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ABSTRACT

This practicum was designed to increase the ability of human services professionals to provide knowledgeable and effective direction and support for adoptive parents of children with attention deficit-hyperactivity disorder. A 1-day training program and materials were developed to reach the goal, and two social workers were trained to present the program to four groups of human services professionals, which included social workers, adoption workers, and related professionals and paraprofessionals. Content of the program consisted of motivational activities, description of the disorder, explanation of diagnosis and treatment, and consideration of case management. A reference handbook was produced for each participant, as well as an informative brochure for use with participants' clients. Results of the practicum indicated significant increases in specifically identified areas of knowledge. Appendices provide a post-test and other materials used in implementing the practicum. (Contains approximately 80 references.) (JDD)

Use of A One Day Training Program for Human Services Professionals to Increase Their Understanding of Attention Deficit-Hyperactivity Disorder and Its Ramifications for Adoptive Families

by

Daniel J. Russo

Cluster XXXVI

A Practicum II Report Presented to the
Ed.D. Program in Early and Middle Childhood
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Education

NOVA UNIVERSITY

1993

PRACTICUM APPROVAL SHEET

This practicum took place as described.

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This practicum report was submitted by Daniel J. Russo under the direction of the adviser listed below. It was submitted to the Ed.D. Program in Early and Middle Childhood and approved in partial fulfillment of the requirements for the Doctor of Education at Nova University.

Approved:

June, 1993
Date of Final
Approval of Report

Mary W. Staggs
Mary W. Staggs, Ed.D., Adviser

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ABSTRACT

Use of A One Day Training Program for Human Services Professionals to Increase Their Understanding of Attention Deficit-Hyperactivity Disorder and Its Ramifications for Adoptive Families. Nova University, Ed.D. Program in Early and Middle Childhood. Descriptors: Attention deficit disorder/Attention deficit-hyperactivity disorder/Adoption/Professional training/Social Services.

The general goal of the practicum was to increase the ability of human services professionals to provide knowledgeable and effective direction and support for adoptive parents of children with attention deficit-hyperactivity disorder (ADHD). It was not the purpose of the program to develop experts in the field of ADHD. Rather, it was hoped that the professionals who completed the program would be better able to serve as effective resources and managers for the populations they serve.

A one day training program and new materials were designed to reach the goal, and two licensed social workers were trained to present the program. The program was presented to five groups of human services professionals. Content of the program consisted of motivation, description, diagnosis and treatment, and case management. A permanent reference handbook was developed specifically for use with the program and distributed to each of the participants. Also developed and distributed was an informative brochure intended for use with the participants' clients.

Results of the practicum show that all nine of the specific objectives were met. Significant increases in all specifically identified areas of knowledge are reported, as well as consistently positive ratings by the participants. Substantial overlap of objectives established for the practicum with objectives set by participants themselves suggests that the program was successful in anticipating and meeting the self-perceived needs of the participants.

Permission Statement

As a student in the Ed.D. Program in Early and Middle Childhood, I do (✓) do not ( ) give permission to Nova University to distribute copies of this practicum report on request from interested individuals. It is my understanding that Nova University will not charge for this dissemination except to cover the costs of microfiching, handling, and mailing of the materials.

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CHAPTER I

INTRODUCTION

Description of Work Setting and Community

The base of operations for this practicum was a private psychological clinic specializing in school- and family-related issues among children and youth between the ages of four years and nineteen years. Services provided by the clinic fall into three broad categories: (a) evaluation, (b) therapy, and (c) consultation with education and social welfare agencies in the community. Thus, the clinic serves both as a provider of direct services to individual clients and as a source of information and expertise for related professional groups. With regard to the latter, active contracts are currently maintained with social welfare agencies in two counties, while services are provided to other agencies or schools on an as-needed basis.

Roughly one-half of direct referrals to the clinic features poor academic performance as the presenting problem, while the other half stresses problem behaviors both at home and at school. Frequently, these two problem areas overlap. Following the evaluation of new clients, a diagnosis of attention deficit-hyperactivity disorder (ADHD) had been indicated for approximately 65% of the youngsters. While the percentage of clients diagnosed with this disorder had increased gradually between 1982 and 1989, it remained stable between 1989 and 1992. This pattern is

attributed both to heightened awareness of the disorder among the general population, and to increased expertise of the writer.

The clinic is situated on the main street of a town of approximately 12,000 people located in the mid-Atlantic region. Within the past fifteen years, the town has changed from a semi-rural center to an essentially suburban community within the greater metropolitan area of a nearby small city which is also the state capital. Clientele are drawn primarily from six counties with a total population of approximately 500,000. With specific regard to consultation services, the service area is extended to fourteen contiguous counties, with access, potentially, to the entire state. Direct services for children and their families are typically provided at the clinic offices. Consultation services are generally, but not always, provided at the client's location.

The primary service area (of either six or fourteen counties) is a region characterized by a population which is dispersed over agricultural and mountain terrain, with groupings of greater density in small towns and small cities. There are no large cities located in the region, and services tend to be as dispersed and uneven as the population. Thus, it is not uncommon for individuals or professional groups to travel up to one hundred miles in order to give or receive needed services.

The target population for this practicum consisted of social workers in public agencies, social workers in private practice, adoption workers in a variety of settings, and related professionals and paraprofessionals. This group will be referred to collectively as "human services professionals."

The Writer's Role in the Work Setting

The writer is owner of the clinic and is directly responsible for all aspects involved in running the business and providing professional services. The writer has sub-contractual relationships with one counselor and two clinical social workers, one of whom is also owner/director of a private adoption agency. The writer is responsible for providing direct services to clients, for supervising the work of sub-contracted professionals, and for maintaining effective liaison with educators, physicians, and representatives of social welfare agencies in the community. Since ultimate decision-making responsibility rests with the writer, there is considerable latitude for initiating and implementing new programs. Because of the central role of the writer, however, there has generally been little support available from others in the organization. One of the sub-contracted social workers, however, has recently been able to provide considerable support and guidance in establishing contact, and working with, county and state agencies.

The writer's educational background includes an M.A. degree in psychology of personality and an M.S.Ed. degree in school psychology. The writer is certified as a school psychologist and is licensed by the state for private practice as a psychologist. Professional experience includes seven years as a special education teacher in a large inner city setting, eight years as a school psychologist in a district of 9,000 students located in the present geographical area, and ten years as owner and director of the private psychological clinic. For five years he has served on the

county-wide multi-disciplinary team of his county's children and youth services agency.

CHAPTER II

STUDY OF THE PROBLEM

Problem Description

Human services professionals in the target area have been found typically to overlook or discount ADHD as a significant factor when placing children for adoption. In those cases in which there may indeed be some awareness of the nature of the disorder, there nevertheless appears to have been neither a genuine understanding of the particular needs which these children and their adoptive families will have in the short run, nor an appreciation of the potential stresses which will have a considerable, and inevitable, impact on these families in the future.

Thus, human services professionals were initially in a position where they arranged for adoptions, and provided follow-up services to adoptive families, without being able to offer effective guidance with regard to ADHD. This situation had an impact both on potential adoptive parents and on established adoptive families. Potential adoptive parents of a child who was already identified as having the disorder could not be given adequate help in understanding the child's current needs and in developing realistic expectations for what lay ahead both for the child and the family. Established adoptive families with undiagnosed children who were beginning to show signs of ADHD did not have effective assistance in identifying, treating, and managing the disorder and its impact.

The problem situation was of particular concern for two reasons. First, as will be shown, adopted children present a higher incidence of ADHD than do nonadopted children. Second, concern over self-worth is a major issue in the emotional development of both adopted children and children with ADHD; when the adopted child also has ADHD, the concern becomes more acute.

Thus, the problem was that (a) human services professionals in the targeted geographical area were not sufficiently knowledgeable in the nature of ADHD, and in its potential ramifications, to provide adequate guidance to adoptive families and, (b) there were no local programs designed to train human services professionals in the nature and ramifications of ADHD, and in the means of identifying and accessing community resources.

Problem Documentation

A review of the 276 children listed by a state-wide adoption agency, conducted by the writer, revealed that 69 of the children, or 25%, had either been identified as having ADHD, or were described in behavioral terms which clearly pointed to such a diagnosis. An analysis of the descriptive materials for each of those 69 children revealed that the disorder was consistently presented to the reader either as incidental or as being without significant consequences for both the child and the family. Particularly notable was a tendency for the ADHD-like behavioral characteristics of the undiagnosed children to be treated as cute or desirable. If one assumed that this agency's professionals were not deliberately attempting to

misrepresent the children in their care, the implication was made that the information and understanding necessary for accurately describing the children and their needs were largely absent among that professional group.

An interview with two licensed social workers in separate private practices indicated that they were not themselves knowledgeable about ADHD. They reported feeling particularly frustrated by this lack of expertise, since they felt that psychologists, medical professionals, and some educators were often speaking a language which they did not understand. Further, their impression from their own extensive contacts with other human services professionals, was that this was a professional group which had been completely bypassed in the recent dissemination of information about ADHD.

The director of a local, private adoption agency had approached the writer with the concern that the other adoption workers with which she regularly came into contact appeared to be untrained in the nature of ADHD and its ramifications, and that they generally did not seem to know which other professionals and agencies in the community could be of help to adoptive families confronted with ADHD or ADHD-like behaviors. Having worked for county and state agencies for many years, in addition to her present work in the private sector, she drew her impressions from a wide range of experiences throughout the state. She cited the apparent lack of specific training opportunities in the target area and asked if the writer were in a position to provide such opportunities.

A review of observations made by the writer over the past ten years revealed that not one human services professional with whom he had discussed children had been knowledgeable about ADHD to the extent that meaningful guidance could be provided to adoptive families. There were some indications that there had been an increasing awareness that ADHD existed and that, once diagnosed, some sort of intervention was required. The seriousness of the ramifications of the disorder, however, did not yet seem to be clearly understood or appreciated. Also noted was an inadequate familiarity with appropriate community resources to which adoptive families might be referred.

Causative Analysis

It was the writer's belief that there were three fundamental causes for the stated problem, two of which stemmed from the essential fact that the target area is not densely populated.

First, population in the community is generally rather widely scattered; a genuine geographical focus for cultural and professional activities is lacking. There is no single adoption authority or agency. Human services professionals form, therefore, a generally fragmented and dispersed target group which is often difficult to identify and which tends to go unnoticed.

Second, because community resources tend to be more limited than those found in larger communities, the focus for training programs in the local area has been on those large, easily-identified groups which are readily seen as being on the

front lines. Thus, psychologists, educators and physicians had already been targeted for some training. Even within these high profile groups, however, many local professionals had had to journey to major population areas in order to be trained.

The third cause lay within the problem itself. While demographic factors have indeed influenced the ability of experts to provide training, it would appear, conversely, that the lack of information and awareness had itself influenced the apparently low level of interest among many human services professionals in seeking training. A rising awareness and interest among a small number of these professionals had, until very recently, led only to frustration in finding the appropriate training.

Relationship of the Problem to the Literature

The literature with regard to both ADHD and adoption is extensive.

Barkley (1990), perhaps the preeminent authority in the field of attention disorders, reports that the consensus of opinion is that ADHD affects between 3% and 5% of all children. He defines ADHD as a lifelong disorder consisting of

> ...developmental deficiencies in the regulation and maintenance of behavior by rules and consequences. These deficiencies give rise to problems with inhibiting, initiating, or sustaining responses to tasks or stimuli, and adhering to rules or instructions, particularly in situations where consequences for such behavior are delayed, weak, or nonexistent. The deficiencies are evident in early childhood and are probably chronic in nature. Although they may improve with neurological maturation, the deficits persist in comparison to same-age normal children, whose performance in these areas also improves with development. (p. 71)

The Diagnostic and Statistical Manual of Mental Disorders, Third Edition - Revised (DSM-III-R) (American Psychiatric Association, 1987) translates Barkley's broad conceptual definition into the following specific, observable behaviors:

1. often fidgets with hands or feet or squirms in seat (in adolescents, may be limited to subjective feelings of restlessness)
2. has difficulty remaining seated when required to do so
3. is easily distracted by extraneous stimuli
4. has difficulty awaiting turn in games or group situations
5. often blurts out answers to questions before they have been completed
6. has difficulty following through on instructions from others (not due to oppositional behavior or failure of comprehension), e.g., fails to finish chores
7. has difficulty sustaining attention in tasks or play activities
8. often shifts from one uncompleted activity to another
9. has difficulty playing quietly
10. often talks excessively
11. often interrupts or intrudes on others, e.g., butts into other children's games
12. often does not seem to listen to what is being said to him or her
13. often loses things necessary for tasks or activities at school or at home (e.g., toys, pencils, books, assignments)
14. often engages in physically dangerous activities without considering possible consequences (not for the purpose of thrill-seeking), e.g., runs into street without looking. (pp. 52-53)

The presence of eight of these behaviors is considered diagnostically significant for elementary school children if onset is seen prior to age seven years; fewer behaviors are considered significant for adolescents.

If Barkley's definition, and several of the fourteen behaviors described in the DSM-II-R, are applied to an individual child, it might reasonably be supposed that such a child would encounter difficulties in one or more of a wide range of areas. And, indeed, the literature reveals that there are significant ramifications of the disorder in all of the major areas of a child's life.

With regard to academic performance, Barkley (1989) reports that more than 90% of children with ADHD are underachieving academically, and that between 20% and 50% also have a specific learning disability, a general pattern similar to that reported by Cantwell and Baker (1991). In a recent study of 182 children identified as having ADHD, Dykman and Ackerman (1991) found that 94, or somewhat more than half of the children, were poor readers, with 82 of that group meeting the diagnostic criteria for a specific reading disability. Nussbaum, Grant, Roman, and Poole (1990), in a study of 72 children with ADHD between the ages of 6 years and 12 years, found that the level of mathematics performance actually declined as the child grew older.

While it has been argued that children with ADHD should not form a new category of exceptionality (Teeter, 1991), a joint interpretive memorandum to chief state school officers from the United States Department of Education and the Office of Special Education and Rehabilitation (Davila, Williams, & MacDonald, 199')

suggests that just such a new category of exceptionality may be in the offing. The memorandum makes it clear that no new legislation is required in order to make children with ADHD eligible for a free and appropriate public education, and that all associated due process rights are to be extended to this group. The memorandum also indicates that youngsters with the disorder are protected both by specific education legislation (PL 94-142) and by civil rights legislation (Section 504 of the 1973 Rehabilitation Act). In issuing their memorandum, the federal officials have clearly indicated that the significant negative effects of ADHD on a child's ability to perform within the regular curriculum have been recognized.

In the areas of emotional and social adjustment, Heilveil and Clark (1990) compared the projective test results of 52 ADHD children with the test standardization sample and found that significantly more of the ADHD children showed significant difficulties in a wide variety of areas. The children with ADHD were seen as impaired in their ability to cope with feelings. They had little awareness of problems in their environment, perceived only marginal support from their environment, and saw much aggression in their environment. They were also found to be significantly depressed. The greater incidence of major affective disorders, such as depression and anxiety, among children with ADHD is well documented (Biederman, Newcorn, & Sprich, 1991; Jensen, Burke, & Garfinkel, 1988; Livingston, Dykman, & Ackerman, 1990; McClellan, Rubert, Reichler, & Sylvester, 1990; Munir, Biederman, & Knee, 1987), as is the greater occurrence of behavior problems, most particularly oppositional defiant disorder (Biederman et al., 1991; Livingston et al., 1990; Munir

et al., 1987; Shapiro & Garfinkel, 1986; Shaywitz & Shaywitz, 1991). Barkley (1989) reports comorbidity of ADHD with oppositional defiant disorder at 60%+.

Although the relatively sparse literature which specifically addresses the issue of delinquent behavior and ADHD is rather vague in its conclusions (Jensen, Burke, & Garfinkel, 1988; Moffitt, 1990), Barkley (1989) reports a comorbidity rate of 25%+. Specifically with regard to substance abuse, Barkley (1990) reports data from the early 1980's which suggest that 12% of older children with ADHD will be identified as substance abusers, while Ingersoll (1988) places the figure as high as 50% for older children and adolescents. Later studies (Halikas, Meller, Morse, & Lyttle, 1990; Loney, 1988), however, conclude that substance abuse may be more closely related to aggressiveness in the youngster than it is to the ADHD per se.

While it may be expected that children with comorbid patterns of major depression or a significant conduct disorder would have an impaired ability to establish and maintain satisfactory social relations, it appears that the behavioral characteristics inherent in the ADHD itself can have a negative effect on this area of a child's life. Landau and Moore (1991), for example, cite the intrusive, boisterous, and annoying behaviors of ADHD children as contributory to their general unpopularity with peers and others. Bickett and Milich (1990) suggest that peer groups see ADHD children as less able to respond appropriately to situational demands and also as being less physically attractive. Even when children with ADHD do display appropriate social behaviors, these behaviors are often accompanied by such high intensity as to result in rejection of the child by peers and

others (Ross & Ross, 1976). In a study by Wallander, Schroeder, Michelli, and Gualtieri (1987) it was found that the use of stimulant medication in ADHD children resulted in a significant decrease in the objectionable behaviors inherent in the disorder, as well as a decrease in negative interpersonal reaction. It was noted, however, that no improvement in actual, specifically social skills was found. The implication, therefore, is that, in those children who lack good development of appropriate social skills, re-training is required even after the ADHD-specific behaviors have been brought under control.

It is not only within the school group or peer group that children with ADHD experience difficulty with interpersonal relationships. Increased stress and adversity are identified as frequent characteristics of the family with one or more ADHD children (Barkley, 1990; Fischer, 1990; Ingersoll, 1988; Rubin, 1991; Schachar & Wachsmuth, 1991). Brown and Pacini (1989), in a study of 51 boys with ADHD aged six to twelve years, found that mothers and fathers of these children reported themselves as more depressed than did the parents of the control group children. These parents also perceived their family environment as less supportive and more stressful than did those in the control group. Similar data is reported for mothers of girls with ADHD in a study by Breen and Barkley (1988), in which the mothers reported greater stress both for the family and for themselves than did mothers of girls without a clinical diagnosis. The incidence of marital stress, separation, or divorce among parents of children with ADHD was also found to be greater (Brown & Pacini, 1989; Fischer, 1990). Although a familial-genetic factor in the incidence

of ADHD has been identified (Biederman, Faraone, Keenan, & Steingard, 1991; Biederman, Faraone, Keenan, & Tsuang, 1991; Biederman, Munir, Knee, & Aabelow, 1986), the direction of causality in these intra-family stresses is unclear. Biederman, Faraone, Keenan, and Knee (1990) and Faraone, Biederman, Keenan, and Tsuang (1991) stress the primacy of the strength of familial-genetic factors affecting more than one generation in the household, while Fischer (1990) suggests that the child-to-adult direction of effect is greater than the reverse. Regardless of the directionality of effect, however, it would seem safe to conclude that intra-family stress in families with an ADHD child is a factor for major concern.

Starting with the perhaps deceptively simple list of fourteen behaviors listed in the DSM-III-R as being diagnostically significant for ADHD, a review of the literature suggests that these behaviors are often associated with significant, dysfunctional ramifications in the areas of academic performance, emotional/affective state, and social adjustment with relation to the peer group, the family, and the society as a whole. It is no wonder, then, that low self esteem is a recurring secondary characteristic of children with ADHD (Barkley, 1990; Ingersoll, 1988; Rubin, 1991).

With regard to adopted children, a review of the literature indicates that not every adoption results in a successful, permanent placement. Barth (1988) reports a disruption rate of 10.2% and, later (Barth, Berry, Yoshikami, Goodfield, & Carson, 1990), a rate of 11%, based on two studies involving over one thousand children in each. In a smaller study involving 99 adolescents, Berry and Barth (1990) report that

25% ended in a disrupted adoption. Moreover, it would seem safe to assume that an appreciable number of adoptive placements result in significant intrafamily stress but do not reach the point of disruption.

The question then arises as to the underlying causes of disruption. Part of the answer may be found in studies which suggest that adopted children are at greater risk for showing behavioral and/or emotional problems than are children in the general population, with Rosenthal, Schmidt, and Conner, 1988) indicating that emotional/behavioral problems, but not cognitive handicaps, predicted disruption. Jerome (1986), in reviewing the records of 1,826 children seen in an outpatient children's mental health clinic, reports that adopted children were seen with twice the expected annual incidence that would be predicted from general community rates. A smaller study of outpatient psychiatric patients (Kotsopoulos, Coté, Joseph, & Pentland, 1988) reports that the referral rate for adopted children was more than twice that seen for nonadopted children.

A similar pattern is seen with regard to children receiving inpatient psychiatric care. Kim, Davenport, Joseph, and Zrull (1988) and Piersma (1987) report that adopted children were significantly overrepresented in the psychiatric facilities they studied. Senior and Himadi (1985), in their study of 160 psychiatric inpatients between the ages of 12 and 19, found that adopted adolescents represented 21.2% of the patient population, as opposed to approximately 3.5% of adopted children in the general population. A somewhat lower figure is reported by Dickson, Heffron, and Parker (1990) who found that 8.6% of 763 pediatric psychiatric inpatients were

adopted. This lower figure is still more than twice the rate of adopted children in the general population. Dickson et al. also report that the length of hospitalization was greater for adopted children than for nonadopted children.

The list of specific symptoms shown by adopted children is fairly extensive, with roots in the so-called "double identity crisis," (Schneider & Rimmer, 1984, p. 345), issues relating to sense of security, modulation and channelling of aggression, resolution of oedipal complex, superego formation (Silverman, 1985-86), and a four-directional anger pattern involving adopted children, their biological parents, and their adoptive parents (Schneider and Rimmer). Kirschner and Nagel (1988) refer to a "recurrent pattern of provocative, antisocial, and delinquent behaviors characteristic of clinically referred adopted children and adolescents" (p.300). In clinical terms, adopted youngsters are reported to have high rates of borderline disorder (Wilson, Green, & Soth, 1986) and depression (Brodzinsky, Racie, Huffman, & Merkler, 1987; Senior & Himadi, 1985), with conduct disorders exceeding anxiety disorders (Kotsopoulos et al., 1988).

Behaviorally, adopted children are seen as showing a higher rate of school-related behavior problems and a lower rate of social competence and school achievement (Brodzinsky, Schechter, Braff, & Singer, 1984). Attention deficit disorder, comprising hyperactivity and/or distractibility, is identified as a major, recurring behavior pattern among adopted children (Rogeness, Hoppe, Macedo, & Fischer, 1988; Brodzinsky et al., 1984). In an earlier study, Deutsch, Swanson, Bruell, Cantwell, Weinberg, and Baren, 1982) studied a group of 200 ADHD

youngsters and found that 17% of them had been adopted. This was eight times the percentage rate of adopted children identified by Deutsch et al. in a group of non-ADHD youngsters. Indeed, Berry and Barth (1989) report, following a study of 85 children adopted over the age of 3 years, that aggressive and hyperactive children displaying antisocial behavior were at greatest risk of adoption instability. McKoy, Grotevant, and Zurcher (1988) state that "...many of the [adopted] children... exhibited early childhood characteristics that may have placed them at risk for later problems; these characteristics typically had to do either with hyperactivity or some other dimension of temperament...." (p. 67). They found that hyperactivity varied directly, more often than by chance, with reports of incompatibility between adoptive parents and adopted children. Deutsch et al. (1982) had earlier found that there was a 32% to 36% chance that a male adoptee would exhibit symptoms of ADHD and a 6% to 14% chance that a female adoptee would exhibit these symptoms. These figures must be placed against a background of the approximately 3% to 5% incidence of the disorder in the general population reported by Barkley (1990).

It has been seen that the literature abounds with studies which point to the considerable, and serious, ramifications of ADHD, as well as studies which highlight ADHD and ADHD-like behaviors as significant factors in the stresses experienced by adoptive families. Going beyond a mere identification of the potent convergence of ADHD and adoption, there are numerous recommendations for addressing the problem. Brodzinsky and Shechter (1990) set the tone:

> Since hyperactivity and attention deficit appear to have serious consequences in regard to adult adjustment, it would be helpful in adoption placement to consider children from biologic backgrounds of alcohol abuse or antisocial behavior more liable to demonstrate this type of behavior. Parents so appraised might be able to recognize the condition earlier and institute corrective measures. (p. 30)

Follow-up recommendations based on several studies include better preparation for adoptive parents in terms of understanding the special needs of their child (Berry, 1990; Berry & Barth, 1989; Schmidt, Rosenthal, & Bombeck, 1988), as well as assistance in identifying and accessing needed professional services (Berry, 1990; Todis & Singer, 1991).

Schmidt et al. (1988) also cite adoptive parents' expectations of a less difficult child as a significant factor in disruption. And yet, according to Berry (1988), it would seem that, among biological, foster, and adoptive families, adoptive families receive the least comprehensive preparatory activities. This is a particularly critical lack in view of adoptive parents' apparent personal/emotional need to achieve the assumed normality of nonadoptive families (Hoffmann-Riem, 1986), and their tendency to try to become "superparents," (Melina, 1986, p. 90) with the attendant inclination to suffer burnout.

The need for additional training for adoption workers is specifically referred to by Backhaus (1989), Berry (1988), Berry (1990), Berry and Barth (1989), Groze and Gruenewald (1991), and Valentine, Conway, and Randolph (1987).

Overall, this review of the literature reveals that ADHD is a disorder with significant ramifications in all major areas of a child's life, that adopted children (and

their families) are at particular risk for suffering the effects of the disorder, and that the academic community has recognized the need for additional training both of adoptive parents and of the human services workers who interact with them. The problem is cast into greater relief by Melina (1986) who, in spite of the overwhelming consistency of the data, states in her widely read guidebook for adoptive parents, that "Parents should not be overly concerned that their adoptee will develop hyperactivity or learning disabilities" (p. 101).

CHAPTER III

ANTICIPATED OUTCOMES AND EVALUATION INSTRUMENTS

Goals and Expectations

The general goal of the practicum was to increase the ability of human services professionals to provide knowledgeable and effective direction and support for adoptive parents of children with ADHD. It was not the purpose of the program to develop experts in the field of ADHD. Rather, it was hoped that the professionals who completed this program would be better able to serve as effective resources and managers for the populations they serve.

Behavioral Objectives

The following behavioral objectives were projected for this practicum:

Objective 1: At the end of the implementation period, participating human services professionals will demonstrate an increased working knowledge of the major behavioral and diagnostic elements of ADHD.

Objective 2: At the end of the implementation period, participating human services professionals will demonstrate increased knowledge of the educational ramifications of ADHD.

Objective 3: At the end of the implementation period, participating human services professionals will demonstrate increased knowledge of the socio-behavioral ramifications of ADHD.

Objective 4: At the end of the implementation period, participating human services professionals will demonstrate increased knowledge of the ramifications for personal and emotional adjustment among children with ADHD.

Objective 5: At the end of the implementation period, participating human services professionals will demonstrate increased knowledge of the stresses affecting families in general which contain a child with ADHD.

Objective 6: At the end of the implementation period, participating human services professionals will demonstrate increased knowledge of ADHD-related issues as they apply specifically to adoptive families.

Objective 7: At the end of the implementation period, participating human services professionals will have the resources to be able to make effective use of their increased awareness and knowledge in order to provide meaningful support and guidance to adoptive parents.

Objective 8: At the end of the implementation period, participating human services professionals will know the sequence of steps which need to be taken for diagnosis and treatment of ADHD.

Objective 9: At the end of the implementation period, participating human services professionals will have the means to identify and access those community

resources which are equipped to provide the specific diagnostic and support services required by a given ADHD child and his/her family.

Measurement of Objectives

Objectives 1, 2, 3, 4, 5, and 6 were considered to have been met if (a) the topics were presented at the workshops, (b) a significant increase in knowledge was demonstrated by participants through means of a pre-test and post-test administered to each participant on the day of the workshops, and (c) 60% of the participants indicated, on a subjective measure, that they felt the objectives had been met to a satisfactory degree. With regard to criterion (b), knowledge was considered to have increased significantly if there was a 50% increase the number of correct responses given to questions on an objective measure designed by writer.

Objective 7 was considered to have been met if (a) the material was presented during each workshop, (b) each participant had in his/her possession the resource manual provided at each workshop, and (c) after conditions a and b had been met, at least 60% of the participants reported subjectively that they felt that they were in an improved position with regard to providing support and guidance to adoptive parents. It was initially intended that this subjective estimate would be solicited from each participant as a follow-up measure either by mail or telephone. The two trainers with whom the writer worked, however, felt strongly that it would be difficult to achieve a 100% response rate through the use of a follow-up measure. Indeed, Borg and Gall (1989, p. 442) report only a 67% response rate to a first mailing. Therefore, in order

to assure a 100% response rate to this crucial item, it was decided to include condition c as part of the post-test instrument administered at the end of each workshop.

Objective 8 was considered to have been met if (a) the material was presented at each workshop, (b) each participant had the resource manual in his/her possession, and (c) 60% of the participants indicated, on a subjective measure, that they felt the objectives had been met to a satisfactory degree.

Objective 9 was considered to have been met if (a) each participant had ten copies of the adoptive parent brochure in his/her possession, and (b) 60% of the participants indicated, on a subjective measure, that they felt the objectives had been met to a satisfactory degree.

Formal measurement of objectives was accomplished by means of a pre-test and post-test developed by the writer and approved by the practicum adviser. The pre-test consisted of 30 objective questions related to Objectives 1 through 6. There were 18 short answer questions and twelve multiple choice questions. The post-test consisted of the identical questions plus a rating scale for each of the nine objectives. Also included in the pre-test was an item allowing each participant to list up to three personal goals for attending the workshop. In the corresponding section of the post-test, each participant was asked to rate the degree to which he/she felt each personal goal had been met. The inclusion and analysis of personal goals was not a formal objective of the practicum, but this data was used in evaluating the overall success of the program.

Within the general context of the training program, the pre-test was identified as "Activity White," while the post-test was identified as "Activity Yellow." Activity Yellow contains all of the formal evaluative elements, and is reproduced in Appendix A.

CHAPTER IV

SOLUTION STRATEGY

Discussion and Evaluation of Solutions

The problem addressed by the practicum was that, (a) human services professionals in the targeted geographical area were not sufficiently knowledgeable in the nature of ADHD, and in its potential ramifications, to provide adequate guidance to adoptive families and, (b) there were no local programs designed to train human services professionals in the nature and ramifications of ADHD, and in the means of identifying and accessing appropriate community resources.

While some attention has been given to actual practice experiences (Firth, 1990; Underwood & Thyer, 1990), a review of the literature reveals a primary emphasis on traditional, workshop training. From the position of a broad overview, Miller and Dore (1991) emphasize the importance of making comprehensive staff training an integral part of every public child welfare program. In addressing the issue of the effectiveness of workshop training, Rooney (1985), reports that the participants in a training program scored significantly higher on a follow-up test of specific applied knowledge, and that their clients reported that the workers were using the taught techniques more frequently. Corcoran and Bryce (1983) have found that the increase in skills provided through workshops can significantly reduce the incidence of burnout among social workers.

Specifically with regard to the adoption of children with special needs, Vaitenas (1981) found that the rate of adoption of these children increased when adoption workers received specialized training. Important factors in the training were found to be perinatal training, the provision of realistic information, and an increased ability to instruct prospective adoptive parents.

While Doueck and Bondanza (1990) report that a twelve-hour staff development training program was effective in increasing the self-reported knowledge and skills of the participating professionals, positive results have also been reported for one-day, or six-hour, training sessions (Cheung, Stevenson, & Leung, 1991; Delewski, Pecora, Smith, & Smith, 1986). Chueng et al. (1991) designed their one-day program around five distinct but interrelated modules and found this approach particularly effective. Delewski et al. (1986) extended the after-effects of their one-day workshop by setting specific, post-workshop goals for implementation.

With regard to the use of technology in training, Starr (1979), in an early study of the applications of video techniques in training social workers, reports considerable success in using videotaped self-confrontation as a supplement to traditional training programs. Lynett (1985) describes a more sophisticated approach involving videodisc, computer, and monitor to provide interactive, individualized learning in several audio and visual modes. Her techniques were applied both to the training of new social workers and for continuing education.

Newlyn and Percival (1989) suggest that the use of more than one trainer during a training session ("co-training") can significantly increase the effectiveness of training programs.

Two ambitious programs of related interest are reported in the literature. Backhaus (1989) describes the steps taken by a private adoption agency to assist adoptive parents in finding needed therapeutic resources for children with special needs. The importance placed by this group on training the adoption workers can be seen from the fact that the workers were trained in six two-day sessions, while a single evening session was provided for adoptive parents.

Groze and Gruenewald (1991) describe the Post Adoption Resources for Training, Networking and Evaluation Services (PARTNERS) Program, conducted by Four Oaks, Inc., a private, nonprofit human services agency. PARTNERS is designed specifically to address the combination of special-needs adoption and child welfare services. Central to the program is the establishment and maintenance of a community-based team which includes members from a wide range of professionals in social service, government, education, medicine, psychology, etc. The team is assigned the task of reviewing individual cases, then making recommendations for, and overseeing, the delivery of services.

The writer felt that there were two alternative general approaches which were feasible in reaching the targeted adult professional audience, both of which approaches involved the use of workshop training sessions. First, recruitment of participants

might focus on individuals. Second, recruitment of participants might target existing, identifiable professional groups .

Description of Selected Solution

The writer believed that direct group training of existing professional groups, by means of a six-hour training program, would be an effective means of attempting to solve the problem. The workshop format was instrumental in meeting goals 1 through 7. During each workshop session, use was made of lecture, discussion, and developmental group activities.

There are several reasons why this approach was considered to be a particularly useful one: (a) Training workshops are widely used and accepted as an effective means of providing continuing education in all professional fields; (b) this approach would allow participants to benefit from the ideas and questions of several other participants; (c) by targeting existing groups rather than individuals, the workshops would carry the sanction of the professional group being trained; (d) by targeting existing groups rather than individuals, the number of individuals who could be reached would be maximized; (e) by targeting existing groups rather than individuals, economy of time would be achieved; (f) this approach facilitated consistency and standardization of the knowledge being transferred; (g) although longer and/or more complex programs are reported in the literature, the literature also supports the notion that a six-hour training session can be an effective educational procedure; (h) the literature supports the notion that well-trained human services

workers are crucial to the eventual improvement of services to families; (i) preliminary enquiries suggested that potential target groups in the local area were highly receptive to the idea of participating in such a program; (j) the required resources and personnel were available to the writer; (k) meeting room facilities for the training sessions would be provided by the groups being trained.

It was decided that two social workers would be trained to present the workshops. There were four reasons for deciding on this procedure. First, the writer was generally not able to be away from his office, repeatedly, for an entire day. Second, the individuals who were trained as trainers already possessed extensive experience in presenting this type of workshop. It was felt, therefore, that their expertise would make a positive contribution to the success of the program. Third, both of the trainers shared a professional identification with the groups to be trained. Fourth, by creating a core group of three knowledgeable professionals (the writer plus the two trainers), the potential for widespread dissemination in the future would be increased. It was anticipated, however, that the writer would participate to some degree as co-trainer, a procedure which has been shown to be effective.

Neither of the video techniques reviewed above appeared relevant or feasible in the situation at hand. It was originally hoped that video would be used, however, as a means of providing participants with exposure to the kinds of ADHD behaviors being discussed and/or to first-hand reports from parents of children with ADHD. Due to limitations of predictably available equipment, however, the video material intended for use was not incorporated into the standard training program.

It was felt that it was not reasonable to expect that participants would remember all of the material that was presented to them during the workshop. They might be expected, however, to remember the awareness of ADHD and its disorders. Therefore, as a means of extending the effects of the training program forward in time, and of capitalizing on the anticipated increase in awareness of the disorder, participants were provided with two carry-away items: (a) a reference manual in a hard binding, and (b) a brochure to be given to their clients, and designed to provide guidance in obtaining needed support services in the community. These carry-away items played a central role in meeting Objectives 7, 8, and 9.

While longer and more complex programs have been used elsewhere, such programs were not feasible in the present setting. Moreover, the literature has shown that six-hour training sessions can be significantly effective.

Report of Action Taken

In broad outline, experienced social workers, with additional experience as trainers, and with a particular interest in the practicum problem, were trained to conduct six-hour training sessions with individual target groups. They then carried out that training with four targeted groups of human services professionals.

There were essentially four major segments to the implementation of this practicum: (a) The training program and associated materials were developed and produced by the writer, (b) the trainers were trained by the writer, (c) the workshops

were presented by the trainers, and (d) the effectiveness of the program was evaluated by the writer. Each of these segments is described below.

Development of the training program. There were five guiding principals in the development of the training program. First, the material presented had to be complete, accurate, and consistent with the presumed experiential level of the participants. Second, there had to be opportunities for both active and passive learning. Third, the program had to be "teachable." This element was of particular concern to the trainers, who felt strongly that their own training materials had to contain enough information to provide breadth and depth of knowledge to support their perceived status as experts, while at the same time being well organized and easily accessible under the stress of presentation. Fourth, participants had to be given carry-away materials which would not only meet the requirements of Objectives 8 and 9 of the practicum, but which would be durable and complete enough to form a lasting resource for the participants. Fifth, the materials used had to have a professional appearance both to facilitate their use and to underscore the credibility of the program.

Content of the program was divided into four segments, as follows.

Motivation. The purposes of this segment were (a) to introduce participants to the program and to each other, (b) to review expectations and establish goals, (c) to provide a basic overview of the material, and (d) to provide a rationale for the importance and relevance of ADHD to human services workers.

Description. The purposes of this segment were (a) to familiarize participants with the diagnostic criteria for ADHD, (b) to familiarize participants with the behaviors typically associated with ADHD, (c) to relate ADHD behaviors and issues to school, home, and community, and (d) to relate ADHD to adoption issues.

Diagnosis and treatment. The purposes of this segment were to (a) familiarize participants with the general processes involved in diagnosis, and (b) to familiarize participants with the predominant modes of treatment.

Management. The purpose of this segment was to introduce participants to the guides for effective management of cases involving children with ADHD (guides were provided with workshop materials).

Allowing for differences in presentation style and group dynamics, rigid time allotments were not specified for each of the program segments. A general weighting for each broad topic, however, was suggested to the trainers, and this is summarized in Figure 1.

The acronym ADDEPT (Attention Deficit Disorder: Effective Professional Training) was devised for the program, and the acronym was incorporated into a distinctive logo. A unified and interrelated set of materials was developed and produced for implementation of the training program. The materials consisted of four major components.

Overhead transparencies ("slides"). Forty-four slides were designed to present core material and visual reinforcement. Each slide was numbered. This number also appeared at the top of the appropriate reference page in the *Trainer's*

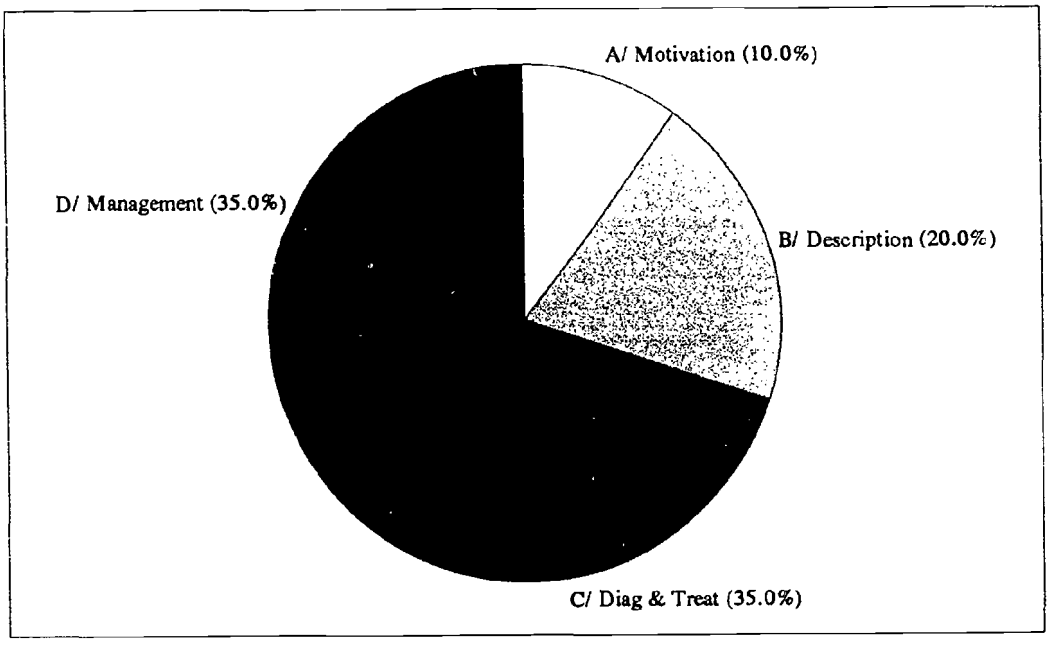

Figure 1. Suggested Time Allotments for Each Major Segment of the Workshop

Manual. Slides were used most extensively during the first segment of the workshop. All slides were designed and produced by the writer.

Trainer's Manual. The *ADDEPT Trainer's Manual* (Russo, 1993) contained all of the materials required by the trainer, with the exception of the slides. All materials for the *Manual* were designed and produced by the writer.

The first section of the *Manual* included three readings. The readings were selected with an eye towards providing the trainer with both the depth and breadth of knowledge needed to support an effective presentation. The first of these readings consisted of major excerpts from *Your Hyperactive Child* (Ingersoll, 1988). These

excerpts were selected because it was felt that they provided the best overall description of ADHD. Although written primarily for the layman, this book's thoroughness, accuracy, and conciseness cause it to be widely used by professionals as well. The second of the readings reproduced two articles which appeared in an area newspaper (Browne, 1992; Browne, 1992). These articles were brief and to the point, and were included in order to help crystalize the wordier material found in the Ingersoll excerpts. The third reading selection consisted of behavioral scenarios developed by the writer. They were designed to place the more technical knowledge into a living context and to help maintain motivation and a sense of relevance. The scenarios provided descriptions of typical, day-to-day experiences of children with ADHD at school, at home, and in the community.

The second section of the *Manual* consisted of the actual teaching program for each of the four segments of the workshop. The core of this teaching material consisted of numbered pages which corresponded to the slides around which the concept under discussion was based. Each of these pages reproduced, in miniature form, an exact replica of the slide in use at the time. Following this reproduction were notes designed to structure the trainer's thinking about the topic. These notes were intentionally designed to highlight crucial material only and maintain the direction of the presentation. Therefore, they were relatively brief. It was hoped that access to crucial material would thus be simple and direct for the trainer, eliminating the need to wade through overly copious material in the midst of a presentation. In preparing these notes, every effort was made to anticipate questions which might arise

both from the trainer and from the participants. Sample pages from the *Manual* can be found in Appendix C.

Also included in the *Manual* was a number of pages providing practical information for the trainer. The two purposes of this material were to provide the trainer with a map of the program and with specific instructions with regard to procedures. Except for the general introduction and overview, these informational pages were inserted into the *Manual* at those points where the information would be immediately needed.

Finally, copies of the materials required for each group activity were included at the places where they were to be implemented. The materials needed for each activity were preceded by specific directions and procedures. Also included was a guide to appropriate/correct responses.

Participants' Handbook. Each participant was given a loose-leaf bound handbook entitled *ADHD Handbook* (Russo, 1993). The *Handbook* was designed to serve both as an aid towards effective participation in the training workshop and as a permanent resource for use in the participant's work place. All materials for the *Handbook* were designed and produced by the writer.

Lecture material comprised the first component of the *Handbook*. This material was grouped according to the first three of the four segments of the presentation, and closely parallelled the slides used during the presentation. In some cases, material from the slides was reproduced verbatim. In others, it was presented

in a "box outline" format which provided boxed areas for structured note taking (Appendix B).

A second component of the *Handbook* consisted of all materials needed for the group exercises. Exercises were designed to allow participants to apply their newly acquired knowledge, in combination with pre-existing knowledge, to ADHD-related issues. One of the activities involved the actual creation of a section of the *Handbook*. A composite of the material developed by each of the workshop groups during the activity was then printed and mailed to the participants for inclusion in their permanent *Handbooks*. For ease of reference and location, each activity was given a color title (e.g. "Activity Green"), and the activity materials were printed on the corresponding colored paper.

A third component of the *Handbook* was devoted to the management of cases involving ADHD. Although presented and reviewed during each workshop, this material was designed primarily to be used in the work place. This material contained specific, step-by-step guidelines for use with four categories of children with whom human services professionals might be expected to come into contact: (a) identified young children, (b) identified older children, (c) unidentified children, and (d) unidentified adolescents. Management guidelines for the identified young child are presented in Appendix E. Development of material for inclusion in a fifth section, that intended for use by those working with unidentified infants, formed the basis of a group activity. This was handled in this manner because there were few if any guidelines available for managing cases involving the unidentified, adopted infant,

and it was felt that the workshop participants might bring their expertise to bear in making a valuable contribution to charting this unknown territory.

A final section of the *Handbook* provided a brief listing of the most important and accessible published material relating to ADHD.

Reference brochure. Ten copies of a brochure entitled *ADHD: A Guide for Parents* (Russo, 1993), developed by the writer, were distributed to each of the participants. The brochure contained a brief overview of ADHD, in question and answer form, as well as a listing of individuals and agencies in the writer's service area who are respected for their work with ADHD. The brochure was designed for use both by human service professionals and by parents. They were designed by the writer and printed commercially.

The greater part of the materials was produced using the *Microsoft PowerPoint* (1993) presentation program, and printed on a laser printer. A schematic summary of all materials, taken from the *Trainer's Manual* is reproduced in Appendix D.

Training the trainers. The core training program for the two trainers consisted of three segments designed to utilize different learning modalities. These were (a) consultations with the writer, (b) readings, and (c) video review. Because of scheduling considerations, each trainer was trained separately.

Consultations with the writer. There were two consultations with the writer. During the first meeting, the goals and structure of the program were described and explained to the trainer. Materials were presented and reviewed in considerable

detail, and preliminary questions and concerns of the trainer were discussed. Readings and video review were assigned. The second meeting was scheduled.

During the second meeting, questions from the trainer were discussed, and suggestions were taken. With the exception of a recommended change in part of the post-test procedure, discussed above, none of the suggestions involved changes to major elements of the program. Indeed, both trainers reported feeling positive about, and comfortable with, the design of the program, and were enthusiastic about starting the training sessions.

Readings. The three reading sections included in the Trainer's Manual, as listed above, were given as assigned reading. It was expected that these would have been completed by the time of the second consultation.

Video review. Each trainer was given a copy of the video entitled *All About Attention Deficit Disorder* (Phelan, 1990). Although the structure and style of this taped presentation were considerably different from the writer's program, it was felt that Dr. Phelan's authoritative presentation was well suited to help the trainers pull their thoughts together into a "living" reality.

While both trainers received the same core training program, one adjustment was made for each of the trainers at that trainer's request. The trainer presenting the first workshop asked that the writer be present for the entire program, and that a third consultation be scheduled in order to critique the presentation. The writer agreed to do this and, although this addition to the training did not result in significant changes

to the program, it was felt that there was considerable benefit derived through enhancement of the trainer's confidence.

The second trainer asked to attend the first workshop as a participant in order to help her own training. Again, this was agreed to, with the similar impression that the trainer's self confidence vis-à-vis the program was enhanced. While both trainers' requests for modifications to the trainer program were different, it would appear that they had as their common factor the provision of a "hands on" experience. Such an experience had been omitted from the original design but might well have been included as a valuable fourth component of the trainer development segment.

Presentation of the workshops. Consistent with the plan of the practicum, it was intended that contact be made with existing groups/organizations of human services workers rather than with individuals. At this stage, the program came to the attention of a relevant statewide agency, and this agency was pleased to form the umbrella group under which participation by members of other, smaller groups was solicited. This not only greatly facilitated organization of the individual workshops, but also significantly enhanced both the credibility of the program for the present and its statewide exposure for the future. Four of the five groups were thus arranged through this statewide organization. The fifth group was contacted and organized separately. As planned, all workshops were held in facilities provided by the groups.

Following the recommendation of the trainers, it was decided that groups of approximately ten participants would be optimal. The original intention was to train

five groups of approximately ten participants each. Because of severe winter weather, however, one of the training sessions had to be cancelled and could not be re-scheduled during the time frame of the practicum. It was possible, however, to combine that group with another scheduled group. Thus, there were two groups of ten participants, one group of eleven participants, and one group of 20 participants; the total number of anticipated participants was not affected.

Evaluation effectiveness of the program. The writer evaluated the effectiveness of the program in three ways. First, the data with regard to the achievement of each of the objectives was analyzed

Second, the trainers were interviewed in order to gather their impressions with regard to the success of the program. Impressions were gathered concerning (a) appropriateness of instructional content, (b) organization of instructional content, (c) quality of materials, (d) ease of mastering and using the program, and (e) perceived response of participants to the program. Input from the trainers consisted of responses to a four-point rating scale and of anecdotal material.

Third, input from workshop participants was gathered and evaluated. This was accomplished in two ways. First, by means of an indirect approach, workshop participants, as part of the pre-test, were asked to list as many as three goals which they themselves hoped to reach as a result of having participated in the workshop. (It was hoped that, in addition to providing useful data for the writer's evaluation of the program, this exercise would also serve to help structure each participant's mindset as

he/she began the program.) Participants were then asked, as part of the post-test, to rate the degree to which they felt their own objectives had been met. The nine specific objectives of the practicum were not presented to the participants until the end of the post-test. A four-point rating scale, ranging from "Not at all" [0] to "Very much" [3] was used in the post-test.

The second way in which input was obtained from participants within this context was to make use of the direct approach by asking them to jot down comments, criticisms, etc. at the very end of the post-test.

CHAPTER V

RESULTS, CONCLUSIONS, RECOMMENDATIONS, AND DISSEMINATION

Results

The problem which existed was that (a) human services professionals in the targeted geographical area were not sufficiently knowledgeable in the nature of ADHD, and in its potential ramifications, to provide adequate guidance to adoptive families and, (b) there were no local programs designed to train human services professionals in the nature and ramifications of ADHD, and in the means of identifying and accessing community resources.

The solution to the problem was to develop a one-day workshop designed to meet the objectives established for the practicum. Two licensed social workers, who were also experienced trainers, were trained to present the program. The program was presented to four groups of human services professionals, with a total of 51 participants. Meaningful, durable carry-away materials were designed especially for the program and were distributed to all participants.

The general goal of the practicum was to increase the ability of human services professionals to provide knowledgeable and effective direction and support for adoptive parents of children with ADHD. It was not the purpose of the program to develop experts in the field of ADHD. Rather, it was hoped that the professionals

who completed the program would be better able to serve as effective resources and managers for the populations they serve.

Nine specific objectives were designed to reach the goal. The following is a review of each objective along with the results related to that objective.

Objective 1: It was projected that, at the end of the implementation period, the participating human services professionals would demonstrate an increased working knowledge of the major behavioral and diagnostic elements of ADHD. There were three criteria established for determining if this objective had been met. First, it was necessary for the material to have been presented at the workshops. Measurement of this criterion consisted of a simple yes-no checklist. As can be seen in Table 1, the first criterion for the success of this objective was met.

Table 1.

Presentation of Topics Associated with Objectives 1 through 8

	Topic Presented							
	Group 1 (n=10)		Group 2 (n=10)		Group 3 (n=20)		Group 4 (n=11)	
Objective	Yes	No	Yes	No	Yes	No	Yes	No
1	X		X		X		X	
2	X		X		X		X	
3	X		X		X		X	
4	X		X		X		X	
5	X		X		X		X	
6	X		X		X		X	
7	X		X		X		X	
8	X		X		X		X	

Second, it was necessary for participants to demonstrate a significant increase in knowledge of material related to the objective. Measurement of this criterion consisted of a pre-test and post-test administered to all participants. A demonstrated increase in knowledge was considered to have been significant if there were at least 50% more correct responses on the post-test than there had been on the pre-test. A comparison of the pre-test and post-test percentages of correct responses related to this objective can be seen in Figure 2, while the amount of increase is summarized in Table 2. With a demonstrated increase of 95% it can readily be seen that this criterion was met.

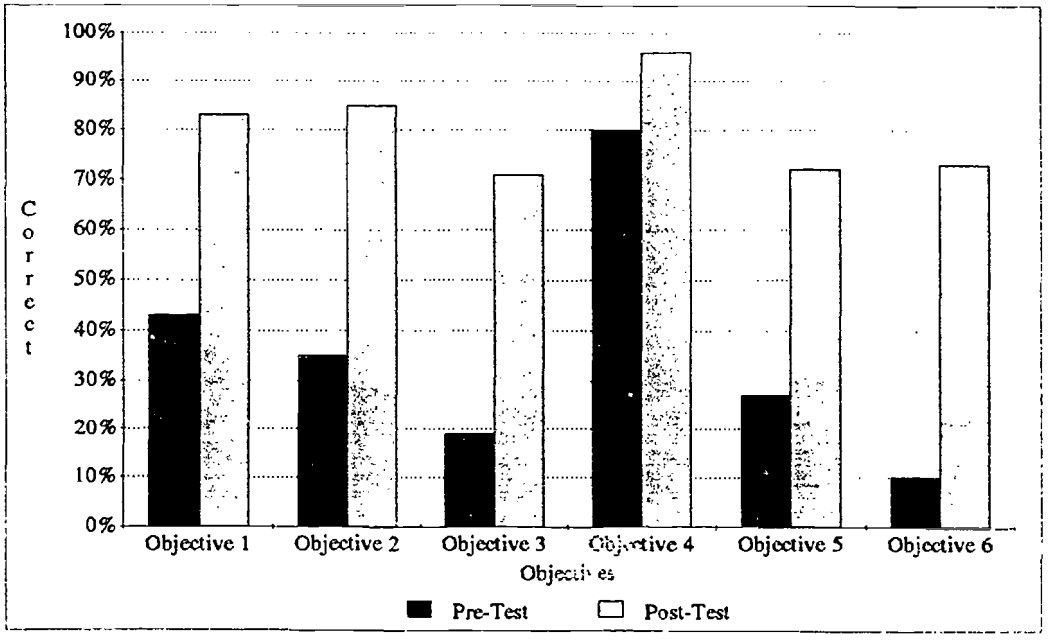

Figure 2. Percentage of correct responses relating to each objective on the pre-test and post-test ($n = 51$)

Table 2

Percent Increase in Number of Correct Responses Relating to Each Objective

Objective Number	Percent Increase
1	95%
2	141%
3	269%
4	20%
5	161%
6	640%

Third, it was necessary for at least 60% of the participants to indicate that they felt the objective had been met to a satisfactory degree. To measure this criterion, participants were asked to rate the degree to which they felt this objective had been met. A four point scale was used for this purpose, and was included in the post-test. The points on the scale were "Not at all" [0], "A little" [1], "Pretty much" [2], and "Very much" [3]. It was determined that the objective would be considered to have been met satisfactorily if at least 60% of the participants rated its success at "Pretty much" or "Very much," and that the mean rating score was 2.25 or greater. Figure 3 presents the distribution of ratings for this objective, while the mean score appears in Table 3. It can be seen from the data that the third criterion was met for this

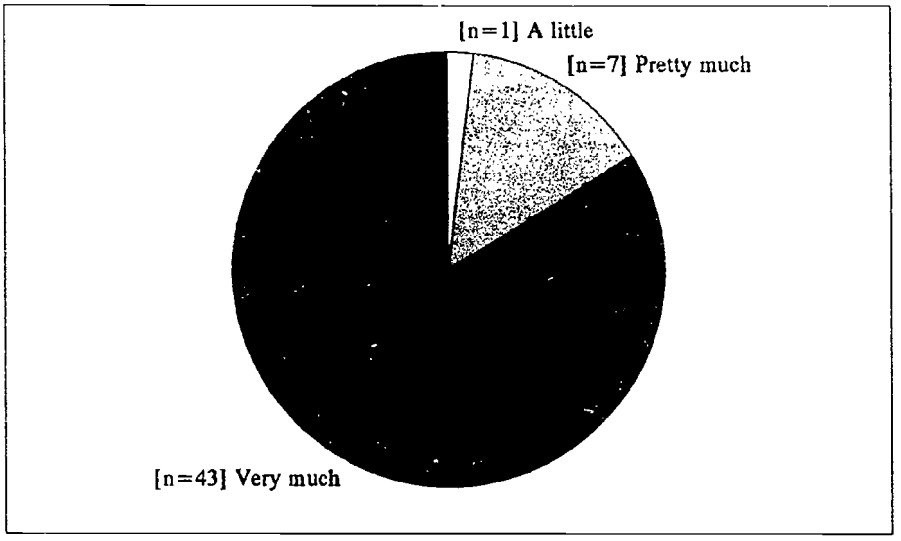

Figure 3. Subjective Ratings for Success of Objective 1 (n = 51)

Table 3.

Mean Scores for Subjective Ratings by Participants for Each Objective (n = 51)

Objective Number	Mean Score
1	2.82
2	2.57
3	2.37
4	2.53
5	2.65
6	2.50
7	2.51
8	2.45
9	2.45
1 through 9	2.54

objective. Therefore, since all three established criteria were met, it was determined that Objective 1 was achieved.

Objective 2: It was projected that, at the end of the implementation period, the participating human services professionals would demonstrate increased knowledge of the educational ramifications of ADHD. There were three criteria established for determining if this objective had been met. First, it was necessary for the material to have been presented at the workshops. Measurement of this criterion consisted of a simple yes-no checklist. Table 1 indicates that this criterion was met.

Second, it was necessary for participants to demonstrate a significant increase in knowledge as measured on a pre-test and post-test given to all participants. A demonstrated increase of 50% in the number of correct answers was considered to reflect a significant increase in knowledge. The percentages of pre-test and post-test correct responses are compared in Figure 2, while the amount of increase can be seen in Table 2. With a demonstrated increase of 141% this criterion is considered to have been met.

Third, it was necessary for 60% of the participants to indicate that they felt the objective had been met to a satisfactory degree. The instrument used, as well as the methods of its use and interpretation, were identical to those for Objective 1. The distribution of ratings for Objective 2 can be seen in Figure 4, while a check of Table 3 indicates that the obtained mean score exceeds the minimum required score. Therefore, the third criterion has been met. Since all three criteria were met, it was concluded that Objective 2 was achieved.

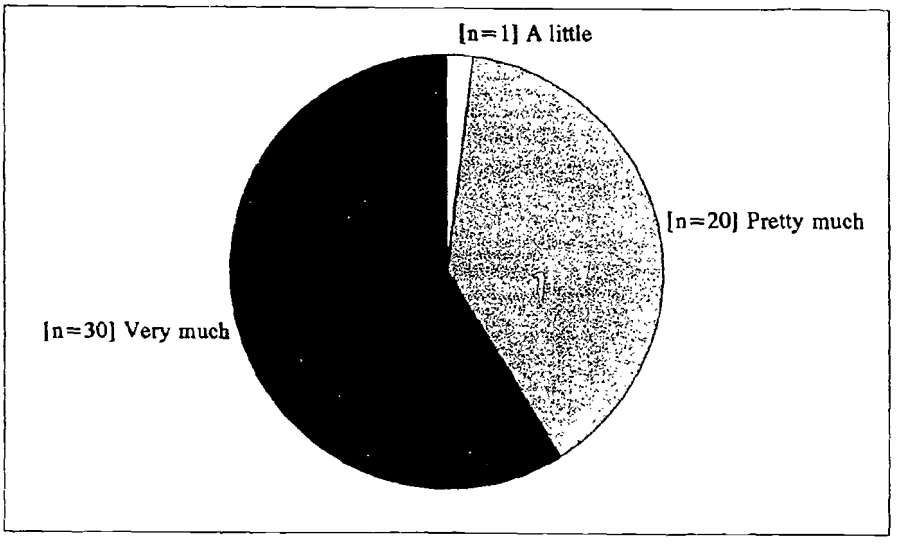

Figure 4. Subjective Ratings for Success of Objective 2 (n = 51)

Objective 3. It was projected that, at the end of the implementation period, the participating human services professionals would demonstrate increased knowledge of the socio-behavioral ramifications of ADHD. Three criteria were established for determining if this objective had been met. First, it was necessary for the material to have been presented at the workshops. A check of Table 1 indicates that this criterion was met.

Second, it was necessary for participants to demonstrate a significant increase in knowledge as measured on a pre-test and post-test given to all participants. The instrument and its use are the same as described for Objectives 1 and 2. Percentages

of correct responses from the pre-test and post-test are compared in Figure 2. The extraordinary increase of 269% (Table 2) indicates that this criterion was met.

Third, it was necessary for 60% of the participants to indicate that they felt the objective had been met to a satisfactory degree. The instrument used in measuring Objectives 1 and 2 was also used in measuring Objective 3. The distribution of ratings for Objective 3 is found in Figure 5, while another look at Table 3 indicates that the required minimum mean score of 2.25 was exceeded. Thus the third criterion was met, and it was concluded that Objective 3 was achieved.

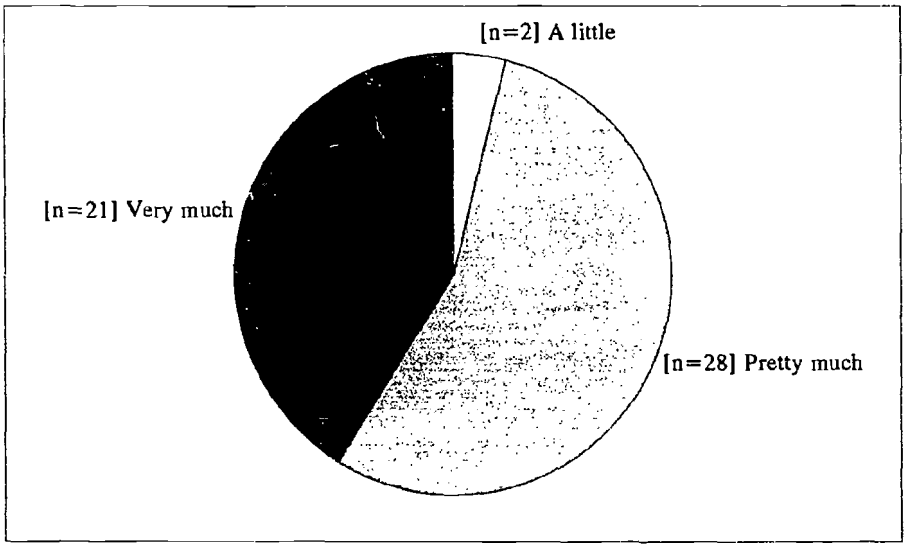

Figure 5. Subjective Ratings for Success of Objective 3 (n = 51)

Objective 4. It was anticipated that, at the end of the implementation period, participating human services professionals would demonstrate increased knowledge of the ramifications for personal and emotional adjustment among children with ADHD. Three criteria were established for determining if this objective had been met. First, it was necessary for the material to have been presented at the workshops. A look at Table 1 reveals that this criterion was met.

Second, it was necessary for participants to demonstrate a minimum 50% increase in knowledge as measured on the same instrument used for measuring Objectives 1 through 3. Referring back to Table 2, it can be seen that a gain of only 20% is posted for Objective 4. A look at Figure 2, however, indicates that the workshop participants had an 80% correct response rate on the pre-test, a rate which reflects a very high pre-existing level of knowledge in this particular area. With such a high pre-score, an increase of 50% would have resulted in a post-test requirement of 120% success. This, of course, is a statistical impossibility.

In spite of the already high pre-test score, however, the post-test score did nevertheless show an increase: the correct response rate for the post-test was 96%. A rigid adherence to a technical interpretation of this criterion for Objective 4 required the conclusion that the criterion had not been met. In view of the fact, however, that pre-test knowledge was already very high, and that it was probably unreasonable to expect a post-test success rate higher than the obtained 96%, it was decided that it was fair to consider that this criterion had, for all practical purposes, been met.

Third, it was necessary for at least 60% of the participants to indicate that they felt the objective had been met to a satisfactory degree. Measurement of this criterion was conduced in the same manner as for Objectives 1 through 3. Distribution of the ratings for Objective 4 are presented in Figure 6, while a check back to Table 3 indicates that the mean rating score for this objective exceeded the minimum required score of 2.25. Thus, while taking into consideration the particular circumstances which apply to the second criterion, it was concluded that Objective 4 had been achieved.

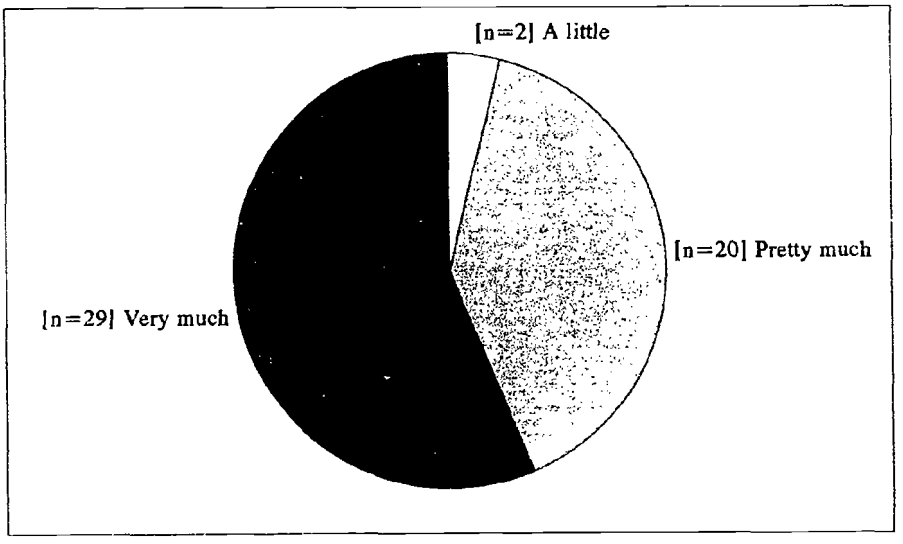

Figure 6. Subjective Ratings for Success of Objective 4 (n = 51)

Objective 5. It was anticipated that, at the end of the implementation period, participating human services professionals would demonstrate an increased knowledge of the stresses affecting families in general which contain a child with ADHD. As with Objectives 1 through 4, three criteria were established for the measurement of Objective 5. First, it was required that the material be presented at the workshops. It can be seen from Table 1 that this criterion was met.

Second, it was necessary for participants to demonstrate a minimum 50% increase in knowledge when measured on the same instrument used in measuring Objectives 1 through 4. Figure 2 presents a comparison of the pre-test and post-test scores, while Table 2 indicates that the increase in correct responses substantially exceeded the minimum requirement of 50%.

Third, it was necessary for at least 60% of the participants to indicate that they felt the objective had been met to a satisfactory degree. Measurement for Objective 5 was completed in the same manner as for Objectives 1 through 4. Distribution of the ratings for Objective 5 may be seen in Figure 7, while a mean rating score in excess of the minimum required score of 2.25 is found in Table 3. Thus, with all three criteria having been satisfied, it was concluded that Objective 5 was achieved.

Objective 6. It was anticipated that, at the end of the implementation period, participating human services professionals would demonstrate increased knowledge of ADHD-related issues as they apply specifically to adoptive families. Three criteria were established for determining of this objective had been achieved. First, it was

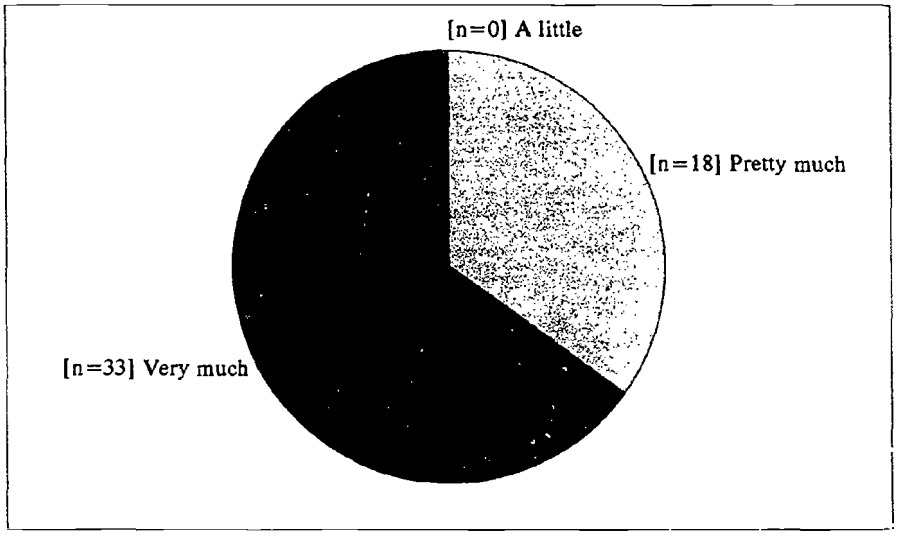

Figure 7. Subjective Ratings for Success of Objective 5 (n = 51)

necessary for the material to have been presented at each of the workshops. Inspection of Table 1 indicates that this was indeed the case for Objective 6.

Second, it was necessary for participants to demonstrate a minimum 50% increase in demonstrated knowledge as measured on the same instrument used for measuring Objectives 1 through 5. Figure 2 presents a comparison of the pre-test and post-test success rates for Objective 6, while Table 2 reports an extraordinary increase of 640%.

Third, it was necessary for a least 60% of the participants to indicate that they felt the objective had been met to a satisfactory degree. This criterion was measured

in the same way as for Objectives 1 through 5. The distribution of ratings is presented in Figure 8, while a look at Table 3 reveals that the minimum required mean score of 2.25 was exceeded. Therefore, with all three criteria having been satisfied, it was concluded that Objective 6 was achieved.

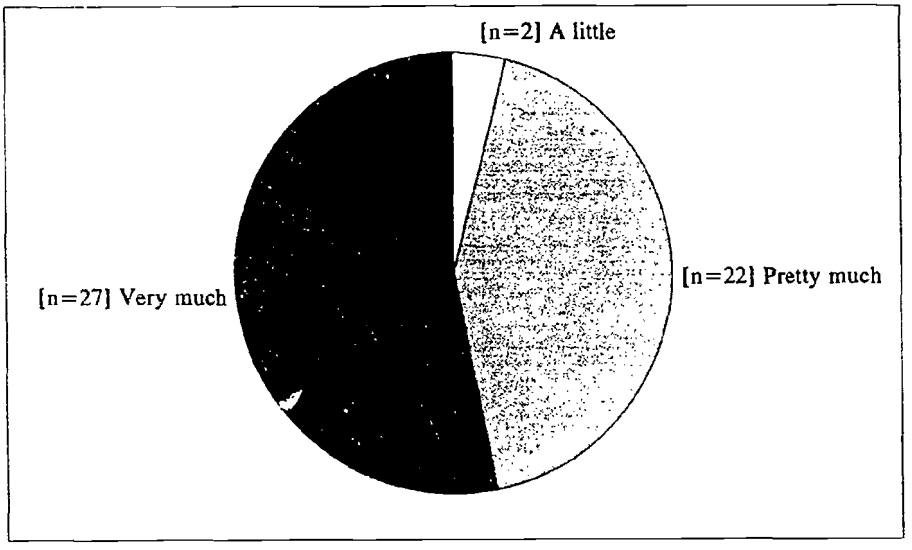

Figure 8. Subjective Ratings for Success of Objective 6 (n = 51)

Objective 7. It was anticipated that, at the end of the implementation period, participating human services professionals would have the resources to be able to make effective use of their increased awareness and knowledge in order to provide meaningful support and guidance to adoptive parents.

Three criteria were established for determining if this objective had been met. First, it was required that the material be presented at all of the workshops. Table 1 indicates that this was done. Second, it was necessary that each participant have in his/her possession the resource manual provided at each workshop. Referring to Table 4, it can be seen that all participants at each workshop did indeed have the resource manual in their possession.

Table 4.

Distribution of Resource Manuals for Meeting Objectives 7 and 8

	Response	
	Yes, have resource manual	No, do not have resource manual
Number Responding	51	0

Third, it was necessary for at least 60% of the participants to indicate that they felt the objective had been satisfactorily met. Measurement of this criterion for Objective 7 was conducted in the same manner as for Objectives 1 through 6. The distribution of ratings is presented in Figure 9, while Table 3 indicates that the

minimum required mean score of 2.25 was exceeded. Therefore, since all three criteria were met, it was concluded that Objective 7 was achieved.

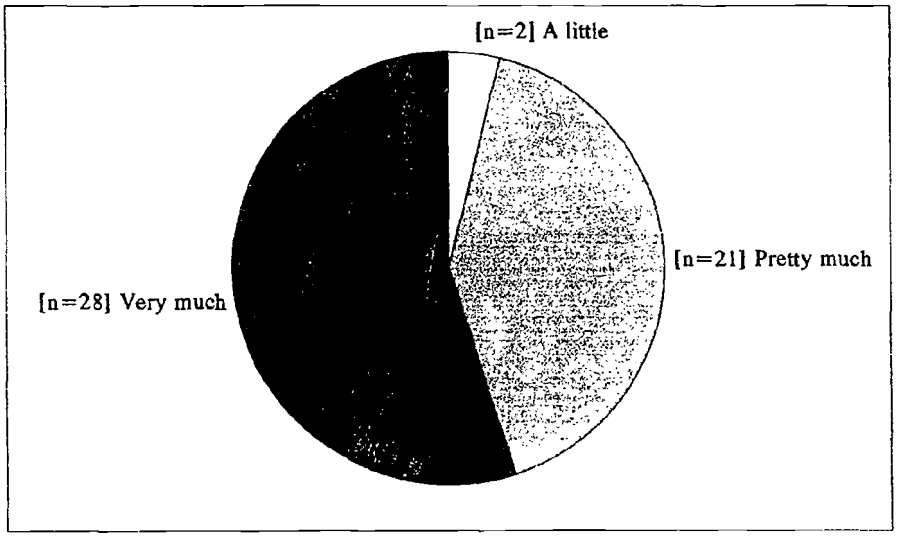

Figure 9. Subjective Ratings for Success of Objective 7 ($n = 51$)

Objective 8. It was anticipated that, at the end of the implementation period, participating human services professionals would know the sequence of steps which need to be taken for diagnosis and treatment of ADHD. The criteria established for determining if this objective was achieved were identical to those established for Objective 7.

First, it was necessary for the material to have been presented at each workshop. Table 1 indicates that this was indeed the case.

Second, it was required that each participant have in his/her possession the resource manual distributed at the start of each workshop. Referring to Table 4 again, it can be seen that all of the participants had received a copy of the resource manual.

Third, it was necessary for at least 60% of the participants to indicate that they felt that the objective had been met satisfactorily. Measurement of this criterion was conducted in the same manner as for Objectives 1 through 7. The distribution of ratings if found in Figure 10, while Table 3 indicates that the minimum required mean score of 2.25 was exceeded for Objective 8. Since all three criteria were met, it was concluded that Objective 8 had been achieved.

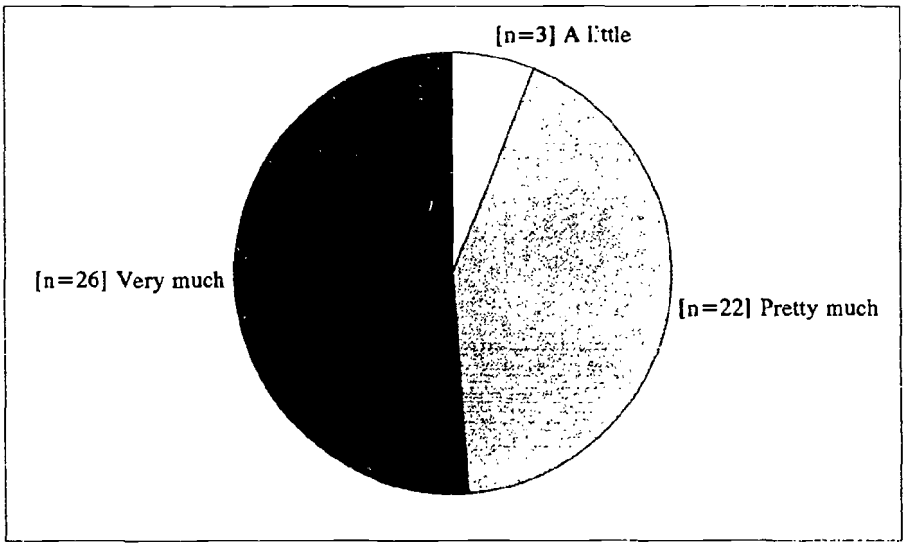

Figure 10. Subjective Ratings for Success of Objective 8 (n = 51)

Objective 9. It was anticipated that, at the end of the implementation period, participating human services professionals would have the means to identify and access those community resources which were equipped to provide the specific diagnostic and support services required by a given ADHD child and his/her family.

Table 5.

Distribution of Reference Brochures for Meeting Objective 9

	Response	
	Yes, have 10 brochures	No, do not have brochures
Number Responding	51	0

Two criteria were established for determining if Objective 9 had been achieved. First, it was necessary for each participant to have in his/her possession ten copies of the brochure entitled *ADHD: A Guide for Parents* (Russo, 1993). Referring to Table 5, it can be seen that this criterion was met.

Second, it was necessary for 60% of the participants to indicate that they felt the objective had been satisfactorily achieved. Participant responses are presented in Figure 11, while a look back at Table 3 shows that the minimum required mean score

of 2.25 was exceeded for Objective 9. Therefore, since both criteria were met, it was concluded that Objective 9 was achieved.

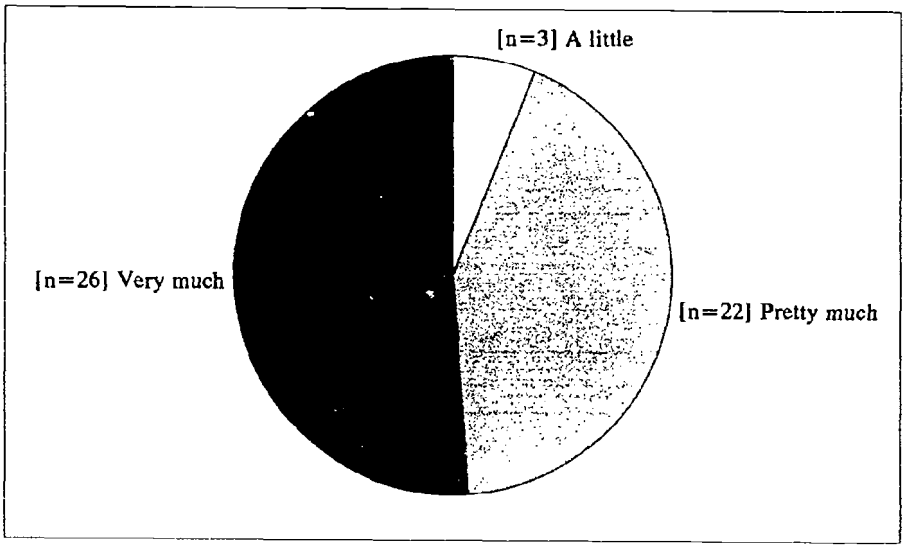

Figure 11. Subjective Ratings for Success of Objective 9 ($n = 51$)

Additional note for Objectives 1 through 9. A presentation of subjective ratings for Objectives 1 through 9, combined, may be found in Figure 12. A mean score of 2.54 was obtained for all objectives, combined.

Evaluation of the effectiveness of the program. Evaluation of the effectiveness of the program consisted of three components. First, the data with regard to the achievement of each of the nine objectives was analyzed. This data has been

presented in the first sections of this chapter, and will be discussed in the the appropriate sections below.

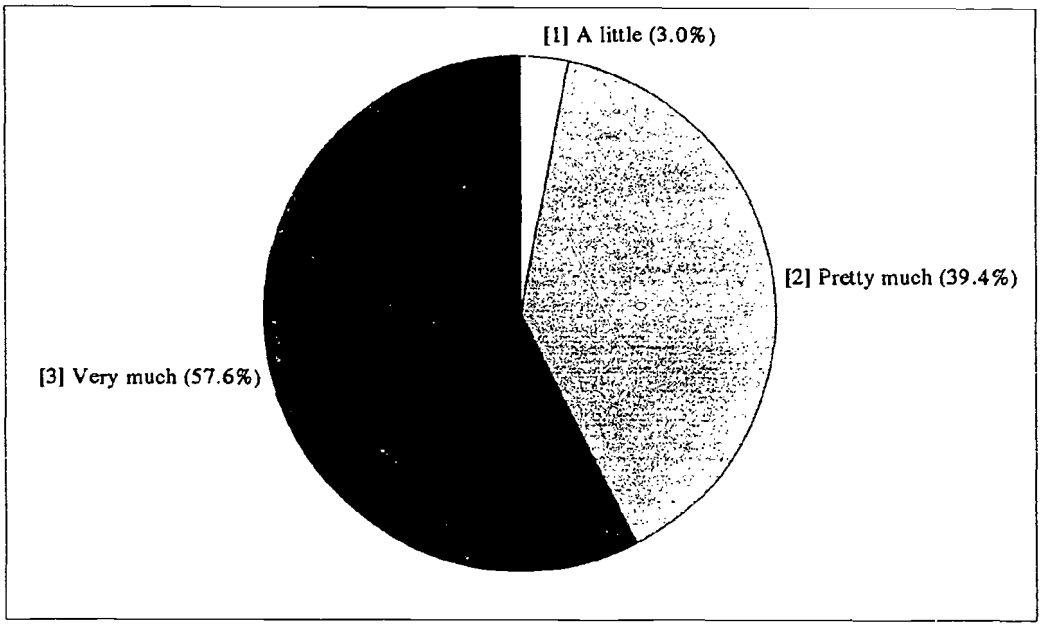

Figure 12. Total Subjective Ratings for All Objectives Combined (n = 459 ratings)

Second, the trainers were interviewed in order to gather their impressions regarding the success of the program. Input from the trainers was in the form of responses along five dimensions of a four-point rating scale, and also in the form of anecdotal material. Responses to the rating scale are presented in Table 6.

Anecdotal material was consistent in indicating that the trainers felt that the program was highly "teachable," that it was effective in anticipating the questions of

Table 6.

Trainer Responses with Regard to the Effectiveness of the Program

	Number Responding (n = 2)			
Dimension	[0] Poor	[1] Fair	[2] Good	[3] Very Good
Appropriateness of instructional content				2
Organization of instructional content				2
Quality of materials				2
Ease of mastery and use				2
Perceived response of participants				2

both trainers and group participants, and that it was well designed to meet the felt needs of the target groups. Trainers also reported that the participants were enthusiastic because the program had been helpful to them in overcoming what was often perceived as an acute sense of inadequacy in dealing with the issues surrounding ADHD, and in counteracting their sense of having previously been left out in the cold. The primary feeling on the part of the participants seemed to be one of relief and gratitude. Both trainers asked to be included in future presentations of the program, and also suggested that, with minor adjustments, the program could be re-designed for use with a variety of target groups.

The third component of the evaluation of the effectiveness of the program consisted of obtaining input from the participants. This was done both indirectly and directly. Using an indirect approach, participants were asked to list their own goals for attending the workshop, then rate the degree to which they felt these goals had been successfully met. Forty-seven participants listed three goals, two participants listed two goals, and two participants listed only one goal, giving a total of 147 goals. The goals fell into eight general categories; these are listed in Table 7. The distribution of the ratings of these self-determined goals is presented in Figure 13. The mean score was 2.62.

Table 7

Participants' Own Goals and Their Frequency

Goal	Frequency
Better able to help/train others	40
Improve general understanding of ADHD	37
Learn how to manage cases involving ADHD	26
Better understanding of diagnosis/identification	18
Better understanding of treatment for ADHD	13
Better understanding of long term effects	07
Better understanding of medication	05
Understanding of ADHD in very young children	01

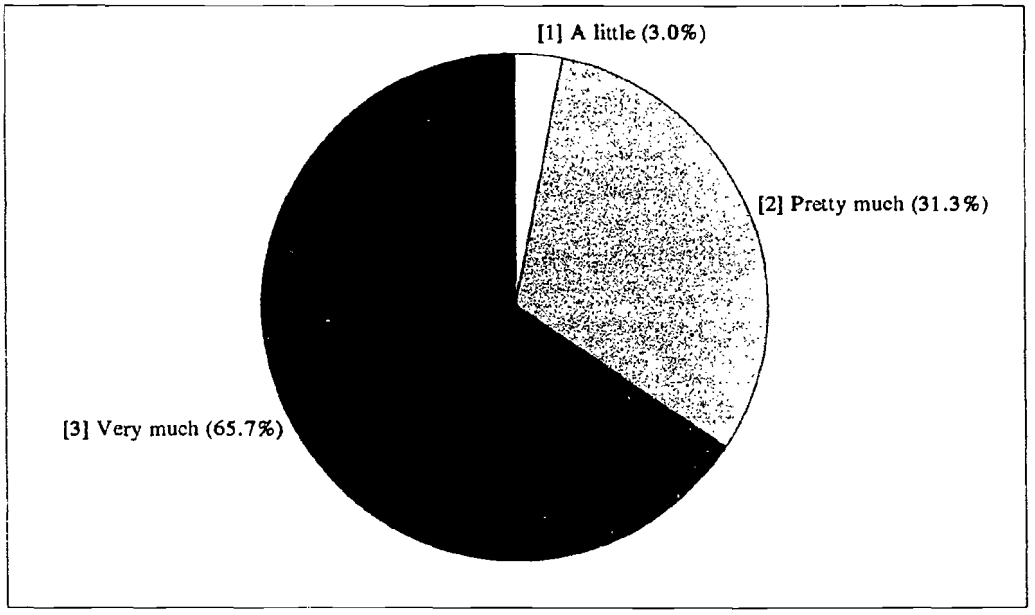

Figure 13. Subjective Ratings of Participants' Own Goals (n = 147 ratings)

Using the direct approach, participants were asked to write down questions, comments, criticism, etc. at the very end of the post-test. Only twelve participants chose to respond in this way, and none of the comments among this small sample was of a negative or critical nature. The common threads among the comments were (a) that the program had been very valuable, and (b) that the program was well designed/organized. There were also numerous, spontaneous comments made to the trainers by most of the participants. The tone of these comments almost unanimously indicated that the participants felt appreciative, newly empowered, and somewhat relieved.

Conclusions

A review of the results obtained from the implementation of the solution strategy indicates that all nine of the specific objectives were met. Several conclusions have been drawn from the results.

The first broad conclusion is that the solution strategy which was implemented was indeed effective in solving the practicum problem. With regard to the program participants, the program is seen to have been successful both objectively and subjectively. Objectively, the program participants showed a significant increase in specific knowledge related to the objectives of the practicum. Subjectively, the program participants reported *believing* that they had indeed significantly increased their knowledge and skills. In addition, this self-perceived benefit was shown to apply both to the objectives established by the writer in designing the program, and to the objectives set by each participant in attending the workshops.

Three secondary conclusions were drawn from the conjunction of objective and subjective factors. First, the writer believes that this conjunction added weight to the conclusion that the program had been successful, overall, in solving the practicum problem. Second, in reviewing the objectives listed by each of the participants, it was found that there was considerable overlap between those objectives and the objectives established by the writer. This concurrence of objectives suggests that the program had been successful in anticipating the self-perceived needs of the participants. Third, the combination of objective and subjective successes suggests

that the program material had indeed been organized and presented in a manner, and at a level, which was readily understood by the participants.

The second broad conclusion is that the lack of knowledge among this professional group about ADHD and its ramifications was perhaps even greater than originally believed by the writer. The dramatic increases in demonstrated knowledge which resulted from this program, while gratifying to the writer, must also serve to point up the very low level of pre-existing knowledge with regard to the subject matter among this vital professional group.

The third broad conclusion is that the program was highly "teachable." Feedback from both trainers consistently indicated that program organization and materials had been successfully designed to facilitate their effective use by the trainers. Trainers felt that their own training had well equipped them for their rôle as expert teacher, and that the materials which were provided to them were highly usable in the training sessions.

The fourth broad conclusion is that, not only had the program been effective in increasing specific knowledge and skill levels, but that it had also been effective in reducing much of the anxiety and isolation experienced by many human services with regard to ADHD. This conclusion is based on the uniformly positive, enthusiastic, and "appreciative" tone of participants' comments following each workshop session. Moreover, there were also several requests for additional workshop sessions both for the originally targeted professional group as well as for other, related groups. Teachers and parents were the related groups most often specified.

The fifth broad conclusion is largely subjective. It was felt that the participants had responded and related better to a trainer who was "one of their own," and who therefore understood their work settings, responsibilities and needs, than they might have responded to a trainer from another discipline, such as psychology or medicine.

Recommendations

Three recommendations are made. First, it is recommended that a formal, hands-on experience be included in the trainer development portion of the program. When this type of experience was added to the original program, at the request of the trainers, it was found to reduce trainer anxiety and increase trainer confidence.

Second, it is recommended that the program be modified for presentation to other, related target groups. This would be a feasible undertaking, since there are only a few, crucial sections which would need to be altered for use with other groups. Two groups, teachers and parents, have already been suggested by workshop participants. Adaptation of the program for parents would be quite practicable. It is felt, however, that adaptation of the program for teachers would be a larger undertaking, since a considerable amount of results-oriented skill-building would have to be included. The program could, on the other hand, readily be adapted for use with educators in non-classroom positions.

Third, ADHD and its ramifications has attracted, and continues to attract, a great deal of interest among researchers. It is vitally important that this research

continually be reviewed so that new information can be incorporated into the training program.

Dissemination

It is the writer's intention to follow up on requests for additional training programs for the targeted group of human services professionals, as well as to adapt the program to related groups. Interest has already been expressed by professional groups within the state, as well as by one group outside the state.

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APPENDIX A

POST-TEST: "ACTIVITY YELLOW"

Activity Yellow (1)

At the beginning of this workshop, you were asked to list three goals which you would like to attain as a result of having attended the workshop. Please refer to those goals when completing this page.

- My first goal was:

  _____

  I feel that this goal was met (circle ***one***):

  Not at all | A little bit | Quite well | Very well

- My second goal was:

  _____

  I feel that this goal was met (circle ***one***):

  Not at all | A little bit | Quite well | Very well

- My third goal was:

  _____

  I feel that this goal was met (circle ***one***):

  Not at all | A little bit | Quite well | Very well

Activity Yellow (2)

1. What do the letters ADHD stand for?

   _____

2. Circle all that apply:

   a. ADHD is hereditary
   b. ADHD is usually outgrown by late adolescence
   c. ADHD causes most of its problems in school
   d. ADHD is caused by a chemical imbalance
   e. Medication is the only proven means of modifying ADHD behaviors

3. The most useful way to control ADHD behaviors is:

   a. Behavior modification / Behavior management
   b. Stimulant medication
   c. Tranquilizing medication
   d. Cognitive training
   e. Psychotherapy

4. List four symptoms of ADHD.

   _____

   _____

   _____

   _____

Activity Yellow (3)

5. What percentage of children with ADHD are likely to be underachieving academically?

   a. 10%
   b. 25%
   c. 50%
   d. 65%
   e. 90%
   f. 100%

6. Fewer students with ADHD go on to college than students without ADHD. Of those who do go on to college, approximately how many graduate?

   a. 10%
   b. 25%
   c. 50%
   d. 65%
   e. 90%
   f. 100%

7. List four of the five fundamental rules of American education which children with ADHD usually cannot follow satisfactorily.

   _____

   _____

   _____

   _____

Activity Yellow (4)

8. List five socio-behavioral ramifications of ADHD. That is, which ADHD-related behaviors are likely to have an impact on society in general?

_____

_____

_____

_____

_____

9. Which is the single most common *emotional* symptom of ADHD?
   a. Depression
   b. Low self esteem
   c. Neurosis
   d. Psychosis
   e. Anxiety

10. List two effects which an ADHD child is likely to have on families *in general.*

_____

_____

Activity Yellow (5)

11. Which groups of children are most likely to have ADHD? Rank order the following from *1* "most likely" to *4* "least likely."

_____ Non-adopted boys

_____ Adopted girls

_____ Non-adopted girls

_____ Adopted boys

12. List three effects which an ADHD child can have within *adoptive* families.

_____

_____

_____

Activity Yellow (6)

Several objectives were used as a framework for the design of this workshop. Please take a few minutes to tell us how well you feel these objectives have been met.

① Do you feel that you have an increased knowledge of the kinds of behaviors usually shown by children with ADHD?

No, not at all | Yes, a little bit | Yes, pretty much | Yes, very much

② Do you feel that you have an increased knowledge of the *educational* ramifications of ADHD?

No, not at all | Yes, a little bit | Yes, pretty much | Yes, very much

③ Do you feel that you have an increased knowledge of the ramifications of ADHD for the greater community (*socio-behavioral* ramifications), with particular reference to adolescents?

No, not at all | Yes, a little bit | Yes, pretty much | Yes, very much

④ Do you feel that you have an increased knowledge of the ramifications for *personal and emotional adjustment* among children with ADHD?

No, not at all | Yes, a little bit | Yes, pretty much | Yes, very much

⑤ Do you feel that you have an increased knowledge of the stresses affecting families *in general* when the family includes a child with ADHD?

No, not at all | Yes, a little bit | Yes, pretty much | Yes, very much

Activity Yellow (7)

⑥ Do you feel that you have an increased knowledge of the stresses of ADHD-related issues as they apply specifically to *adoptive families*?

No, not at all | Yes, a little bit | Yes, pretty much | Yes, very much

⑦ Do you feel better equipped to provide meaningful support and guidance to adoptive families with regard to ADHD?

No, not at all | Yes, a little bit | Yes, pretty much | Yes, very much

⑧ Do you feel that you have the resources available to you which can help in determining the appropriate series of steps to take when working with adoptive parents on ADHD-related issues?

No, not at all | Yes, a little bit | Yes, pretty much | Yes, very much

⑨ Do you feel that you have the resources available to you which can help in identifying and accessing professional diagnostic and support services within the community?

No, not at all | Yes, a little bit | Yes, pretty much | Yes, very much

⑩ Do you have ten copies of the brochure entitled *ADHD: A Guide for Parents*?

Yes No

Activity Yellow (8)

Thank you for participating in this workshop and for sharing your expertise with us. We hope that your goals have been met.

Please feel free to use the remainder of this page for comments, questions, suggestions, etc.

APPENDIX B

BOX OUTLINE FORMAT

Non-Physical Means

Psychotherapy.

Individual therapy.

Family therapy.

Group therapy.

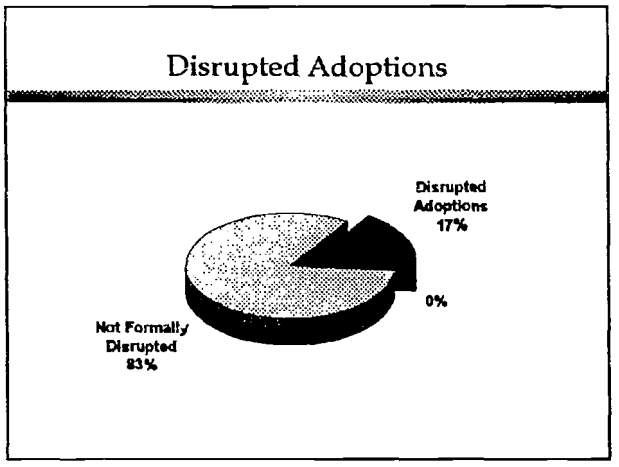
Cognitive training.

Behavior modification.

APPENDIX C

SAMPLE NOTES PAGES FROM

TRAINER'S MANUAL



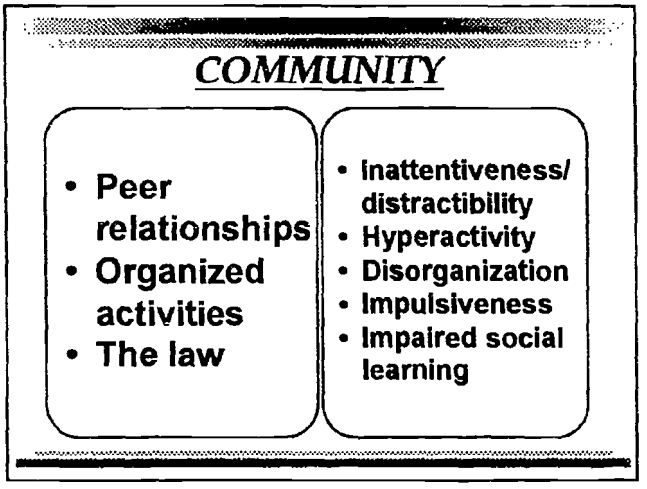
Note: These studies refer to *non-infant* adoptions.

Three major studies of disruptions yield figures between 10% and 25%. The 17% given in this graph is the mid-point.

With possibly a 17% disruption rate, it is reasonable to conclude that a considerable percentage of families experience similar stress but do not end in disruption.

With 17% ending in disruption, it is a *conservative* estimate that 35% of families may be experiencing the same type of stress and distress.

Some of these factors will be discussed in greater detail later on. *It is likely, with the higher incidence of ADHD among adopted children, that ramifications of the disorder contribute significantly to the stresses which may lead to disruption.*



A specific scenario for community life has not been developed.

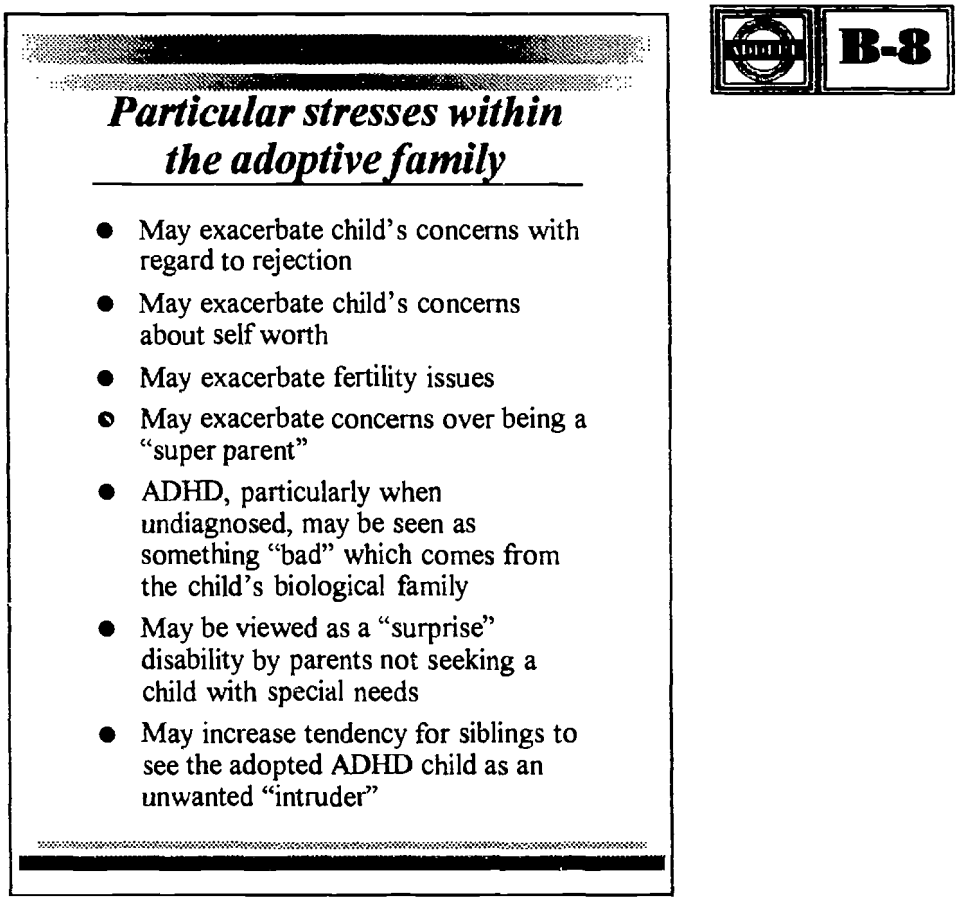
Using the knowledge you already have about ADHD behavior in school and at home, it should be possible for you to extrapolate to the community setting. Think in terms of following rules, "getting along," acting appropriately, etc. Think also of how behavioral difficulties *in public* tend to *reflect on parents.*

Some activity areas to consider are:

- ScoutingSunday school
- Sports teams
- Hanging out
- Eating in restaurants
- Shopping
- Music lessons
- Karate lessons
- Driving
- Parties (all ages)

You and the workshop participants may well suggest other settings to discuss.

As always, the purpose of these discussions is not simply to give information but to relate the factual information to situational concerns of adoptive families.

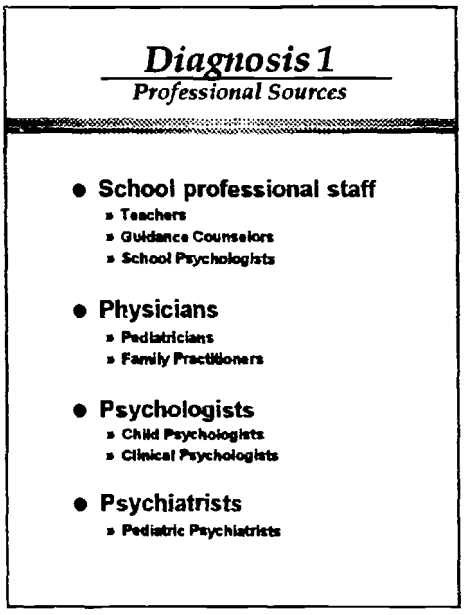


- This overhead may be used during the discussion which follows Activity Pink.

- This list does not pretend to be exhaustive. You and/or group participants may wish to suggest additional areas of adoptive family stress which are pertinent.

- With an understanding of the ***ongoing, persistent, pervasive behavior pattern*** of the ADHD child, it should be possible to expand this into a particularly significant segment of the workshop.

This might be a good time to review the school, home, and community scenarios.



C-1

School Professional Staff

- Teachers and guidance counselors are *not* qualified to diagnose.
- School psychologists *may* be qualified to diagnose, but school districts generally avoid making a diagnosis because of perceived controversy over the use of medication.
- School professional staff *participate* in diagnosis in two major ways:
  - Initiate referrals to outside professionals
  - Provide valuable input concerning child's in-school behavior.

Physicians

- *Some* pediatricians and family practitioners are knowledgeable and may make a complete diagnosis.
- Frequently, physicians diagnose cases of obvious hyperactivity.
- Typically, physicians refer to a psychologist.

Psychologists

- *Child* psychologists (as opposed to clinical psychologists) predominate in diagnosis; not all psychologists, however, are trained in this area.
- Psychologists generally handle liaison with schools, physicians, and other agencies; psychologists manage follow-up; some psychologists help monitor medication.
- *Children are referred back to a physician for medication.*

Psychiatrists

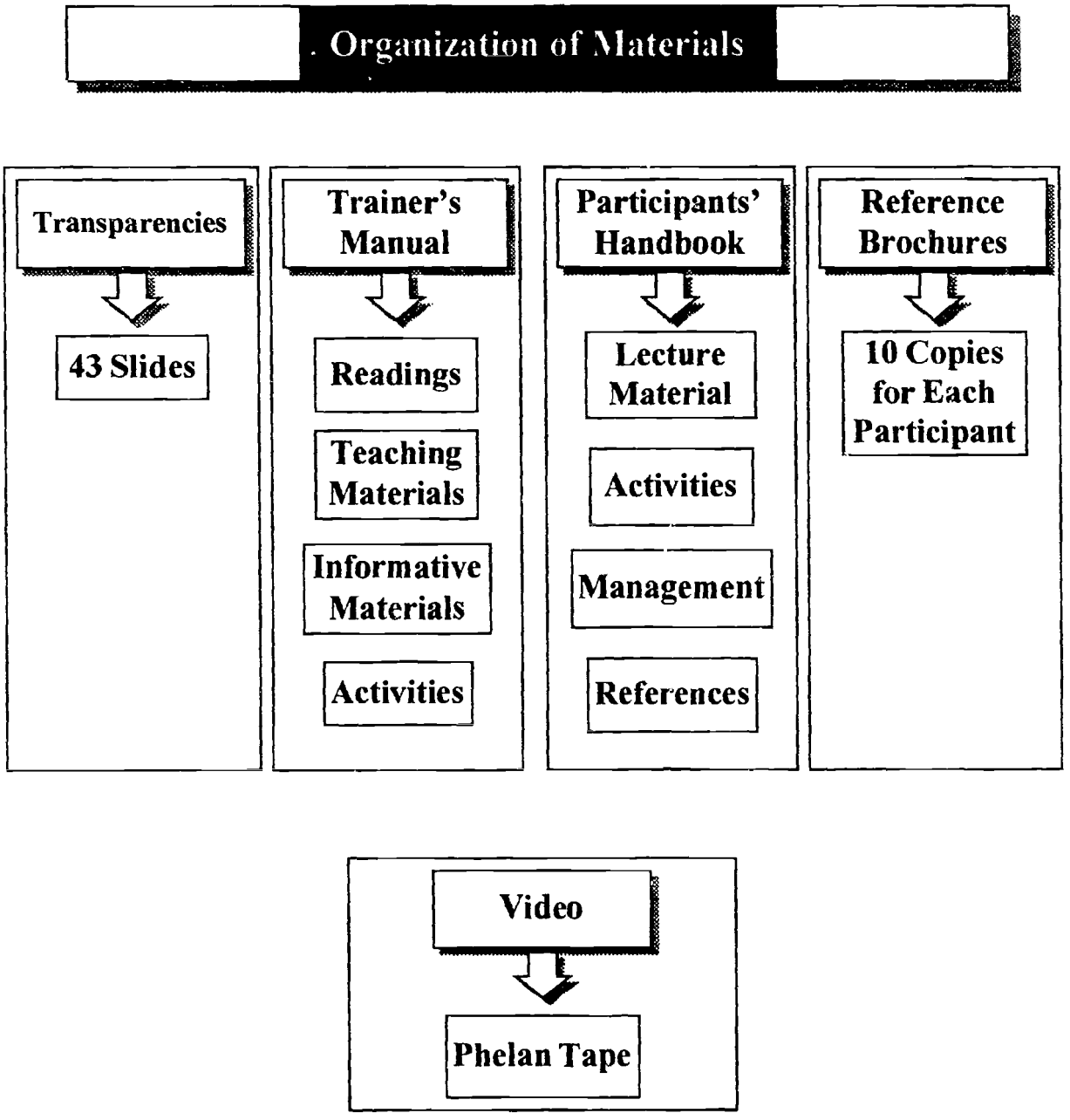
- *Pediatric* psychiatrists are also actively involved in diagnosis, particularly with cases in which differential diagnosis is needed (e.g. identifying primary diagnosis as ADHD, anxiety, depression, personality disorder, etc.).
- Can prescribe medication; frequently return child to regular physician for monitoring.
- There are fewer psychiatrists than psychologists; may be less accessible.

APPENDIX D

SCHEMATIC SUMMARY OF

ALL PROGRAM MATERIALS

Schematic Summary 2



APPENDIX E

MANAGEMENT GUIDELINES

FOR THE

IDENTIFIED YOUNG CHILD

Parents need to know the current status.

- This child *has* been identified as having ADHD.
- This child is a special needs child.
- This child is already taking medication to help with his/her behaviors

OR

- This child will probably need to start taking medication during the elementary school years.

Parents need to know the basic facts.

- This is an organic disorder, not an emotional disorder.
- This disorder generally runs in families.
- This is typically a life-long disorder.

Parents need to know the ramifications.

- The effects of the disorder are generally felt in school, in the family and in the community.
- The child will probably have significant difficulties in one or more of the following areas:
    - Focusing and maintaining attention
    - Controlling impulses
    - Getting and staying organized
    - Remembering
    - Hyperactivity
    - Self esteem

Parents need to know what the child will need.

- This child will probably need to continue/start taking medication on a regular basis in order to help bring the ADHD symptoms under control.
- This child will probably need to have special adaptations made to his/her academic program.
- This child will need a well-structured, consistent and predictable environment.
- This child may need periodic, individual counseling/psychotherapy.
- Parents may need supportive counseling/psychotherapy.

Parents need to know what will be expected of them.

- Parents will need to do the following:
  - Provide a *well-structured environment* containing elements of consistency, flexibility, patience and humor
  - Be prepared to be an active advocate for the child when dealing with the school and with community organizations
  - Be able to deal repeatedly with difficult situations at home and in public settings
  - Seek and coordinate professional services
  - Be prepared to be actively involved in the details of the child's daily life beyond the age when this is generally considered to be appropriate
  - Be able to apply management techniques which seem to "go against the grain" of spontaneous parenting

Parents need to know what to do now.

*** If the treating professionals are already known:**

① Contact the physician supervising the medication, if any, so that the medication will not be interrupted
② Contact the professional who made the diagnosis and arrange for a consultation
③ Ask the diagnosing professional for *at least* the following:
- A summary and written report of the evaluation and diagnosis
- Recommendations for management and follow-up
- Recommendations concerning educational needs

④ Contact the local chapter of CHADD for further guidance and support

*** If the treating professionals are not known or accessible:**

① If the child is already taking medication, identify and contact a local physician who is knowledgeable in treating ADHD, so that medication will not be interrupted
② Attempt to obtain a copy of the original diagnostic report
③ Identify a child psychologist knowledgeable in working with ADHD
④ Arrange for a consultation with the psychologist
⑤ Ask the psychologist to review the diagnostic report, if available, and to work as your consultant in providing direction
⑥ Contact the local chapter of CHADD for further guidance and support