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Children with Attention-Deficit/Hyperactivity Disorder at Home and School: Effective Intervention Strategies and Barriers to Services

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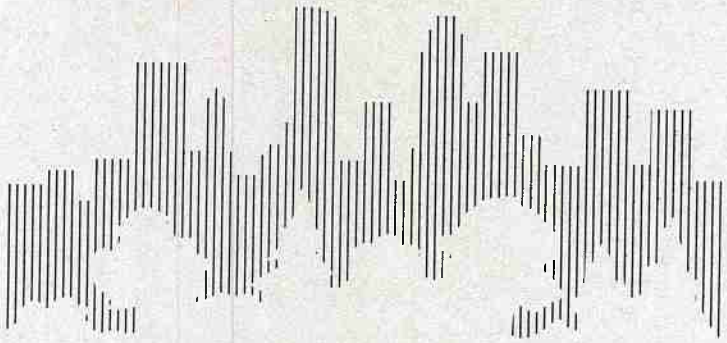

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MASTERS IN SOCIAL WORK THESIS

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1997

CHILDREN WITH ATTENTION-DEFICIT/HYPERACTIVITY DISORDER AT HOME AND SCHOOL: EFFECTIVE INTERVENTION STRATEGIES AND BARRIERS TO SERVICES

by

Deana M. Loven

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CERTIFICATE OF APPROVAL

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DEDICATION

This thesis is dedicated to the children and families affected by ADHD and to the school social workers, teachers, and administrators who provide a comprehensive approach to helping students experience success and reach their full potential.

ACKNOWLEDGEMENTS

To my parents, Tom and Marlene, a very special thank you for instilling in me the importance of education and a strong belief in myself. Your love and support have helped make this possible.

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ABSTRACT OF THESIS

CHILDREN WITH ATTENTION-DEFICIT/HYPERACTIVITY
DISORDER AT HOME AND SCHOOL:
EFFECTIVE INTERVENTION STRATEGIES
AND BARRIERS TO SERVICES

METHODOLOGY: RESEARCH

DEANA M. LOVEN
MAY, 1997

Attention-Deficit/Hyperactivity Disorder(ADHD) is one of the most frequently diagnosed and thoroughly researched disorders of childhood, however, little is known about ADHD in the school setting. This research study explored effective intervention strategies and barriers to services for children with ADHD at home and school. The research design utilized a self-administered survey questionnaire distributed to school social workers, parents, and special education teachers and general education teachers. Of the 63 returned surveys, 37 met criteria for inclusion in the research. Findings from quantitative and qualitative data indicate that school social workers are critical team members to the comprehensive approach of educating a child with ADHD. The roles of the school social worker range from the individual case level to the system level. Implications for school social work practice and research about interventions with children with ADHD are presented.

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CHAPTER I

INTRODUCTION

Overview of the Problem

Imagine living in a fast-moving kaleidoscope, where sounds, images, and thoughts are constantly shifting. Feeling easily bored, yet helpless to keep your mind on tasks you need to complete. Distracted by unimportant sights and sounds, your mind drives you from one thought or activity to the next.

For many people, this describes what it's like to have Attention-Deficit/Hyperactivity Disorder, or ADHD. They may be unable to sit still, plan ahead, finish tasks, or be fully aware of what's going on around them. To their family or classmates, they seem to exist in a whirlwind of disorganized activity. Unexpectedly, on some days and in some situations, they seem fine, often leading others to think the person with ADHD can actually control these behaviors. As a result, the disorder can hinder the person's relationships with others in addition to disrupting their daily life, consuming energy, and diminishing self-esteem.

When asked where the greatest assistance is needed, parents of children with ADHD consistently reply, "School!" Teachers' expectations are often not

consistent with hyperactive children's abilities and readiness. Homework is a major area of concern and conflict among parents, teachers, and children with ADHD. An additional concern is whether the school can provide special services to accommodate a child's academic, social, and emotional difficulties.

Prior to the late 1940's, children with ADHD were regarded as equivalent to the mentally retarded, unteachable and suitable only for custodial educational services. In the 1950's and 1960's, children with ADHD were considered learning disabled and developmentally delayed in the physiological systems necessary for learning. In 1975, Public Law 94-142 was passed to guarantee equal education for all children (Reid, 1994).

School programs for children with ADHD range, however, from elaborate special classes to no special help. The extent of awareness and cooperation among teachers and administrators is wide, with flexible individualized approaches at one extreme, and outright denial of the disorder at the other.

In a class of thirty students, each child should theoretically require approximately 3% of the teacher's time and energy. The child with ADHD who demands 10% of the teacher's energy destroys this important equation.

From an educator's perspective, the presenting profile of children with ADHD is classic. The children struggle to remember and follow written and verbal instructions, to write legibly, to spell accurately, to decode language, to

read with comprehension, to sit still, to stay on task, and to control their bodies. The parents of children with ADHD are also on the receiving end of a continual stream of negative feedback. Everyone seems to blame them for their child's behaviors. The clear implication is that the child is misbehaving because they are doing an inadequate job of parenting. These parents are often confused about the issues, overwhelmed by the choices they are expected to make, and unsure of their options.

Purpose of this Research Study

There have been thousands of scientific articles about hyperactivity and attention deficits in children published in professional journals. However, until recently there have not been resources available to parents and teachers in how to work effectively with a child with ADHD.

According to Parker (1994) the most frequently expressed concern that parents of children with ADHD have is with respect to their child's performance at school. Children with ADHD often have serious problems at school. Daily reports of poor school performance cause frustration and discouragement for parents and their children with ADHD.

For quite some time no one seemed to have the answers to help students with ADHD in school. Most teachers didn't know what to do with these

inattentive, hyperactive children who took up a large part of the day with poor behavior. According to Parker (1994), it is estimated that eighty percent of students with ADHD could be taught appropriately in regular education classes as long as teachers are willing to make accommodations in school to meet the child's needs.

Many teachers view ADHD as a significant educational problem that hinders students in their learning initiatives. They feel there should be increased input from school staff and community service professionals, such as physicians and counselors, to assist them in teaching students with ADHD. Previous studies indicate that teachers reported the need for information to better understand students with ADHD and felt they needed enhanced training in behavioral management strategies and greater knowledge of effective classroom interventions. ADHD is one of the most frequently diagnosed and thoroughly diagnosed disorders of childhood; however, little is known about ADHD in the school setting (Reid, 1994).

ADHD has become one of the most heavily researched childhood disorders. Numerous studies spanning the fields of medicine, psychology, and education have appeared on this topic. Much of the initial work on ADHD reflected a medical perspective. In the area of interventions in working with these children, little is available that is school-based. The majority of

studies were conducted in controlled settings, such as hospitals or university clinics. Only a handful of school-based researched projects have contributed to more effective educational practice in either general or special education.

Traditionally, educators have relied on the clinical (DSM) definition of ADHD. The medical emphasis typically has involved diagnosis within the clinical setting, without assessing the impact of the disorder on the student's education. Several events have prompted educators to re-evaluate the reliance on a medical definition and diagnosis of ADHD. First, the scientific literature over the last decade indicates that ADHD can be a serious, handicapping disorder not adequately addressed through current laws and policies. This gap between medical diagnosis and educational treatment has led to the application of Section 504 of the U.S. Rehabilitation Act of 1973 to help students with ADHD receive reinterpretation by the U.S. Department of Education. Students with ADHD have begun receiving special education services as "other health impaired" under IDEA regulations (formerly Public Law 94-142). Given these changes, it is in the best interest of the children and our school system to address the ADHD issue as an educational concern, not solely as a medical issue.

Characteristics of Children with ADHD

The incentive for this research study came from this researcher's experience with teachers and parents who are frustrated with how to deal with the daily behaviors exhibited by children with ADHD. According to Taylor, classroom behavior problems including difficulty in staying seated, paying attention, working independently, and following directions and rules. Children with ADHD can also be disruptive and interrupt class lessons and quiet work periods. They also tend to be very disorganized and have great difficulty in keeping track of their academic materials and assignments. ADHD is the most recent diagnostic label for children presenting with significant problems with attention, impulse control, and overactivity. Children with ADHD are a heterogeneous population who display considerable variation in the degree of the symptoms, the pervasiveness across situations of these problems, and the extent to which other disorders occur in association with it. The disorder represents one of the most common reasons why children are referred to mental health practitioners in the United States, and it is one of the most prevalent childhood psychiatric disorders (Barkley, 1990).

According to a 1995 CH.A.D.D. Fact Sheet, ADHD affects up to 5% of all children in the United States. Without early identification and proper treatment ADHD can have serious consequences including school failure and drop out,

depression, conduct disorders, failed relationships, and even substance abuse. CH.A.D.D.(Children and Adults with Attention Deficit Disorders) is an advocacy and support group founded in 1987. It presently has 28,000 members in 48 states.

Many characteristics of children with ADHD are socially appropriate and desirable. Their spontaneity, enthusiasm, intensity, and curiosity have their useful moments. There is probably a link between ADHD and giftedness. These children have rich imaginations and can quickly generate new and different ideas. When they are successfully treated biochemically, these personal expressions display even greater variety, depth, and attention to detail.

From the 4th edition of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association, the following are the criteria for the diagnosis of ADHD:

A. Either (1) or (2):

(1) Inattention: At least six of the following symptoms of **inattention** have persisted for at least six months to a degree that is maladaptive and inconsistent with developmental level:

(a) often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities

(b) often has difficulty sustaining attention in tasks or play activities

(c)often does not seem to listen when spoken to directly

(d) often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)

(e) often has difficulty organizing tasks and activities

(f) often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)

(g) often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)

(h) is often easily distracted by extraneous stimuli

(I) is often forgetful in daily activities

(2) Hyperactivity-Impulsivity: At least six of the following symptoms of hyperactivity-impulsivity have persisted for at least six months to a degree that is maladaptive and inconsistent with developmental level:

Hyperactivity

(a) often fidgets with hands or feet or squirms in seat

(b) often leaves seat in classroom or in other situations in which remaining seated is expected

(c) often runs about or climbs excessively in situations in which remaining seated is expected

(d) often has difficulty playing or engaging in leisure activities quietly

(e) is often "on the go" or often acts as if "driven by a motor"

(f) often talks excessively

Impulsivity

(g) often blurts out answers before questions have been completed

(h) often has difficulty awaiting turn

(I) often interrupts or intrudes on others (e.g., butts into conversations or games)

B. Some symptoms that caused impairment were present before age seven.

C. Some symptoms that cause impairment are present in two or more settings (e.g., at school, work, and at home).

D. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.

E. Does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia or other Psychotic Disorder, and is not better accounted for my Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder.

Code based on type:

314.01 **Attention-Deficit/Hyperactivity Disorder, Combined Type:** if both Criteria A1 and A2 are met for the past six months.

314.00 **Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type**: if Criterion A1 is met but Criterion A2 is not met for the past six months.

314.01 **Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type:** if Criterion A2 is met but Criterion A1 is not met for the past six months.

When hyperactivity is present, it is difficult to miss such a child as s/he may create much havoc at school and home. Consequently, this may be the first child to be referred for evaluation and the first to receive help. Without hyperactivity, the child with ADHD may be misidentified and labeled as "just lazy," withdrawn, "in a dream world," slow, or even "emotionally disturbed."

Recent research evidence indicates that ADHD is a physiological disorder characterized by some structural or chemically based neurotransmitter problem in the nervous system. Although the exact underlying cause or causes have not been identified, it appears that this condition is basically inherited, although ADHD-like behavior may also be "acquired."

Attention-Deficit/Hyperactivity Disorder will be referred to as ADHD in this paper, unless research is cited, or a direct quote is used where ADD may be used.

CHAPTER II

LITERATURE REVIEW

This chapter will address the historical background of ADHD and a discussion of the review of the existing literature according to three topics: Conceptual Frameworks; Educational Performance; Multi-modal Interventions; and Instructional Implications/Interventions.

Historical Background

ADHD was described as early as 1845 by the German physician, Heinrich Hoffman, in his classic *Der Struwelpeter* (Slovenly Peter), a collection of humorous moral tales for children. The heroes were drawn from his observations of children, including "Fidgety Philip" (McBurnett, 1993).

In 1902, one researcher, Dr. G. F. Still, described the behavior of a group of apparently hyperactive children. He knew of no medical reasons for their behavior and made no mention of their educational needs or social skills. He expressed one of the classic lines of unfair criticism most consistently leveled against parents of children with ADHD: that part of the problem was "deficient training in the home" (McBurnett, 1993).

In 1923, subsequent to an acute encephalitis outbreak at the end of World War 1, a researcher, F.G. Ebaugh, chastised physicians for confining their concern to medical management and for not showing enough interest in providing the parents of this large group of brain-damaged children and adolescents with genuine assistance for their disruptive behavior. Ebaugh was perhaps the first to publish a professional paper recognizing ADHD as a long-term problem requiring cooperation and intervention by several professional disciplines (McBurnett, 1993).

During the 1960's and afterwards, inattentive and hyperactive children became popular subjects for research studies which focused on identifying characteristics of such children. With new information constantly being discovered about them, the name given to this group of children changed through the years to keep up with the growing body of knowledge.

Terminology of the 1950's and 1960's emphasized the motor component of the disorder and terms like hyperkinetic and hyperactive were in common usage. Starting in 1980 the attentional problems that were characteristic of these children received more significance. Researchers realized that inattention, not hyperactivity, was the most prominent feature of the disorder and caused children the greatest problem.

Different Names for Children with ADHD Through the Years

1902 - Defects in moral character
1934 - Organically driven
1949 - Minimal Brain Syndrome
1957 - Hyperkinetic Impulse Disorder
1960 - Minimal Brain Dysfunction (MBD)
1968 - Hyperkinetic Reaction of Childhood (DSM II)
1980 - Attention Deficit Disorder (DSM III)
with hyperactivity
without hyperactivity
residual type
1987 - Attention-deficit Hyperactivity Disorder
(DSM III-R)
Undifferentiated Attention Deficit Disorder
(DSM III-R)
1994 - Attention-Deficit/Hyperactivity Disorder
combined type
predominantly inattentive type
predominantly hyperactive-impulsive
(DSM IV) (Reid, 1994).

Federal Laws and Children with ADHD

Children with ADHD are guaranteed a free and appropriate public education by two federal laws-the Individuals with Disabilities Education Act(IDEA) and Section 504 of the Rehabilitation Act of 1973. Children with ADHD must receive access to special education and/or related services when needed. This education must be designed to meet each child's unique educational needs through an individualized education program(IEP) under IDEA, or in a comparable 504 plan tailored to a child's specific needs. These two federal laws may require a

multidisciplinary team evaluation of a child with ADHD to determine when and whether special education and/or related services are needed (CH.A.D.D., 1993).

Conceptual Frameworks

Overview

Theoretically, the approach to interventions with children with ADHD at home and at school is made of various theories. The conceptual frameworks covered in this section are Family Systems Theory, Developmental Theory, and the Ecological Perspective.

Family Systems Theory

Several areas of evidence suggest that a more systemic approach may be particularly useful with families of children with ADHD. First, during the course of the child's development, families of children with ADHD will be confronted with a substantially larger number of behavioral, developmental, and educational problems than those of normal children. The time, demands, and energy required to cope with these difficulties places an enormous burden of stress on all aspects of marital and family functioning (Emery, 1982; Epstein, Bishop, & Levin, 1978). The systems-oriented program described here, is designed to develop the problem-solving skills, collaborative approaches to management,

and supportive communication that should allow families to cope effectively with the stress imposed by an unusually difficult child with ADHD.

Developmental Theory

The applicability and success of interventions will vary as a function of the child's age and cognitive-developmental level as well as social factors. The primary recipients of the intervention for a preschooler with ADHD symptoms will most likely be the child's parents and preschool teacher. Problem-solving strategies, such as cognitive self-instruction, are likely to be more appropriate for school-age children (Kendall, Lerner, & Craighead, 1984).

Ecological Perspective

The person is observed as a part of his/her total life situation. Person and situation are a whole in which each part is interrelated to all other parts in a complex way through a complex process in which each element is both cause and effect (Compton & Galaway, 1989). From this perspective, the child with ADHD and his or her environment are reciprocally determined. The ADHD child poses persistent and critical challenges to the ecology(including the family, school, and community), and the environment in turn critically influences the development of the child (Mueller, 1992).

Theoretical Implications

I present the idea that students with ADHD have an attentional preference for novelty and a greater need for active responding. Researchers have argued for the heritability of activity level (e.g. Willerman, 1973). Researchers have documented a genetic factor in ADHD. Some have reported findings of similar characteristics for anywhere from 60% to 75% of the relatives of students with ADHD and from 30% to 50% of their siblings (Goodman & Stevenson, 1989). Students with ADHD have a greater need for stimulation, or, as reported in the literature, they are physiologically underactive or underreactive to stimulation or to differences among stimuli (Satterfield, Schell, Nicolas, Satterfield, & Freese, 1990). That is, in some situations and tasks, we all need more stimulation to perform effectively. For example, to get focused in the morning, we may need the stimulation of coffee. Sometimes in the evening, when stress and stimulation reach a peak, we bring ourselves back to a more comfortable level, perhaps using television.

Educational Performance

Studies examining the academic achievement of children with ADHD indicated that they are more likely than children without disabilities to receive lower grades in academic subjects and lower scores on standard measures of reading and math (Barkley, Fischer, Edelbrock, & Smallish, 1990). For

example, more than 80% of 11-year-olds with ADHD were reported behind at least 2 years in reading, spelling, math, or written language (Anderson, Williams, McGee, & Silva, 1987). These learning difficulties contribute to followup reports that over half of the children with ADHD who are taught in regular classrooms will experience school failure or fail at least one grade by adolescence (Barkley et al. 1990; Brown & Borden, 1986) and over one third will fail to finish high school (Weiss & Hechtman, 1986). Children with ADHD in the regular classroom face a risk of school failure two to three times greater than that of other children without disabilities but with equivalent intelligence (Rubenstein, & Brown, 1981).

Multi-Modal Interventions

Interventions for the child with ADHD usually requires a multi-modal approach frequently involving a team made up of parents, teachers, physicians, and behavioral or mental health professionals. The four corners of this intervention program are as follows:

Educational Planning — Medical Management

Multi-modal
Intervention Planning

Psychological Counseling — Behavior Modification

(CH.A.D.D., 1988).

The use of medication alone in treatment of ADHD is not recommended. While not all children having ADHD are prescribed medication, in certain cases the proper use of medication can play an important and necessary part in the child's overall treatment.

Home-School Collaboration

The issue of collaboration between home and school to improve outcomes for children with ADHD has not been studied directly. The literature contains no empirical studies of strategies or programs designed specifically to implement or promote home-school collaboration. From the literature, however, strategies can be identified in two areas, tested with children with ADHD in clinical settings. These strategies have implications for ways educators and parents can work together. At first, O'Leary (1986) evaluated the effectiveness of a combined home-school behavioral treatment for elementary school children and found that the behavioral treatment program, which included parent reward of the child for progress toward daily goals, led to significant improvements in hyperactive behaviors.

The second area of strategies with implications for home-school collaboration involves parent training and the direct use of parents to provide treatment. The literature contains many examples of parent-training programs that have demonstrated some effectiveness in reducing activity level, conflict,

and anger intensity and in increasing on-task behavior and compliance.

Roles and Tasks of the School Social Worker

The present description of the school social worker's role in helping children with ADHD derives from the work of Costin (1975) and Staudt (1991). These authors described the various roles and tasks engaged by school social workers nationally from the individual case level to the system level. These activities include: participation in special education assessment and placement, individual counseling, group counseling, parent counseling and education, teacher inservice training and classroom consultation, liaison between home and school, program planning in the school, and program planning for the community.

Teacher Knowledge, Attitude, and Training

Where teachers have a poor grasp of the nature, course, outcome, and causes of this disorder and misperceptions about appropriate therapies, attempting to establish behavior management programs within that classroom will have little impact (Barkley, 1990).

Dr. Michael Gordon conducted a study that asked teachers about the training they had received about ADHD and whether or not they consider ADHD a legitimate educational problem. Only 11 percent had received one or more hours of undergraduate training on ADHD. Only 8 percent had received more

than two hours of training in ADHD after they began teaching. When asked if they could benefit from additional training surrounding treatment of ADHD, 98 percent agreed (Bauer, 1993).

Effective Parenting

Several studies of families with children with ADHD indicate that these children are notably better behaved when in the company of their fathers as opposed to their mothers (Parker, 1994). The fact that they behave better for their fathers than for their mothers may be due to the finding that fathers tend to deliver behavioral consequences more immediately to the child and more punitive in their reactions to inappropriate behavior than mothers tend to be.

Other studies have shown that, in general, parents of children with ADHD tend to use more punitive discipline. They yell more, and agree with each other less in how to treat their children than do parents of non-hyperactive children (Ibid., 1994). One might easily draw the conclusion that the parents of children with ADHD have poorer parenting skills and that this might contribute to the child's behavioral problems. However, when hyperactive children who were treated with medication displayed better behavior at home and in school, a remarkably positive change was also noticed in their parents' behavior. These parents became less punitive, less coercive, and less negative in their approach to the children. Thus, it is not necessarily poor parenting skills that causes the

poor behavior of children with ADHD. It is more likely that the children's hyperactivity, impulsivity, and inattentiveness bring out the worst in parents.

Instructional Implications/Interventions

Overview

Within the classroom, "some simple, practical things work well," says Reid (1994). "Let hyperactive kids move around. Give them stand-up desks, for instance. I've seen kids who from the chest up were very diligently working on a math problem, but from the chest down, they're dancing like Fred Astaire." To minimize distractions, students with ADHD should sit very close to the teacher and be permitted to take important tests in a quiet area. "Unfortunately," Reid observes, "not many teachers are trained in behavior management. It is a historic shortfall in American education."

In Irvine, California, James Swanson has tried to create the ideal setting for teaching students with ADHD. The Child Development Center, an elementary school that serves 45 kids with the disorder, is a kind of experiment in progress. The emphasis is on behavior modification. Throughout the day students earn points for good behavior. High scores are rewarded with special privileges at the end of the day, but each morning students start all over with rewards. Special classes also drill in social skills, sharing, being a good sport, ignoring annoyances rather than striking out in anger. Only 35% of the students

the Center are on stimulant medication, less than half the national rate for children with ADHD.

Classroom Management

Teachers frequently respond to the challenging problems exhibited by children with ADHD by becoming more interactive and commanding (Haenlien & Caul, 1987). Over time, teachers may become frustrated in working with these difficult children and become less positive and more negative in their interactions as well. A positive teacher-student relationship may not only improve academic and social functioning in the short-term, but may also increase the likelihood of long-term success.

The success of elementary teachers confronted with ADHD depends heavily on two things: control of the classroom environment and the students' ability to understand and follow verbal directions.

Behavioral Interventions

Teacher-administered positive and negative consequences are the most commonly used behavioral interventions with ADHD children in the classroom. Most classroom management programs involve a combination of these interventions. In general, praise appears to be most effective when it specifies the appropriate behavior being reinforced when it is delivered in a genuine fashion

(Douglas and Parry, 1983).

Intervention procedures which are based on learning principles have been well documented to help children with a wide range of behavior problems. Behavior management techniques are often an essential component in a multi-modal intervention program for students with ADHD. These procedures are based on a contingency management, manipulation or application of consequences contingent on specified behaviors. The most widely used and successful behavioral interventions used include: token reinforcement programs, behavior contracts, response cost procedures, time out from positive reinforcement, and home-school contingencies based on daily home-school report cards (DuPaul, Stoner, Tilly and Putnam, 1992).

Problem Solving Social Skills Training

A number of programs are now available for direct use with students and to train teachers and clinicians on how to use cognitive-behavioral interventions with children. Several of these programs teacher problem-solving strategies and the application of these strategies within a social context.

A recently published text by Drs. Lauren Braswell and Michael Bloomquist entitled Cognitive Behavioral Therapy with ADHD Children describes their model of teaching problem-solving and self-instructional skills to small groups of children in a clinical setting. Their program focuses on teaching children problem

recognition skills, helping children learn to think of alternative solutions to problems, anticipate possible consequences and obstacles to conceived solutions, and to evaluate the results of their planning, once they follow through with action (Parker, 1992).

Children with ADHD often experience significant problems with social interaction. The hyperactive child's behavior readily stands out in the classroom and is perceived negatively by other students. These children exhibit more intrusive, aggressive behavior than others.

Children with ADHD who are not hyperactive tend to have a somewhat different set of social problems. Characterized by their tendency to be overly passive and somewhat anxious, this child may have problems in forming and maintaining social relationships.

CHAPTER III

METHODOLOGY

Research Design

This research study can be designed to investigate effective intervention strategies that can be applied by teachers in general education classrooms and parents at home, with children who have ADHD and have taken medication for that disorder. The role of the school social worker in working with teachers and parents of children with ADHD is explored. Also, support services inside and outside of school, training and education, are questioned.

This study is an exploratory study using a self-administered, mailed questionnaire to gather quantitative as well as qualitative information. The scope of this study is concerned with three groups of people: 1) elementary school general and special education teaching staff who work with children with ADHD, 2) school social workers who assist teachers with suggestions and also work with children with ADHD, and 3) parents of children with ADHD.

Research Questions

The four research questions the researcher will attempt to address in the

course of the thesis are as follows:

1) What positive intervention strategies can be applied by teachers in general education classrooms with children who have Attention-Deficit/Hyperactivity Disorder and have taken medication for that disorder, during January 1995 - January 1996?

2) What positive intervention strategies can be applied by parents at home with children who have Attention-Deficit/Hyperactivity Disorder and have taken medication for that disorder, during January 1995 - January 1996?

3) What are the roles of the school social worker in intervention on behalf of children with ADHD and their families?

4) What are the barriers confronting school social workers in providing services in schools to students with Attention-Deficit/Hyperactivity Disorder?

Operational Definitions

The key terms widely used in this research project are: general education teacher, special education teacher, school social worker, parent, and effective interventions. The terms are defined as follows for the purpose of this study:

1. General Education Teacher: a teacher who teaches a classroom of students ranging from twenty to thirty-five students. This classroom includes students with, and without special education needs, that can be met in the class room, or in a resource room for a small amount of the day.

2. Special Education Teacher: a teacher who provides educational services to students in a resource room. The students qualify to receive special education assistance through an extensive testing process that includes Minnesota special education policies and laws.

3. School Social Worker: an individual who is licensed by the state of Minnesota and currently in the position of a school social worker. This person serves any grade(s) between, and including, kindergarten through fifth. School social workers specialize in social work oriented toward helping students make satisfactory school adjustment and in coordinating and influencing the efforts of the school, the family, and the community to help achieve this goal (Barker, 1995).

4. Parent: a mother, father, or guardian with whom the child resides.

5. Effective Interventions: successful strategies used in working with children.

Subject Selection

A single unit of analysis was used in this evaluation. It consisted of thirty general and special education teachers, three elementary school social workers, and thirty parents from three elementary school buildings surveyed in the North St. Paul, Maplewood, Oakdale School District who have worked with a child with ADHD within the past year. Three elementary schools were used in

this study and one in the pretest. The subjects in this study were selected using a convenience sampling design. The Principals at the three participating elementary schools identified possible participants, by using a medication log they maintained that lists all the children in the building who are presently on medication, the dosage, and the name of the classroom teacher.

Instrument Design

The study questions were designed by the researcher as a result of reviewing the literature. The study questionnaire used two data seeking tools. These included open-ended questions (n=33) and fill-in blanks (n= 5). A variety of data gathering tools were used in order to improve reading ability, variance of questions, and overall interest of the questionnaire.

Section A: All participants were asked to complete this section. This section confirmed medication use of the child the participant was referring to when completing the questionnaire.

Section B: This section was to be completed by the Parents only. Questions and statements were developed to determine what services and support through the school children with ADHD and their families receive. This section sought information regarding positive intervention strategies parents use at home and support families seek through counseling and support groups.

Section C: This section was to be completed by School teachers only.

Questions were directed at positive intervention strategies teachers use in the classroom, services available at school for children with ADHD, and barriers to providing services.

Section D: This section was to be completed by School Social Workers only. Questions in this section were developed to acquire information regarding adequate training to educate staff on ADHD, barriers to providing services in schools to students with ADHD, and role in assisting families with behavior management techniques at home.

Section E: This section of the questionnaire asked for basic demographic information, such as: Gender, Age, Position, Educational Level, Household Income, Number of Persons in Household, about study participants.
No personal identification was sought from the survey participants.

Data Collection Procedures

The researcher sent letters of introduction and invitation to the Principals at each of the identified elementary schools requesting permission for the study. (Appendix: B). The Principals were asked in that letter to start the process of identifying potential individuals to participate in the study. The Principals used a medication log they have that indicates all of the children in the building who are presently on medication, the dosage, and name of the classroom teacher. The Principals were provided with the questionnaires and cover letters (Appendix: D)

and stamped envelopes to be addressed by the Principal and sent in the mail to the home of the teachers, school social workers, and parents. The completed questionnaire was then returned to the address of the researcher.

The sample was taken from a total of sixty-three (n=63) respondents who are parents, teachers and social workers in three elementary buildings in the North St. Paul, Maplewood, Oakdale School District. The Principals mailed an initial cover letter explaining the research study and requested voluntary participation from the participants. The self-administered questionnaire was mailed along with the initial cover letter on February 20, 1996. Participants were asked to return the questionnaires on or before March 4, 1996.

A followup letter was mailed to all participants two weeks after the initial cover letter requesting participation in the research study. A second self-administered questionnaire (identical to the first one) was mailed along with the follow-up letter. The participants were to disregard the follow-up letter if a completed questionnaire had already been returned or there had been a decision not to participate in the research study. The completion and return of the self-administered questionnaire were sent in enclosed self-addressed, stamped envelope to the researcher.

Ethical Protections

Measures were taken to protect the respondents as required by research

ethics. Through an initial cover letter (Appendix: C), the identified participants were informed that their anonymity was protected as the Principals at the three participating schools mailed out the letters and questionnaires. Moreover, the researcher did not know the names of the participants, or had ever worked with them. All cover letters informed all participants of their right to not answer any question or to stop at any time. Prospective participants were informed in the cover letter that their participation in the study was voluntary and that his or her choice to participate would not affect his or her relationship with the North St. Paul, Maplewood, Oakdale Schools or Augsburg College. The completed and returned questionnaires were kept in a safe place and will be destroyed after the research is completed. Information from this questionnaire will be used for the thesis in summarized form only. This study was approved by the Institutional Review Board of Augsburg College (IRB). (See Appendix: A).

Pre-test: Methodology and Evaluation

The pre-test survey was given to eight (n=8) participants, three (n=3) parents, three (n=3) general education teachers, one (n=1) special education teacher, one (n=1) school social worker. Of the eight surveys distributed, four (n=4), 50% were returned. Participants ranged in age from twenty to fifty years old. Of the four participants, one male participant has completed a Master's degree. Three female participants have a four year college degree. The

purpose of the pre-test was to obtain clarity and to identify any potential bias of the survey questions.

CHAPTER IV

FINDINGS

On February 20, 1996, sixty-three participants, including social workers, parents, general education and special education teachers were mailed an eight page questionnaire seeking insight into their awareness of positive intervention strategies that can be applied at home and school. Within nine working days, thirty-eight questionnaires were returned and twenty-five were not returned. Thirty-seven of the returned questionnaires met criteria for the research. This resulted in an overall return rate of 60% and a return rate of 59% for those who met criteria for the research. Findings will be presented by reporting demographics first. Other findings are organized by categories including school social workers, parents, and teachers.

Two questions on the survey questionnaire screened respondents for the eligibility criteria for the research. One question asked, "Are you a parent to a child with Attention-Deficit/Hyperactivity Disorder who has taken medication for that disorder during January 1995 - January 1996?" Ninety-two percent (n=11) answered "yes" to the question; 8% (n=1) answered "no" to the question. The

second question asked, "Are you a regular or special education teacher or school social worker to a child who has taken medication for that disorder during January 1995 - January 1996?" One hundred percent (n=26) answered "yes". Ninety-seven percent (n=37) of the respondents met the criteria for the study and are included in the analysis and presentation of findings.

The thirty-seven questionnaires that were used included; three school social workers, with two (n=2) responding, for a 66% response rate, thirty parents, with twelve (n=12) responding, for a 40% response rate, twenty-four general education teachers, with eighteen (n=18) responding, for a 75% response rate, and six (n=6) special education teachers, with six (n=6) responding, for a 100% response rate.

Background Information of Study Participants

Respondents was asked seven questions related to demographic information in an attempt to better describe the survey population. Fourteen percent (n=5) of the respondents were male; 86 % (n=32) were female. The age group ranged between twenty-one and sixty years. One male and seven females were between the ages of twenty-one and thirty years. One male and fourteen females were between the ages thirty-one and forty years. Three males and nine females were between the ages of forty-one and fifty. Three females were between the ages of fifty-one and sixty. Figure 1 & 2 illustrates the age and

Figure 1

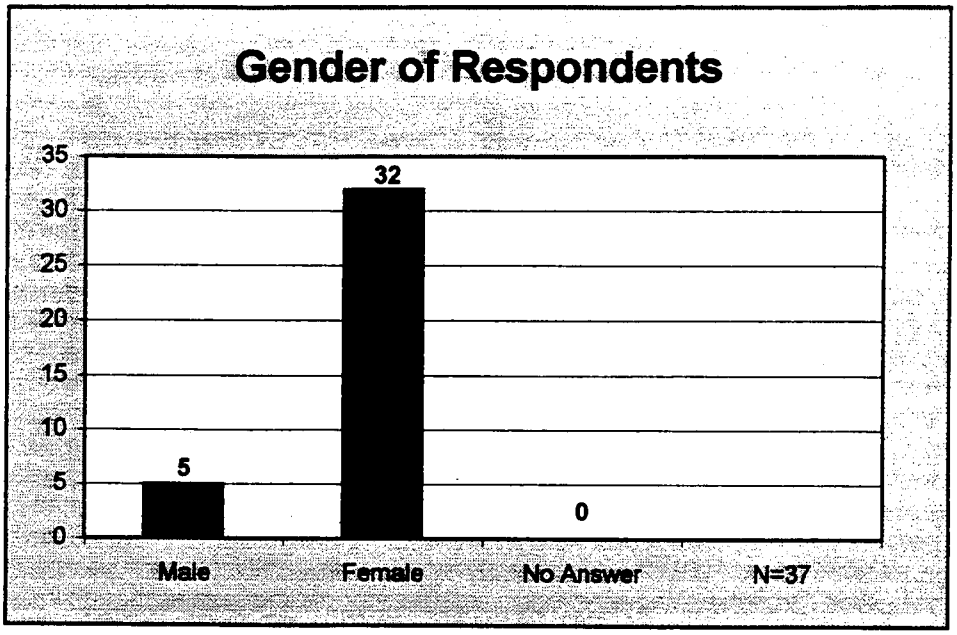
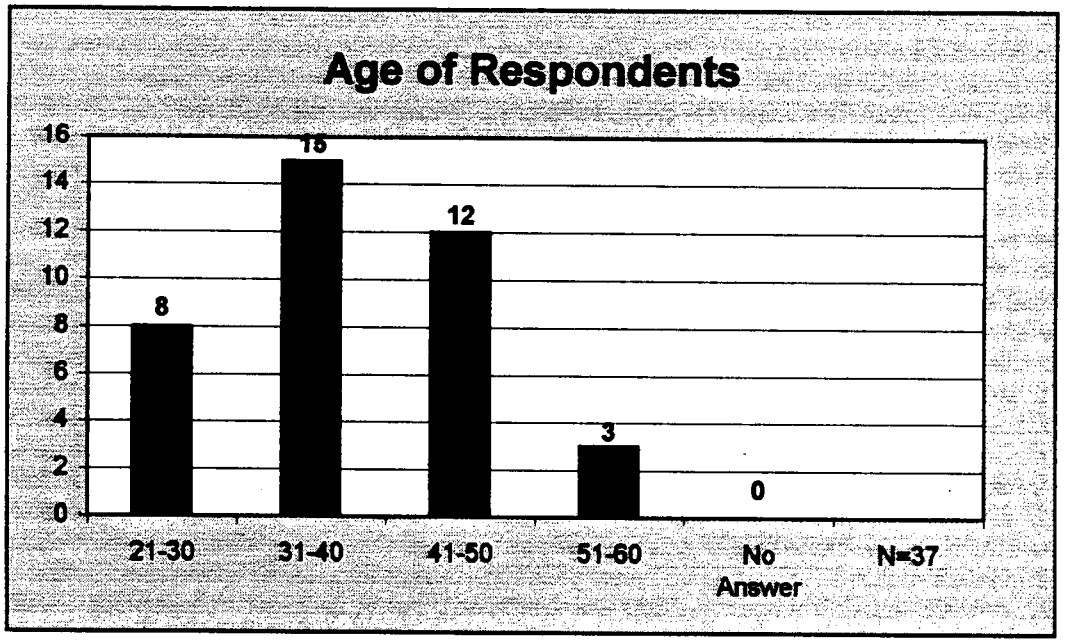


Figure 2



gender of the respondents.

Table 1 shows the relationships between education and gender of the participants. Of the thirty-three female (n=33) participants, six (n=6) completed high school, sixteen (n=16) completed four years of college, and eleven (n=11) completed a Master's Degree. Of the four male (n=4) respondents, one (n=1) completed high school and three (n=3) completed a Master's Degree.

Table 1

Education and Gender of Study Participants

	GENDER	
EDUCATION	**Male**	**Female**
High School	1	6
Four Years of College	0	16
Masters Degree	3	11

Of the thirty-seven participants, four (n= 4) had household incomes of under $15,000. Four participants (n=4) had incomes of $25,001-$35,000. Five participants (n=5) had incomes of $35,001-$45,000. Twenty-four participants (n= 24) had incomes of $45,001 and above.

Of the thirty-seven participants, three (n=3) lived in a household comprised of one person. Nine participants (n= 9) lived in a two person household. Seven participants (n= 7) lived in a three person household. Twelve participants (n=12) lived in a household comprised of five people. Six participants (n=6) lived in a household comprised of six or more people.

Finally, one participant (n=1) was of the ethnic group, African/ American. Thirty-three participants (n=33) were Anglo/Caucasian. One participant (n=1) were of the ethnic group, Asian/Asian-American. Two participants declined to answer this question.

School Social Workers

Table 2 shows the type of medication prescribed for students that school social workers work with. Five types of medication were provided. Two social workers work with students who are prescribed the standard form of Ritalin; one works with students taking time release Ritalin; one stated Methylphenidate; one stated Dexedrine; two social workers have students taking Clonodine; and two social workers have students that are prescribed Cylert.

Table 2

Type of Medication Prescribed for Student (N=2)

TYPE OF MEDICATION	n	PERCENTAGE
Standard form of Ritalin	2	100%
Time release Ritalin	1	50%
Methylphenidate	1	50%
Dexedrine	1	50%
Clonodine	2	100%
Cylert	2	100%

Respondents were asked, "Have parents requested informal consultation in working with their child at home?" As indicated in Table 4, 100% of the respondents (n=2) reported that parents requested informal consultation in working with their child at home.

Table 3

Parental Request for Informal Consultation (N=2)

REQUEST FOR CONSULT.	n	PERCENTAGE
Yes	2	100%
No	0	0

The respondents were asked about parental involvement with implementing behavior management programs at home. As indicated in Table 4, 50% of the respondents (n=2) answered yes and 50%(n=2) answered no.

Table 4

Behavior Management Programs at Home (N=2)

HOME BEHAVIOR MANAGEMENT	n	PERCENTAGE
Yes	1	50%
No	1	50%
Unsure	0	0

Respondents were asked, "Are the parents actively involved in planning intervention programs at school?". One hundred percent of the respondents (n=2) indicated they believed that parents were not actively involved in with planning intervention programs at school.

Table 5 reports that 100% of respondents (n=2) indicated yes to having been provided with an adequate amount of training and education to provide services to children with ADHD.

Table 5

Adequate Amount of Professional Training and Education (N=2)

TRAINING AND EDUCATION	n	PERCENTAGE
Yes	2	100%
No	0	0
Unsure	0	0

One hundred percent of respondents (n=2) indicated that parents ask for literature or other reading material regarding ADHD.

Table 6

Parental Request for Literature Regarding ADHD (N=2)

REQUEST FOR LITERATURE	n	PERCENTAGE
Yes	2	100%
No	0	0
Unsure	0	0

Respondents were asked to identify support staff available for consultation with interventions at school. As indicated in Table 7, 50% of the respondents reported that the psychologist was available; 50% identified the school nurse; 50% answered the special education teacher and 50% identified other, including regular education teachers as support staff available for consultation.

Table 7

Support Staff Available for Consultation With Interventions (N=2)

SUPPORT STAFF	n	PERCENTAGE
Psychologist	1	50%
School Nurse	1	50%
Special Education Teacher	1	50%
Other(a)	1	50%

a. Other support staff available included: regular education teachers.

The respondents were asked about barriers to providing services, in the schools, for students with ADHD. Respondents could choose more than one barrier. Not enough staff received one response (n=1); not enough time received one response (n=1); one respondent (n=1) chose not enough parent support; not enough teacher support was chosen one time (n=1); not enough training was chosen by two respondents (n=2); one respondent (n=1) chose other, including more training for teachers so they can be more supportive.

Table 8

Barriers to Providing Services (N=2)

BARRIERS	n	PERCENTAGE
Not enough staff	1	50%
Not enough time	1	50%
Not enough parent support	1	50%
Not enough teacher support	1	50%
Not enough training in building	2	100%
Other(a)	1	50%

a. Other barriers included: more training for teachers so they can be more supportive.

PARENTS

Table 9 shows the type of medication parents identified that is prescribed for their child. Seventy-three percent (n=8) of the respondents reported that their child takes the standard form of Ritalin; 9% (n=1) reported the medication as time release Ritalin; 18% (n=2) reported Methylphenidate.

Table 9

Type of Medication Prescribed for Child (N=11)

TYPE OF MEDICATION	n	PERCENTAGE
Standard form of Ritalin	8	73%
Time release Ritalin	1	9%
Methylphenidate	2	18%
Dexedrine	0	0
Clonodine	0	0
Cylert	0	0

Table 10 and 11 identify the number of parents who reported that their child received special education services and what area of service. Twenty-seven percent of the parents (n=3) reported that their child received special education services. Fifty percent of the respondents (n=3) identified the area of learning disabilities(LD) as the services their child receives. This includes one child who receives learning disabilities and speech/language service. Twenty-five percent (n=1) reported speech/language as the area of service their child receives.

Table 10

Child Receives Special Education Services (N=11)

SPECIAL EDUCATION	n	PERCENTAGE
Yes	3	27%
No	8	73%

Table 11

Area of Special Education Services (N=3)

SERVICES	n	PERCENTAGE
Learning Disabilities (LD)	3	75%
Emotional/Behavioral Disordered (E/BD)	0	0
Speech/Language	1	25%
Occupational Therapy (OT)	0	0
Other	0	0

Table 12 identifies the respondents' answers to their child's involvement in a social skills group at school. Twenty-seven percent (n=3) answered "yes" to their child's involvement. Seventy-three percent (n=8) answered "no."

Table 12

Child Involvement in School Social Skills Group (N=11)

SOCIAL SKILLS GROUP	n	PERCENTAGE
Yes	3	27%
No	8	73%

The respondents were asked about their involvement in parent support groups. As indicated in Table 13, 36% of the respondents (n=4) reported that they are involved in a parent support group; 64% (n=7) indicated that they were not involved.

Table 13

Involvement in Parent Support Groups (N=11)

PARENT SUPPORT GROUPS	n	PERCENTAGE
Yes	4	36%
No	7	64%

Table 14 reports that 73% of respondents (n=8) indicated that their child is involved in counseling related to issues regarding ADHD. Twenty-seven percent of the respondents (n=3) indicated that their child is not involved in counseling.

Table 14

Child Involved in Counseling Related to ADHD Issues (N=11)

INDIVIDUAL COUNSELING	n	PERCENTAGE
Yes	8	73%
No	3	27%

Table 15 identifies the interventions used at home by parents. Respondents could indicate more than one intervention. Eighty-two percent of the respondents (n=9) chose time-out as one intervention; 27% (n=3) chose a behavior contract as an intervention; 9% indicated that a point system was used at home; 91% (n=10) use positive reinforcement at home; 36% (n=4) of the respondents indicated a reward system was in place at home for positive behavior; 82% (n=9) reported firmness when setting limits; 82% (n=9) reported that they check their child's backpack daily; 36% (n=4) indicated that having a time and place to do homework was used at home.

Table 15

Interventions at Home
(N=11)

INTERVENTIONS	n	PERCENTAGE
Time-out	9	82%
Behavior contract	3	27%
Point system	1	9%
Positive reinforcement	10	91%
Reward system-positive behavior	4	36%
Firmness when setting limits	9	82%
Checking child's backpack daily	9	82%
Time and place to do homework	4	36%

Tables 16 and 17 report the respondents satisfaction of school accommodations and support from child's teacher. Seventy-three percent of the respondents (n=8) reported that they are satisfied with the school accommodations; 3% (n=3) reported that no accommodations are made. In area of support from the child's teacher, respondents were able to choose more than one answer. Fifty-five percent (n=6) indicated that they had communication of the teacher's expectations; 91% (n=10) indicated that their child had a teacher that was accessible; 73% of the respondents (n=8) reported that the teacher is responsive and sensitive to the child's needs; 91% (n=10) reported regular parent/teacher conferences; and one respondent, 9%, indicated that additional support was provided by the individual education team.

Table 16

Satisfaction of School Accommodations (N=16)

SATISFACTION	n	PERCENTAGE
Yes	8	73%
No	0	0
None made	3	27%

Table 17

Support from Child's Teacher
(N=11)

SUPPORT	n	PERCENTAGE
Communication of teachers expectations	6	55%
Accessibility of teachers	10	91%
Teachers responsiveness and sensitivity	8	73%
Regular parent/teacher conferences	10	91%
Other(a)	1	9%

a. Other teacher support included: Individual Education Team.

Teachers

Respondents were asked about the types of medication prescribed for students they work with. Respondents could chose more than one answer. As indicated in Table 18, the types for special education teachers included: 21% (n=5) use reported the standard form of Ritalin; 8% (n=2) reported time release Ritalin; 8% (n=2) reported Methylphenidate; 8% (n=2) indicated the medication as Dexedrine; 13% (n=3) indicated Clonodine; 13% (n=3) reported the use of Cylert; 4% (n=1) reported another medication.

The medication responses for general education teachers included: 46% (n=11) for the standard form of Ritalin; 25% (n=6) reported time release Ritalin; and 4% (n=1) indicated another medication.

Table 18

Type of Medication Prescribed for Child (N=24)

	MEDICATION	
	SPECIAL ED.	GENERAL ED.
Standard form of Ritalin	5 (21%)	11 (46%)
Time release Ritlain	2 (8%)	6 (25%)
Methylphenidate	2 (8%)	0
Dexedrine	2 (8%)	0
Clonodine	3 (13%)	0
Cylert	3 (13%)	0
Other(a)	1 (4%)	1 (4%)

Tables 19 and 20 indicate responses regarding consultation with parents regarding, progress and concerns and behavior modification at home. Thirteen percent (n=3) of special education teachers and 21% (n=5) of general education teachers indicated that staff are consulting with parents regarding student progress and concerns; 4% (n=1) of special education teachers and 33% (n=8) of general education teachers reported that staff at school are not

consulting with parents; 8% (n=2) of special education teachers and 21% (n=5) of general education teachers are unsure as to whether any school staff are consulting with parents regarding student progress and concerns.

Eight percent (n=2) of special education teachers and 29% (n=7) of general education teachers reported that school staff are consulting with parents regarding behavior modification at home. Eight percent (n=2) of special education teachers and 21% (n=5) of regular education teachers indicated that school staff are not consulting with parents; 8% (n=2) of special education teachers and 25% (n=6) of general education teachers indicated that they are unsure as to the status of staff consultation with parents regarding behavior modification at home.

Table 19

Consultation with Parents Regarding Progress & Concerns (N=24)

	PROGRESS & CONCERNS	
	SPECIAL ED.	**GENERAL ED.**
Yes	3 (13%)	5 (21%)
No	1 (4%)	8 (33%)
Unsure	2 (8%)	5 (21%)

Table 20

Consultation Regarding Behavior Modification at Home (N=24)

	BEHAVIOR MODIFICATION	
	SPECIAL ED.	GENERAL ED.
Yes	2 (8%)	7 (29%)
No	2 (8%)	5 (21%)
Unsure	2 (8%)	6 (25%)

In response to a list of classroom interventions for teachers to use with children with ADHD, study participants were asked which interventions they use. Twelve response categories were specified. Respondents were asked to check all that apply. Table 21 identifies the interventions. The most frequently reported interventions for special education teachers were: shortened assignments with 25% (n=6), proximity with 21% (n=5), frequent reminders with 21% (n=5), and a home/school log with 21%)n=5). The least used interventions for special education teachers were peer tutoring with 8% (n=2) and a behavior contract with 13% (n=3). The most frequently reported interventions for general education teachers were frequent reminders with 71% (n=17), preferred seating

with 67% (n=16) and proximity with 58% (n=14). The least used were: time-out in another room with 13% (n=3), a point system with 29% (n=7), and a behavior contract with 29% (n=7).

Table 21

Classroom Interventions (N=24)

	INTERVENTIONS	
	SPECIAL ED.	**GENERAL ED.**
Shortened assignments	6 (25%)	12 (50%)
Peer tutoring	2 (8%)	12 (50%)
Frequent breaks	4 (16%)	11 (46%)
Preferred seating	3 (13%)	16 (67%)
Frequent reminders	5 (21%)	17 (71%)
Time-out in classroom	4 (16%)	9 (38%)
Time-out in another room	2 (8%)	3 (13%)
Proximity	5 (21%)	14 (58%)
Home/school log	5 (21%)	10 (42%)
Behavior contract	3 (13%)	7 (29%)
Point system	4 (16%)	7 (29%)
Other(a)	0	6 (25%)

The respondents were asked about school services that are available. Table 22 identifies the participants answers to the five identified response categories. For the category, resources for referrals, 21% of special education teachers (n=5) and 8% of general education teachers indicated there were resources available in their school. In the area of staff training/inservices, 13% of special education teachers (n=3) and 21% of general education teachers (n=5) indicated this was available. Twenty-one percent (n=5) of special education teachers and 38% of general education teachers reported that social skills groups, for students with ADHD, were available in their school.

Table 22

School Services Available
(N=24)

	SCHOOL SERVICES	
	SPECIAL ED.	**GENERAL ED.**
Resources for referrals	5 (21%)	2 (8%)
Staff training/inservices	3 (13%)	5 (21%)
Consult. with support staff	4 (17%)	14 (58%)
Social skills group	5 (21%)	9 (38%)
Other(a)	0	1 (4%)

a. Other services included: parental support.

Table 23 shows the responses to the open-ended question, "What types of training and education have you had to assist you in providing services to children with ADHD in the classroom?" College coursework (21%-(n=5)) and workshop/inservices (13%-(n=3)) received the most responses from special education teachers, as to their training and education in the area of ADHD. Workshop/inservices (50%-(n=12)) and books/journal articles (33%-(n=8)) received the most responses from general education teachers regarding their type of training for working with students with ADHD.

Table 23

Type of Training & Education
(N=24)

	TRAINING & EDUCATION	
	SPECIAL ED.	**GENERAL ED.**
College coursework	5 (21%)	2 (8%)
Workshop/Inservice	3 (13%)	12 (50%)
Books/journal articles	2 (8%)	8 (33%)
Consultation with school staff	2 (8%)	3 (13%)
Independent research	1 (4%)	0
Very little	0	3 (13%)
District ADHD class	0	2 (8%)
Video	1 (4%)	0
Staff meeting	0	2 (8%)
Parent information	0	1 (4%)
None	1 (4%)	1 (4%)

The respondents were asked about barriers to providing services, in the schools, to children with ADHD. Table 25 shows that participants were given five response categories and could check all that apply. Twenty-one percent of special education teachers (n=5) indicated that not enough staff and not enough time were barriers. Forty-two percent of general education teachers (n=10) reported that both, not enough staff and not enough training were barriers to providing services.

Table 24

Barriers to Providing Services
(N=24)

	BARRIERS	
	SPECIAL ED.	**GENERAL ED.**
Not enough staff	5 (21%)	10 (42%)
Not enough time	5 (21%)	12 (50%)
Not enough parent support	1 (4%)	3 (13%)
Not enough training	4 (17%)	10 (42%)
Other(a)	1 (4%)	0

a. Other barriers included: over-identification of the problem, time taking away from other students, not enough proper supplies (i.e.manipulatives and computer software) and no set building plan for misbehavior.

Table 25 shows responses to effective interventions for students with ADHD. The most effective interventions reported for special education teachers included: a classroom reward system, with 25% (n=6) and modification of curriculum-student's use of a computer to complete assignments, with 25% (n=6). The least effective were: tapping on desk, with 0%, and self-esteem building, with 0%. General education teachers reported the following as effective interventions: home/school communication, with 54% (n=13), classroom reward system, with 50% (n=12) and firm discipline, with 46% (n=11). The lease effective interventions for general education teachers were: visual aids, with 8% (n=2), self-esteem building, with 8% (n=2), and tapping on desk, with 8% (n=2).

Table 25

Effective Interventions
(N=24)

	INTERVENTIONS	
	SPECIAL ED.	**GENERAL ED.**
Time-out/quiet areas	2 (8%)	6 (25%)
Classroom reward system	6 (25%)	12 (50%)
Home/school communication	5 (21%)	13 (54%)
Preferred seating	2 (8%)	6 (25%)
Visual aids	1 (4%)	2 (8%)
Clear expectations/instructions	1 (4%)	8 (33%)
Limiting distractions	2 (8%)	7 (29%)
Ind. reward/point system	5 (21%)	4 (17%)
Curr. Modification/Computer	6 (25%)	4 (17%)
Tests/assign.-resource room	3 (13%)	3 (13%)
Groups(i.e.social skills)	3 (13%)	6 (25%)
Self-esteem building	0	2 (8%)
Frequent praise	3 (13%)	8 (3%)
Frequent breaks	4 (17%)	10 (42%)
Firm discipline	0	11(46%)
Seat next to a calmer child	1 (4%)	3 (13%)
Tapping on desk	0	2 (8%)
Flexibility of teacher	4 (17%)	4 (17%)
Gentle reminders to stay on task	3 (13%)	8 (33%)
Other(a)	2 (8%)	2 (8%)

CHAPTER IV

DISCUSSION AND IMPLICATIONS

Overview

This chapter will cover the limitations of the study as they relate to external and internal validity and survey instrument design. Key findings will be highlighted and discussed as they relate to the role of the school social worker, effective interventions, and barriers to services. Implications for practice and research will conclude the chapter.

Limitations of the Study

The primary limitation of this research involved the external validity of the study, which is decreased due to the lack of representativeness of the sample (Rubin & Babbie, 1993). Due to time and financial considerations, the sample only included three schools in the school district. Also, the sample included schools in a suburban district with 10,000 students, which further reduced the sample size. The sample was elementary schools only, so the results cannot be generalized to middle and high school students. In an attempt to increase the number of respondents, a followup reminder letter was sent ten days after the initial mailing of the survey questionnaire. Respondents were also given two

weeks to return the survey, and a self-addressed, stamped envelope was provided for return of the survey.

A limitation of the survey instrument was that 85% of the questions, 33 of the 39, were close-ended questions. As discussed by Rubin and Babbie (1993), this may have hindered a respondent's ability to answer each of the questions in a natural way, and ultimately limited the amount of information that was received. The researcher did offer six open-ended questions, several "other" categories with requests for comments and a section for additional comments.

Internal validity of this study may have been improved by including triangulation. According to Rubin and Babbie (1993), the findings of this study have no ability to show cause and effect and are susceptible to response bias. The survey, questionnaires did not ascertain the professionals' level of knowledge with the issue thereby impacting the validity of the research (Rubin & Babbie, 1993). To increase overall internal validity, in-depth interviews and field observations with the sample population, could have been included in the methodology.

Discussion of Findings

Based on the results of the research, in addressing the needs of a child with ADHD, the most effective approach is a multifaceted one which could include:

School Social Workers

* Develop individual and classroom-wide behavior modification systems.

* Assist classroom teachers with specific behavior management techniques.

* Attend student staffings/conferences.

* Inservice school staff regarding ADHD and the impact on the teacher.

* Provide social skills/ADHD support groups during the day for students. The focus should be on: focusing attention, completing classwork, cooperating with classmates, recognizing his or her special needs and providing coping strategies.

* Assist parents in developing home behavior management programs.

* Provide parents with literature regarding parents support groups or alternative treatments for ADHD.

* Educate parents regarding school services available to students.

* Continue professional training and education regarding ADHD.

Parents

* Involvement in family counseling.

* Become active in a parent support group.

* Implement various interventions at home including:
    Time-out

    Behavior contract

    Point system

    Positive reinforcement

Reward system for positive behavior

Firmness when setting limits

Checking child's backpack daily

Time and place to do homework

* Frequent contact with child's teacher regarding progress/concerns

* Regular attendance at parent/teacher conferences

* Provide for physical outlet for the child through daily play activities and/or organized team sports

* Update personal knowledge through literature, etc..

General Education Teachers

* Close communication between school and home through phone calls, or a daily/weekly contact log.

* Classroom Environment:
  - Highly structured and predictable

  - Rules and expectations are clear and consistent

  - Enclosed classroom to reduce distractions

  - Display classroom rules

  - Tape a copy of the child's daily schedule on the student's desk

  - Ease transitions between classes and activities by providing clear directions and cues, such as a five minute warning

  - Seat child away from distractions

- Seat the child next to students who will be positive role models

* Classroom Management:
  - Plan academic subjects for morning hours

  - Provide regularly scheduled and frequent breaks

  - Establish a "secret signal" with the child to use as a reminder when he, or she is off task

* Modifying curriculum:
  - Include organization and study skills, such as color coding and assignment books, as part of the curriculum

  - Allow student to use the computer for some written assignments

  - Reduce the amount of work assigned, or modify assignments

  - Use a mixture of high and low interest tasks

* Provide a physical outlet for the child through physical education class, or a break outside.

* Value students' differences and help bring out their strengths. Provide many opportunities for children to demonstrate to their peers what they do well.

Special Education Teachers

* Assist general education teachers with developing specific behavior modification programs with students, including, token-based economy, behavior contract, or point system.

* Provide teachers with specific classroom interventions including the following:
  - Shortened assignments

  - Peer tutoring

  - Frequent breaks

- Frequent reminders
- Time-out in the classroom
- Time-out in another classroom
- Proximity
- Home/school log

* Provide regular consultation with parents regarding progress/concerns
* Consult with parents regarding behavior modification at home
* Continue professional training and education regarding ADHD

Barriers to Providing Services

The following are significant barriers to providing services, for teachers and school social workers, developed from the findings:

- Lack of support staff at school
- Lack of training by school staff, in the area of ADHD
- Lack of teacher awareness of the increased prevalence of students with ADHD in the classroom
- Lack of teacher flexibility in providing interventions for children with ADHD

Research and study participants' experiences shows that positive, proactive interventions used with students with ADHD are most effective. Based on the findings, few teacher training programs provide training in proactive

interventions and teachers, as well as parents, may find themselves with little information and few resources when attempting to implement proactive interventions. This research gathered strategies that are useful for the school social worker, teacher, and parent, of the child with ADHD.

Implications for Social Work Practice and Other School Professionals

This study is significant for school social work practice, as the results conclude the following are the tasks and roles of the school social worker, ranging from the individual case level to the system level.

School Social Worker's Roles

* Individual Counseling- To be provided on an incidental, or short-term basis at school, or through a private psychologist, or clinical social worker. The focus of the counseling should be in the areas of: focusing attention, self-esteem building, and behavior management techniques.

* Group Counseling- To be provided at school through a social skills, or ADHD support group. Through group counseling, students receive support from other students who encounter some of the similar challenges. Through role-playing, and other activities, students practice specific coping techniques.

* Parent Counseling and Education- Updated information to be provided to parents through phone calls and literature. Parents should be encouraged to attend local parent support groups or attend a class

provided through the school district. School social workers could develop a parent support group in each school.

* Classroom Consultation- Teachers need assistance with individualized behavior management plans, ways to proactively intervene before a misbehavior occurs, and ways to alter the environmental structure of the classroom.

* Liaison Between Home and School- The school social worker is critical in establishing a positive relationship between home and school.

* Program Planning for the Community- Children with Attention Deficit Disorders (CH.A.D.D.) and the Attention Deficit Disorders Association are two national organizations that support parents and families. Parents should be encouraged to join local chapters of these organizations, or supported in establishing a chapter in their community.

Administrations' Roles

* Professional Growth Opportunities- Principals and special education administration need to understand the importance and support opportunities for continued growth in the area of ADHD. They should allow, encourage, and support staff attendance at workshops, inservices, and invite speakers to address the staff on current issues in education. Through the special education department, or school library, professional resources relating to ADHD could be

provided.

* Develop an Awareness and Support Teachers' Efforts in Working With Students With ADHD- Administrators should look into the possibility of lowering the class size of a teacher who encourages students with ADHD to be scheduled into his, or her classroom. The teacher could be provided release time to plan interventions, or to meet with parents, or support staff.

* Encourage Non-Supportive Teachers to Improve Skills- Teachers who are "burned out," or unwilling to change or grow, should be encouraged and provided opportunities to improve their teaching skills.

Suggestions for Future Research

Further research on this topic could be conducted in the following areas:

1) Interventions that specifically addressed issues relevant to children with ADHD from diverse cultural backgrounds.

2) What type of preparation and training are made available to future teachers in their undergraduate coursework?

3) What specific instructional materials do students with ADHD need?

4) What implications for interventions does the presence of multiple disorders have?

5) How should responsibility for interventions be shared among schools, social agencies and medical professionals?

6) The same study could be repeated in other school districts, so the sample would be larger and more comprehensive.

7) The dramatic increase over the last ten years of students identified with ADHD.

Recommendations

With the ever increasing numbers of students being diagnosed with ADHD, there are several areas of need where attention and resources must be provided to assist in the goal of helping students reach their full potential.

Universities and Colleges

* Research indicates one to three students with ADHD are present, on the average in each elementary school classroom. There needs to be more emphasis in coursework on diagnostic procedures and intervention techniques, as part of a teacher's training and education.

* More research is needed in determining the most effective strategies in assisting teachers to help those identified students become more productive and maintain a high level of self esteem.

* Resources need to be developed that are beneficial to classroom teachers when they are in need of assistance. These resources include, speakers resource library, and inservice programs.

School Districts

* Through special education departments, resources and materials need to be available for teachers.

* Provide inservice programs for teachers on a proactive basis in an effort to develop awareness of the problem and means of assisting students in their classroom.

* Serve as a catalyst in bringing parents of students with ADHD into the schools and provide information and support for their benefit in coping with their children both in and out of school.

Medical Profession

* Provide more training and information to those involved with the health and welfare of elementary-aged children so that a more comprehensive approach involving identification and treatment can be utilized that would include the parents, schools, and the medical profession.

Conclusion

In the past, if a person were to visit a health service office in your local elementary school, you would find a child that was in need of a band-aid, having their ears or eyes tested, or feeling ill.

More recently, if you visited a school's health service office you will find many medications being given to students, with the most frequent medication being Ritalin, for students with ADHD.

There are more special education programs being included in the elementary schools throughout the State of Minnesota. Most of these newer programs are being developed for students with more severe learning and behavior problems.

The elementary schools is the place where the students with ADHD first come to the surface. It is here where, with sufficient resources, a raised level of awareness, a comprehensive approach to the problem, is where the best opportunities are available to meet the needs of the child, assist parents in coping with the problem, and providing the school staff the means to be as effective as possible, in a comprehensive manner to a complex problem.

The implications of providing, or not providing needed services for these children have had a direct impact on the degree of success the child experiences in school; of becoming a socially acceptable, well-adjusted student and becoming a productive citizen of the future.

The following are key components in providing students with ADHD to reach their full potential:

School Social Workers

* To provide support to the child both in and out of the classroom

* To give assistance to the teachers by providing information, support, and direct assistance to the child, when needed.

* Assist parents by providing liaison services among school, medical staff, and other agencies

* To provide resources and inservice programs to administration, school staff, and parents.

Classroom Teachers

* To provide the patience and flexibility necessary to meet the needs of students with ADHD.

* To become familiar with the most effective interventions and design a program accordingly.

* To communicate the status and progress of the student with all those involved.

Special Education Teachers

* To assist students with specific skills and programs to meet the children's needs.

* To support the classroom teacher and parents in coping with specific behaviors that need improvement.

Parents

* To support and love their child.

* To take advantage of the opportunities to learn about ADHD.

* To be an active participant and involved in all aspects of the program designed for their children.

The treatment of ADHD is a team effort involving parents, teachers, school social workers, administrators, and health professionals. This team can help children with ADHD lead fulfilling and productive lives.

The schools that are most successful in helping students with ADHD make certain that individual student differences are reflected in the design of their educational plans. The teachers and administrators demonstrate a common commitment to working with students with ADHD, understanding the complexity of the disorder, and believe strongly in the services the are providing to all children. Such schools work as a team to deal effectively with students with ADHD by matching techniques and modifications to students' individual potential and methods of learning.

Successful schools realize that students with ADHD are not "problem children," but children with a problem. They encourage the school, parents, and teachers to work together with the child in order to help that child develop skills and work habits that he, or she will need to be successful in school and in life.

Ultimately, the success of a child with ADHD depends on a collaborative effort between the child and a committed team of caregivers - parents, school social, workers, educators, and medical personnel.

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RECOMMENDED RESOURCES FOR PARENTS:

Attention Deficit Disorder Association (ADDA)
Pamela Murray, President
8901 South Irland Way
Aurora, CO 80016

Bimonthly Newsletter- Challenge
P.O. Box 2001
West Newbury, MA 09185

Children with Attention Deficit Disorder (CH.A.D.D)-of the Twin Cities
c/o Arc of Hennepin County
Diamond Hill Center, Suite 140
Mpls., MN 55416-5810
612/920-0855

Parent Advocacy Coalition for Educational Rights (PACER)
Marge Goldberg/Paula Goldberg, Directors
PACER Center
4826 Chicago Ave. S.
Mpls., MN 55417
1-800-53-PACER

RECOMMENDED RESOURCES FOR CHILDREN:

Gehret, Jeanne. Eagle Eyes. Verbal Images Press, 1991.

Gordon, Michael. Jumpin' Johnny Get Back to Work. GSI Publications, 1991.

Moss, Deborah. Shelly, the Hyperactive Turtle. Woodbine Press, 1989.

Nadeau, Kathleen & Dixon, Ellen. Learning to Slow Down and Pay Attention. Chesapeake Psychological Services, 1991.

RECOMMENDED RESOURCES FOR SCHOOL STAFF:

ADD Hyperactivity Handbook for Schools. H.C. Parker (1992). ADD Warehouse - 1-800-233-9273.

How to Reach and Teach ADD/ADHD Children. Sandra Reif, Ph.D. ADD Warehouse - 1-800-233-9273.

Structuring Your Classroom for Academic Success. Pain, S.C. and Radicchi, J. Champaign, IL Research Press - 1-217-352-3273.

The Tough Kid Book: Practical Classroom Management Strategies. Rhode, Jensen, and Reavis, Available from Sopris West, Inc., 1-303-651-2829.

APPENDIX A

IRB LETTER OF APPROVAL

AUGSBURG

C • O • L • L • E • G • E

DATE: 2/15/96

TO: Deana Loven
1591 Granada Ave. Apt #113
Oakdale MN 55128

FROM: Rita Weisbrod, Ph.D.
Chair
Institutional Review Board

RE: Your IRB application "Interventions with children with Attention Deficit/Hyperactivity disorder at school and home"

I have received you memorandum of February 11 noting the acceptance of conditions and suggestions following our review of your application. I assume you are changing the due date for your surveys which is currently listed as February 15 !

Your applications has now been approaved. Your IRB approval number is:

`# 95 - 37 - 3.

This number should appear on your cover letter and suravey instruments.

If there are substantiave changes to your project which change your procedures regarding the use of human subjects, you should report them to me in writing so that they may be reviewed for possible increased risk.

I wish you well in your project!

Copy: Vincent Peters, Thesis Advisor:
Bethel College

2211 Riverside Avenue • Minneapolis, MN 55454 • Tel. (612) 330-1000 • Fax (612) 330-1649

APPENDIX B

NORTH ST. PAUL-MAPLEWOOD-OAKDALE SCHOOLS

LETTER OF APPROVAL

hool District 622

North St. Paul
Maplewood
Oakdale

COWERN ELEMENTARY SCHOOL 2131 N. Margaret Street, North St. Paul, MN 55109

January 5, 1996

Rita Weisbrod
Augsburg College
Augsburg Internal Review Board Chairperson
2211 Riverside Avenue
Minneapolis, MN 55454

Dear Rita,

Deana Loven has permission to study and evaluate Interventions with Children with Attention-Deficit/Hyperactivity Disorder at School and Home. She will be supplying the principals with stamped envelopes,including the questionnaire, to be addressed and sent to participants.

Sincerely,

Jerry Hauble, Principal
Carver Elementary School

Arlys Larson, Principal
Cowern Elementary School

Sharon Sandberg, Principal
Webster Elementary School

ARLYS LARSON, Principal • (612) 770-4672

APPENDIX C

SURVEY QUESTIONNAIRE COVER LETTER

IRB approval # - 95- 37- 3

INTERVENTIONS WITH CHILDREN WITH ATTENTION-DEFICIT/ HYPERACTIVITY DISORDER AT HOME AND SCHOOL

February 20, 1996

Dear Participant,

I am a graduate student working toward a Masters in Social Work degree at Augsburg College in Minneapolis, MN. I am also employed as a school social worker in District #622.

For my Master's thesis, I am researching interventions with children with Attention-Deficit/Hyperactivity Disorder (ADHD) at home and school. You were selected by the principals as a possible participant because you are: a) a parent to an elementary-aged child with ADHD, who has taken medication at school, for that condition, within the past twelve months, or b) a general or special education licensed teacher, or a school social worker in an elementary school, who has worked with a child with ADHD, within the past twelve months. This research study has been approved by and is being done in cooperation with Beaver Lake, Carver, Cowern, and Webster Schools, in District #622. I ask that you read this form very carefully.

BACKGROUND INFORMATION:
This research study is being conducted to provide me with information for my Master of Social Work degree. The purpose of this study is to provide you an opportunity to express your methods of interventions with a child who is diagnosed with ADHD.

VOLUNTARY NATURE OF THIS STUDY:
Your experiences and opinions are important! It is up to you whether or not to participate in this research study. Your decision will not affect your current or future relationship with District #622 or Augsburg College.

PROCEDURES AND ANONYMITY:
I am surveying parents, general and special education teachers, and school social workers who have worked or parented a elementary-aged child with ADHD, within the past twelve months. Your anonymity is protected as the selected elementary school principals will be mailing out this questionnaire. I do not know your name, nor will I have worked directly with you or your child.

Please do not place your name or any other identifying information on the questionnaire. Completed and returned questionnaires will be filed in a locked drawer in the office of the researcher and will be destroyed by September 30, 1996. Information from this questionnaire will be used for my thesis in summary format and will not include any information that make it possible to identify participants.

RISKS OF BEING A PARTICIPANT IN THIS STUDY:
Completion of the questionnaire may raise some uncomfortable feelings. Should you need any help, please contact the School Social Worker or the Principal at your school.

BENEFITS OF BEING A PARTICIPANT IN THIS STUDY:
While there are not direct benefits to participating in this research study, this is an opportunity for your to report effective interventions in working with children with ADHD, which may, in turn, assist the school district in assessing the quality of services provided to children and families.

Will you please help in this research study by completing this questionnaire? This questionnaire is a one-time commitment on your behalf and may take you approximately twenty (20) minutes to complete. Once completed, please return this questionnaire in the enclosed self-addressed, stamped envelope as soon as possible and no later than March 4, 1996. The completion and return of this questionnaire will indicate your consent to participation in this study as well as conclude your role in this research study.

If you have any questions regarding this research study, please feel free to contact me at (612) 770-4644. You may also contact Vincent Peters, my thesis advisor at Bethel College, at (612) 638-6124.

Please keep this copy for your records.

Thank You!

Sincerely,

Deana M. Loven

Deana M. Loven
Graduate Student and Principal Investigator

APPENDIX D

SURVEY QUESTIONNAIRE

IRB approval - # 95-37-3

INTERVENTIONS WITH CHILDREN WITH ATTENTION-DEFICIT/HYPERACTIVITY DISORDER AT HOME AND SCHOOL

PARTICIPANT QUESTIONNAIRE

INSTRUCTIONS

ADHD is an acronym for children with Attention-Deficit/Hyperactivity Disorder.

1. Either a pen or a pencil may be used to complete the questionnaire.
2. Most of the questions in the survey can be answered by simply checking the response that reflects your perspective; other questions ask for written-in answers.
3. If you choose not to answer a particular question, please move on to the next question. You may stop at anytime and mail back the questionnaire.
4. At the end of the questionnaire, there is space for you to offer comments.
5. Upon completion of this survey, please place it in the envelope provided and mail back by March 4, 1996. Thank you for your participation in this survey!

SURVEY QUESTIONS:

1.* Are you a parent to a child with Attention-Deficit/Hyperactivity Disorder who has taken medication for that disorder during January 1995 -January 1996?

Yes _____ No _____

2. * Are you a regular or special education teacher or a school social worker to a child who has taken medication for that disorder during January 1995 - January 1996?

Yes _____ No _____

If you answered "No," to "Both" of the questions, please STOP! Your have completed the questionnaire. Please place the questionnaire in the envelope provided and mail it back to me as soon as possible. Thank You!

If you answered "Yes," to either of the questions, please continue answering the questions.

** Please answer the following questions by checking the response which best reflects your experience.

SECTION A: All participants complete this section.

1. Does your child or the children you work with take medication for ADHD?

   Yes _____ No _____

2. What type of medication does your child, or the children you work with take?

   _____ Standard form of Ritalin
   _____ Time release Ritalin
   _____ Methylphenidate
   _____ Dexedrine
   _____ Clonodine
   _____ Cylert
   _____ Other (please specify). _____

SECTION B: Parents only complete this section.

1. Does your child receive special education services related to ADHD?

   Yes _____ No _____

2. If yes, in what area(s): (check all that apply).

   _____ Learning Disabilities (LD)
   _____ Emotional/Behavioral Disordered (E/BD)
   _____ Speech/Language
   _____ Occupational Therapy (OT)
   _____ Other (please specify). _____

3. Is your child currently, or has been involved in a social skills group at school?

   Yes _____ No _____

4. Are you involved in any service/support groups for parents of children with ADHD?

Yes _____ No _____

If yes: please specify_____

5. Is your child currently, or has been involved, in individual or family counseling outside of the school setting, related to issues regarding ADHD?

Yes _____ No _____

6. Does your child receive counseling at school for issues related to ADHD?

Yes _____ No _____

7. What interventions do you use, or have you used with your child at home? (check all that apply).

_____ Time-out
_____ Behavior contract
_____ Point system
_____ Positive reinforcement
_____ Reward system for positive behavior
_____ Firmness when setting limits
_____ Checking child's backpack daily
_____ Specific time and place to do homework
_____ Other (please specify).____

8 Are you satisfied with the accommodations made by your child's classroom teacher?

Yes _____ No _____ No accommodations are made _____

9. Do you feel your have the following support from your child's teacher? (check all that apply).

_____ Clear communication of teachers expectations
_____ Accessibility of teachers
_____ Teachers responsiveness and sensitivity
_____ Regular parent/teacher conferences
_____ Other (please specify). _____

9. Other comments/opinions:

SECTION C: School teachers only complete this section.

1. What field are your currently teaching in?

_____ General education
_____ Special education

2. Does someone from your school regularly confer with the parents on progress or concerns with the child with ADHD in your classroom?

Yes _____ No _____ Unsure _____

3. Is anyone from your school working with the parents to conduct behavior modification at home?

Yes _____ No _____ Unsure _____

4. What interventions do you use, or have you used with children with ADHD in the classroom? (check all that apply).

_____ Shortened assignments
_____ Peer tutoring
_____ Frequent breaks
_____ Preferred seating near teacher
_____ Frequent reminders to stay on task
_____ Time-out in classroom
_____ Time-out in another room (i.e. classroom or office)
_____ Other (please specify). _____

_____ Proximity control
_____ Home/school log
_____ Behavioral contract
_____ Point system

5. What services are available in your building related to ADHD?(check all that apply).

_____ Resources for referrals to outside agencies/programs
_____ Staff training/inservices
_____ Consultation with support staff
_____ Social skills group
_____ Other (please specify)._____

6. What types of training and education have your had to assist you in providing services to children with ADHD in the classroom?

7. What barrier(s) if any, are there to providing services in schools to students with ADHD?

_____ Not enough staff
_____ Not enough time to implement interventions
_____ Not enough parent support
_____ Not enough training in building
_____ Other (please specify). _____

8. What types of interventions have you found to be effective in working with children with ADHD?

9. Are the children responding to your intervention?

8. Other comments/opinions:

SECTION D: School social workers only complete this section.

1. Have parents requested informal consultation in working with their child at home?

   Yes _____ No _____

2. Are the majority of parents you have been involved with implementing behavior management programs?

   Yes _____ No _____ Unsure _____

3. Are the parents actively involved in planning intervention programs at school?

   Yes _____ No _____ Unsure _____

4. Do parents ask you for literature or other reading material regarding ADHD?

   Yes _____ No _____ Unsure _____

5. Do you feel that you have been provided with an adequate amount of training and education to provide services to child with ADHD?

   Yes _____ No _____ Unsure _____

6. Which support staff are available for consultation with interventions?

   _____ Psychologist
   _____ School nurse
   _____ Special education teacher
   _____ Other (please specify). _____

7. What barrier(s), if any, are there to providing services in schools to students with ADHD? (check all that apply).

_____ Not enough staff
_____ Not enough time to implement interventions
_____ Not enough parent support
_____ Not enough teacher support
_____ Not enough training in building
_____ Other (please specify)._____

8. Other comments/opinions:

SECTION E: BACKGROUND INFORMATION: All participants complete.

GENDER: (Check one). [ ] Female [ ] Male

AGE: (Check one).
[ ] under 25 years old [ ] 21-30 years old [ ] 31-40 years old
[ ] 41-50 years old [ ] 51-60 years old [ ] over 60 years old

POSITION: (Check one).

[ ] parent
[ ] school social worker
[ ] general education teacher
[ ] special education teacher

EDUCATIONAL LEVEL: (Check one).

[ ] GED/High School Degree
[ ] College Degree
[ ] Masters Degree
[ ] Ph. D.
[ ] Other: _____(please specify)

HOUSEHOLD INCOME: (Check one).

[ ] Under $15,000 [ ] $15,001 to $25,000 [ ] $25,001 to $35,000
[ ] $35,001 to $45,000 [ ] $45,001 and above

NUMBER OF PERSONS IN HOUSEHOLD: (Check one).

[ ] 1 person [ ] 2 persons [ ] 3 persons [ ] 4 persons
[ ] 5 persons [ ] 6 persons or more

****Optional:**
RACE/ETHNICITY GROUP: (Check one).

[ ] African-American [ ] American-Indian/Native American
[ ] Anglo/Caucasian [ ] Asian/Asian-American [ ] Latino
[ ] Biracial (please specify)._____
[ ] Other: (please specify). _____

Thank You for your participation!