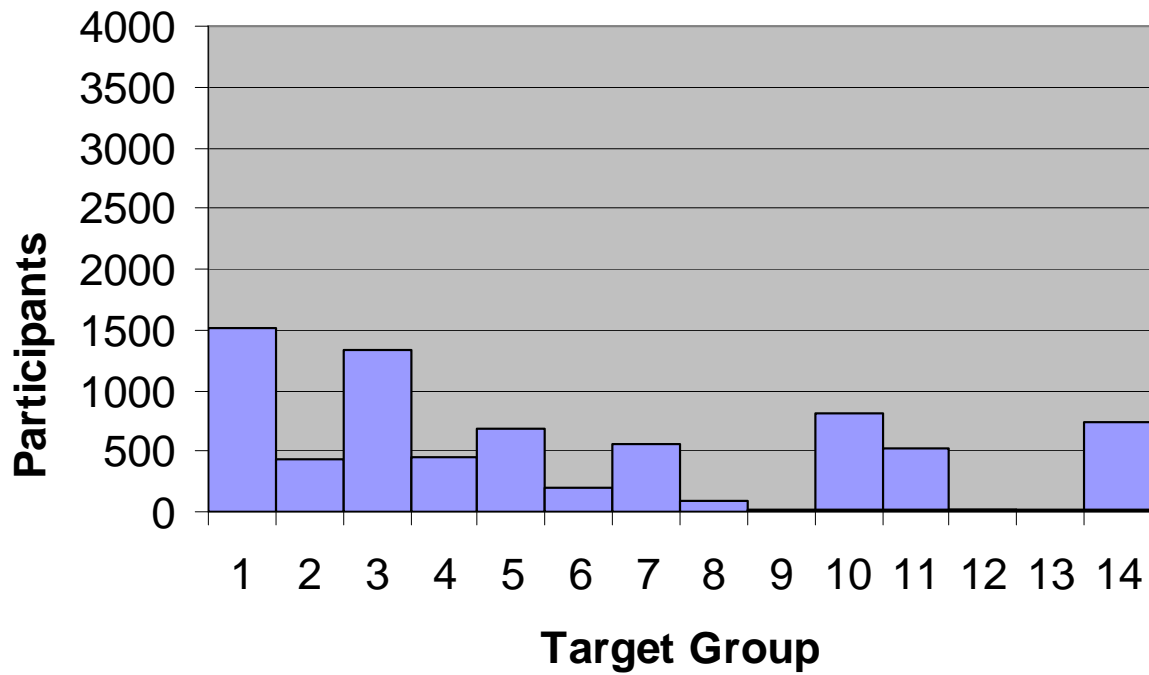
As explained in the review of program records, the loosely gathered data on training participants greatly impedes the accurate assessment of coverage of the target population. My sample was N=9661 and came from several different databases. The spreadsheet of the 2005 trainings contained individual level data that was too detailed to be useful for comparison. For this reason, I worked with the program leaders to define target groups in which to code these individuals. For example when program records identified a participant from Kentucky River Community Care, I subsequently coded them into the Mental Health/Substance Abuse target group. I broke down participants into fourteen categories.

Agency Code	Target Group
1	Law Enforcement/Legal
2	Child Protection
3	Schools
4	Mental Health/Substance Abuse
5	Health Departments
6	Family/Child Services
7	Other Social Services
8	Universities
9	Extension Offices
10	Medical
11	Community coalition
12	Environmental
13	Emergency response
14	Unspecified or Not Targeted

The information in the 2006 and 2007 training databases was in aggregate form. Instead of individual-level information on occupation and agency, the Training Network program administrators only recorded the subject of the training and the type and number of participants. As I discussed earlier this has an effect on the accuracy and level of detail in their records. (Some of the group types they used are of course similar to the codes I needed to develop, but the 2006-07 trainings did not include all of the target groups.)

One single training in Seattle in 2006, regarding drug courts, was recorded as having 2300 participants. All other trainings were in and for Kentucky, so for purposes of comparison, it is worth throwing out this specific training. Had I included this training in the data, the law enforcement/legal target group would have accounted for 39% of training participation. As an outlier this training is skewing the data and removing this changes the participation landscape significantly. With the Seattle training removed the law enforcement/legal target group accounts for 20.5% of the training participation. The following bar chart shows training participation with this drug court training removed.

Training Participation



Agency Code	Target Group	Number of Participants	Percentage
1	Law Enforcement/Legal	1515	20.5%
2	Child Protection	425	5.8%
3	Schools	1332	18.1%
4	Mental Health/Substance Abuse	451	6.1%
5	Health Departments	676	9.1%
6	Family/Child Services	200	2.7%
7	Other Social Services	561	7.6%
8	Universities	86	1.1%
9	Extension Offices	25	.3%
10	Medical	809	11%
11	Community coalition	527	7.1%
12	Environmental	12	.1%
13	Emergency response	3	.04%
14	Unspecified or Not Targeted	739	10%
		7361	99.54%*

*Total % not exact due to rounding

The law enforcement/legal target group still has the highest participation level at 20.5 % even excluding the Seattle training. Several other things are worth pointing out as well. The “unspecified or not targeted” participants made up 10% of those trained. A participant was placed in this category when they either had no identifying information so that I could not categorize them or they did not fit into any of the 13 established target groups. Efforts should be increased to record this essential data whenever possible. Examining this group in further detail 116 training participants were actually federally incarcerated men taking part in Victim Awareness training. For political reasons, training outside their target groups may be beneficial, but each time the DECTN should carefully consider whether they are keeping other high-priority groups from receiving training.

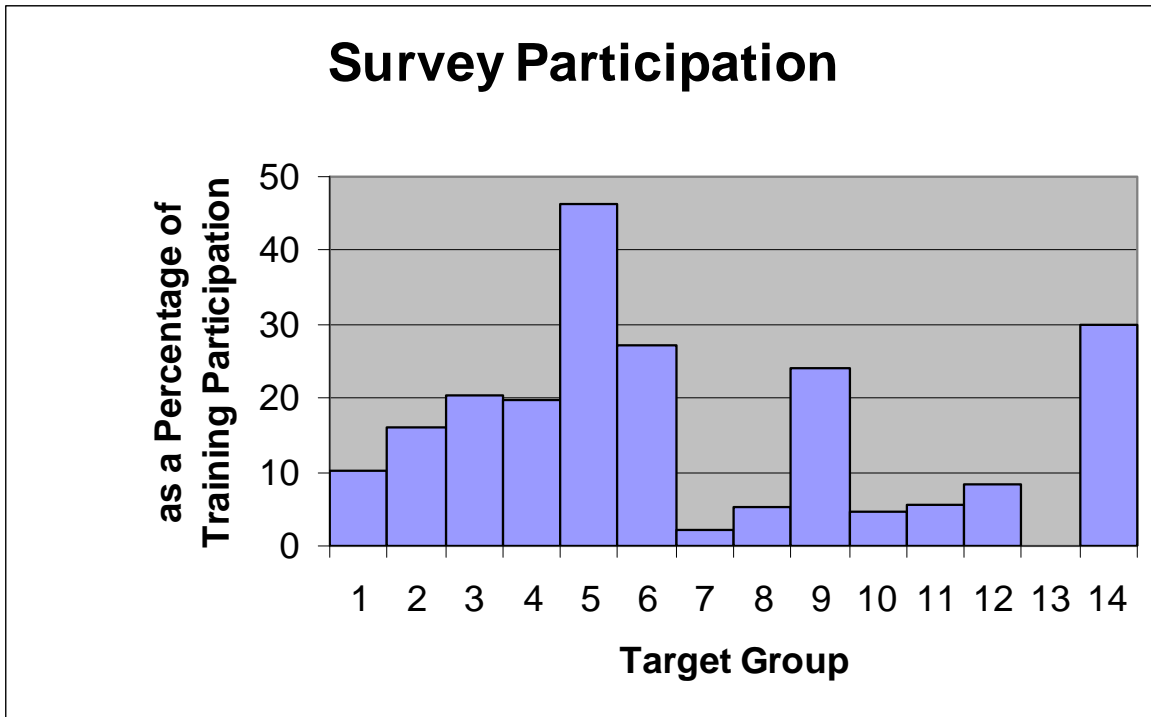
The coverage analysis forced the program managers to think about the categories of agencies and community service providers they are serving and categorize them by their purpose in attending trainings. However, a limitation is created from what is meant to be a strength. As I mentioned earlier, when discussing the program records, the trainers have various professional backgrounds and provide training to those in occupations with which they are familiar. For instance, one individual works with EMTs in his profession and frequently trains them for the Training Network. The program administrators know they have trained many EMTs through this individual, but the numbers in their database do not reflect this- it shows they have trained 3 emergency responders. Again, the DECTN encourages, but does not demand, that trainers record participant data. There is no standardized method for collecting information on program participants and no central database in which the information is stored. The limitations presented by this lack of data may push the DECTN to request more forcefully that at least minimal data be collected on program participants. They would likely receive less resistance to gathering this data if they developed a standard method and even forms for recording participation.

Finally, although the program may be able to create a more targeted presentation for these disciplines by using trainers that train their own professions, the program should consider the impact on communication. Communication is difficult to improve across occupations and disciplines when the participants do not often come together for trainings which are an ideal place for them to meet.

~Participant Acceptance~

Another source of information was a web-based survey constructed by the DECTN that asked training participants many questions about their communities, including community awareness of the meth problem, awareness of the DECTN, and the steps that have been taken in each community to combat the problem. They also requested the respondents' opinion regarding the effectiveness of training and the usefulness of DEC teams to combat problems with drug endangered children.

The survey results yielded only 198 responses out of 900 successfully delivered. (1089 e-mails were sent out but only 900 were deliverable.) The people responding to this survey come from the people that attended the first four trainings in 2005. Below is a bar chart showing the level of survey response from the 2005 training participants. For example 216 training participants came from schools in the 2005 trainings. Of those that participated in the training 20.3 % (44 individuals) responded to the survey.



Agency Code	Target Group	Number of Training Participants	Number of Survey Participants	Survey Participation as a Percentage of Training Participation
1	Law Enforcement/Legal	87	9	10.3%
2	Child Protection	291	47	16.1%
3	Schools	216	44	20.3%
4	Mental Health/Substance Abuse	127	25	19.6%
5	Health Departments	56	26	46.4%
6	Family/Child Services	99	27	27.2%
7	Other Social Services	42	1	2.3%
8	Universities	37	2	5.4%
9	Extension Offices	25	6	24%
10	Medical	21	1	4.7%
11	Community coalition	53	3	5.6%
12	Environmental	12	1	8.3%
13	Emergency response	3	0	0%
14	Unspecified or Not Targeted	20	6	30%
	Total Survey Participation	1089	198	18.1%

The overall survey participation from the 2005 training participants was only 18.1%. This response rate can be improved in the future by gathering accurate up-to-date e-mail addresses and explaining future surveys at trainings and their importance. The Training Network may also consider

using postal mail to send reminders to agencies with many training program participants or even to deliver the surveys to agencies that can distribute them to training participants.

The Health Department target group stands out because while they are only the sixth largest group represented in the training they have the highest survey response rate. In fact, it was 19.2% higher than the next highest response rate from Family/Child Services, with 27.2%. Looking into a possible reason for this higher survey participation from Health Departments may yield ways to increase future survey participation from all groups.

Of the few questions asked in the survey, the responses that I measured were on questions regarding how confident the respondent was that they could start a DEC effort in their community, and how confident they were that community based DEC teams could improve the lives of children in their community. Respondents were asked to respond using a Likert-type scale of not confident, somewhat confident, confident or very confident. The reason this question is important is that most training is not done unless the community or agency in which the training is to occur commits to starting or participating in a DEC team.

The results of the item asking whether the respondent felt confident that they could start a DEC team in their area after receiving training showed that the majority of respondents did not feel confident (21%) or felt somewhat confident (48%). There were also a significant percentage of people (19%) who did not respond to the question.

Not Confident	42	21%
Somewhat Confident	95	48%
Confident	17	9%
Very Confident	7	4%
No Response	37	19%

The item regarding the confidence the respondent had that a DEC team in their community would improve the lives of children in the responses varied widely. There was no *single* response that seemed to capture the opinion of most respondents. However, it is noteworthy that *confident* and *very confident* together accounted for 58% of respondents and only 3 respondents, 2% of the sample, were not confident at all.

Not Confident	3	2%
Somewhat Confident	47	24%
Confident	63	32%
Very Confident	52	26%
No Response	33	17%

Together these findings suggest that although those who responded to the survey *did not* feel confident creating a DEC team in their area they *did feel* that having one in their area would have a positive impact on the lives of children in the area. The DECTN should see these findings as encouraging in that members of the community have bought into the idea of a DEC team. However, the

findings also show evidence that while considered useful or valuable, few people feel prepared to actually organize a DEC team in their area. This could change some of their focus in trainings to being more hands-on in DEC team building efforts rather than simply being an advocate for creating a DEC team with little instruction or support.

Recommendations

I have several specific suggestions for revising the Training Network and building regular evaluation into their program. The first step is to evaluate the current status of methamphetamine in the state and whether the program's current training methods are meeting the need. There have been major changes to the aspects of meth use in Kentucky in the past two years. For example, KASPER, the Kentucky All Schedule Prescription Electronic Reporting System, has made it difficult for home drug manufacturers to buy the amount of ingredients they need and there has been a declining number of reported meth home drug busts. However, fewer reported meth labs does not necessarily mean less meth abuse and addiction which is a leading cause of children being placed in foster care. Changes such as these are important and should not be ignored lest trainings tackle an issue that is obsolete. They should research what regions are still struggling the most with this issue so they can effectively target their limited resources. Knowing how changes such as these have affected their training goals and methods is essential.

Once they have evaluated the current landscape of meth and other drugs in Kentucky, they must then standardize their trainings to the point that they can at least be assumed comparable. As it is, trainers create presentations that are then approved by program administrators. The program should have a standard presentation that can be modified or supplemented for different audiences such as school administrators or law enforcement. Preferably these agencies would be trained together since training separately means that the Training Network is missing a prime opportunity to build collaboration and

encourage the formation of DEC teams. If the Training Network finds this impossible then they should at least have a standard presentation. Without some level of standardization, survey results from program participants will be meaningless because everyone will have received disparate trainings.

The next step is to do as much pre-training registration of training participants as possible. People do not randomly show up to these trainings; they are pre-planned events that often target specific agencies. Registration overcomes the problem of inconsistent program records due to reluctant trainers and provides a reliable record of participation. It also provides a reliable record to send surveys later and keep in touch with training participants starting DEC teams.

With standardized training and registration pre- and post-tests become possible. The pre-test can occur as part of the registration or right before the training begins. This would be a great resource for the Training Network as it will provide immediate feedback about the current level of knowledge among program participants and give post-training feedback about how well their training is disseminating knowledge and breaking down myths surrounding meth and drug endangered children. Pre-post tests are also helpful examples to interested outside parties if the Training Network is seeking funding.

No measurements regarding success or degree of collaboration have been attempted among the DEC teams that have formed in Kentucky. The desire to evaluate the success of any of the current DEC teams was a desire of the organization identified in the program records. Making it a high priority will help to improve this essential area of their program. Designing focus groups with several DEC teams in a standardized way can yield results about how differences in membership or methods shaped success. Another possible tool is the Team Observation Tool used in the Spokane DEC research detailed in the literature review. (Altshuler, 2005) The Team Observational Tool can be found in Appendix C. This tool may be more effective than a focus group because of the structure and comparability it provides. Focus groups are often ineffective and inconclusive without a well trained discussion leader.

I am afraid I could write another ten pages on all of the ways that the Training Network could improve. The Alliance and Training Network has been established for almost three years now and it is time to evaluate their intentions, goals and the landscape of methamphetamine in the state.

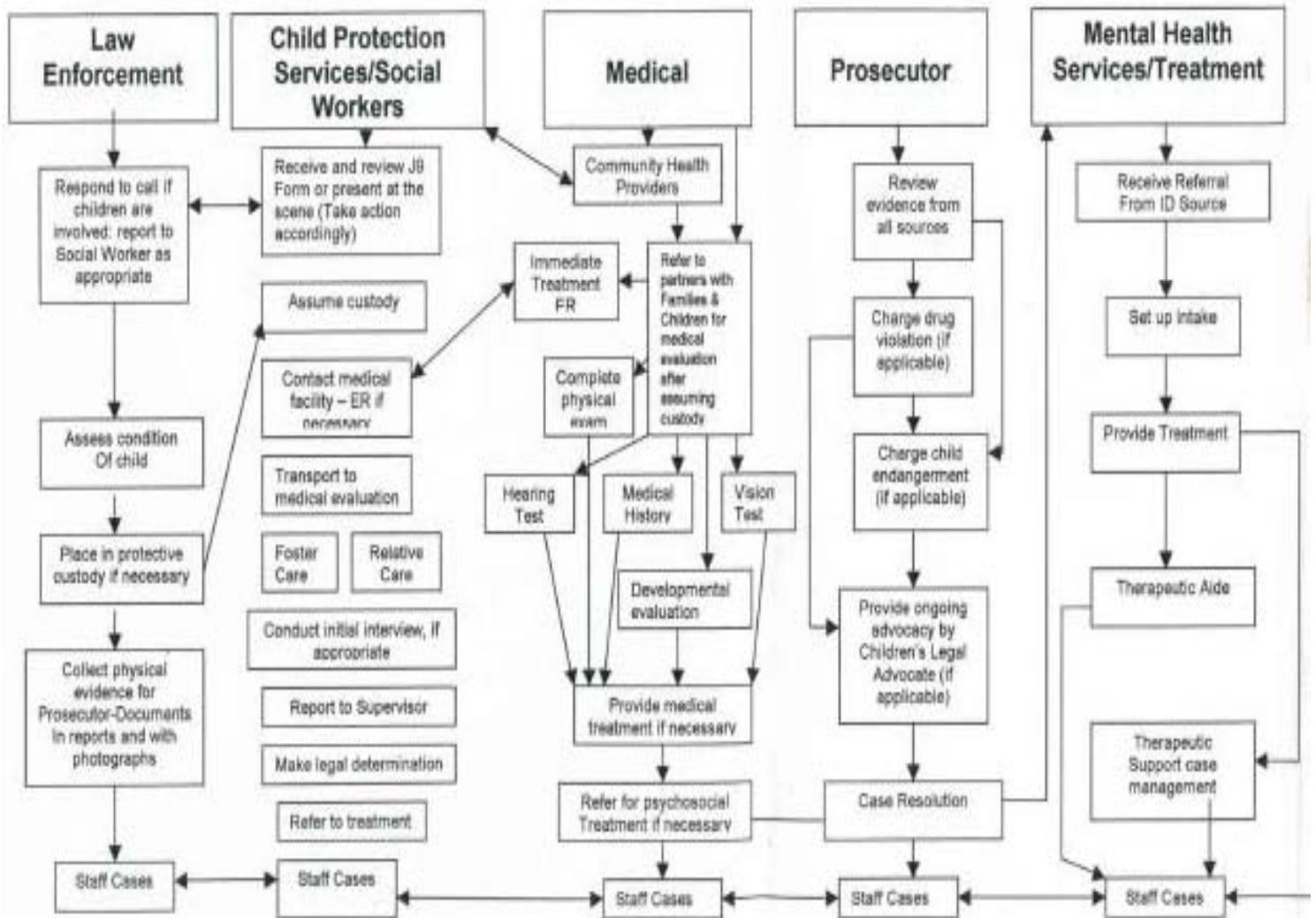
Another benefit is that the perception of a fresh start may make stakeholders more willing to participate in evaluation. Like many social programs, spending time, money, or effort on evaluation is derided within the Training Network. But reaching a consensus on program theory and deciding on evaluation tools will mean gathering helpful and essential data along the way, instead of playing catch-up. When data collection is built in to the program it is seen as more effortless. For the past three years, using incomplete data has led to haphazard, last-minute attempts at evaluation. No doubt this is frustrating to everyone involved. But continual evaluation will be less of a burden.

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Kentucky's Collaborative Region/Community Response To Drug Endangered Children
Region/Community



Resources/Inputs	Activities	Outputs	Outcomes		
			Initial	Intermediate	Long-Term
<p>Training network uses a variety of trainers with different professional backgrounds that can use knowledge to train specific groups. Their backgrounds are in public health, EMT, nursing, social work, law enforcement and pediatrics.</p> <p>Financial support from regional agencies to fund training- Pennyrile Narcotics Task Force, KY National Guard, UK, Appalachian Regional Commission, Operation UNITE, and Rural Law Enforcement Technology Center</p> <p>Partner with other state agencies with similar goals to provide trainings</p>	<p>Trainers build presentations which are reviewed by Alliance for quality control</p> <p>Training occurs in communities that have requested training or intend to begin a DEC team</p> <p>Multiple training topics all focused around meth are presented to the appropriate groups</p> <p>Connect community leaders that don't know about each other to build DEC teams</p>	<p>Different community service providers attend trainings-</p> <p>Social workers, Law enforcement, Medical community, emergency response</p>	<p>Trained individuals will implement protocol and effectively make use of information taught in training</p> <p>Break down myths and disseminate factual information</p>	<p>Those trained will build support and adoption of new protocol and information by among others in their profession</p> <p>Community awareness built</p> <p>Connect community leaders that don't know about each other to build DEC teams</p>	<p>Build a competent knowledgeable work force</p> <p>Build strong DEC team</p> <p>Children treated appropriately by all services involved when found in a drug endangered environment</p>

Team Observation Tool¹

Team: _____

Date: _____

Team Goals

1. Does this team have an apparent goal? Yes No What is it? _____

Professional Roles

2. Circle the disciplines attending the meeting. LE CPS EMT MED SCH

3. Do team members appear knowledgeable about their roles? Y N

4. Do team members appear knowledgeable about the roles of other disciplines? Y N

5. Are there disciplines participating on the team whose roles you are not familiar Y N

If so which ones? _____

Leadership

6. Who is (are) the team leader(s)? _____

7. Does the leadership change during the meeting? Y N

8. What behaviors do the leaders use (summarizing, initiating...) _____

Communication and Conflict

9. Is there any open sharing of information? Y N

10. Note any barriers to communication you observe (side conversations...) _____

11. Is there an opportunity for differences of options to be discussed? Y N

12. What are the examples of conflict? How were they handled?

Conflict

Strategies used to handle

Meeting Skills

13. How is the meeting organized? (agenda...) _____

Outcome

14. What was accomplished or produced during the meeting? _____

15. Are decisions and next steps clear? Y N

16. Was the meeting efficient? Y N Elaborate _____

¹ Long DM, Wilson NL, (eds.) *Houston Geriatric Interdisciplinary Team Training Curriculum*. Houston, TX: Baylor College of Medicine's Huffington Center on Aging; 2001