

ABSTRACT

DANCE THERAPY AND PSYCHOEDUCATIONAL GROUPS FOR ATTENTION

DEFICIT HYPERACTIVITY:

A GRANT PROPOSAL

By

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The purpose of this project was to design a program, identify potential funding sources, and write a grant to fund a dance/movement therapy group to reduce disruptive behaviors of children diagnosed with Attention Deficit Hyperactivity Disorder (ADHD). This proposed project also would provide psychoeducational groups for the children's parents/caregivers.

An extensive literature review was conducted in order to examine the risk factors, symptoms, causes, and consequences for children with ADHD. In addition, innovative treatment approaches such as dance movement therapy and support groups were researched in the literature review. The identified potential funding source for the proposed program was the California Endowment Foundation. Actual submission of this grant was not required for completion of this project.

DANCE THERAPY AND PSYCHOEDUCATIONAL GROUPS FOR ATTENTION

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A GRANT PROPOSAL

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CHAPTER 1

INTRODUCTION

Statement of the Problem

The most common behavioral disorder diagnosed among children and adolescents is Attention Deficit Hyperactivity Disorder (ADHD; Mattox & Harder, 2007). ADHD is not only the most common mental disorder but also the most controversial due to treatment involving medicines for children and adolescents diagnosed with ADHD (Mayes, Bagwell, & Erkulwater, 2009). In addition, those diagnosed with ADHD as children will often have the mental health disorder continue through adolescence and adulthood (National Institute of Mental Health [NIMH], 2008; Spencer, 2009). Symptoms include difficulty staying focused and paying attention, difficulty controlling behavior, and hyperactivity (NIMH, 2008). According to the NIMH (2008), the percentage of children who are affected by ADHD is 4.1%. However, disruptive behaviors associated with this disorder affect as many as 16% of all children (Bagner & Eyberg, 2007). Disruptive behaviors include behaviors such as temper tantrums, physical aggression, excessive argumentativeness, and defiance (Bagner & Eyberg, 2007). It was found that approximately 5% of children ages 3 to 17 are diagnosed with ADHD (American Psychiatric Association [APA], 2000). Disruptive behaviors are the most common referral to children's mental health clinics (Bagner & Eyberg, 2007).

Statement of Purpose

The purpose of this project was to write a grant to obtain funding for a program to assist children living with ADHD along with their families at the Step by Step Edu-Play (SBS), Santa Monica, California. The program's purpose is to educate, support, and empower children and their families through a children's dance/movement therapy (DMT) program and a parent-education/support group. The program is designed to decrease hyperactivity among children and increase their attention span through positive physical outlets. Parents will be part of a psycho-education support group that will provide them with education about ADHD and best ways to be supportive of their children. The group facilitator will foster a trusting environment in which parents can provide ideas and resources to each other. The program will provide linkages to resources in the community. The program is envisioned to be an 8-week program that will provide childcare for additional children in the families.

Definition of Terms

For the purpose of this project the following definitions are provided:

Attention Deficit Hyperactivity Disorder (ADHD): According to the NIMH, "attention deficit hyperactivity disorder (ADHD) is one of the most common childhood disorders and can continue through adolescence and adulthood. Symptoms include difficulty staying focused and paying attention, difficulty controlling behavior, and hyperactivity or over-activity" (2008, p.1).

Dance/movement therapy: Dance/movement therapy is a creative therapy that uses movements to improve the mental and physical well-being of individuals (American Dance Therapy Association [ADTA], 2013). According to ADTA, dance/movement

therapy is the psychotherapeutic use of movement to fulfill the emotional, cognitive, physical, and social integration of the individual (ADTA, 2013). Dance/movement therapy is used with people of all ages, races, and ethnic backgrounds. It is sometimes incorporated by mental health practitioners as a treatment option, and has been shown to produce positive results with developmental, medical, social, physical, and psychological impairments (ADTA, 2013).

Parent psycho-education: Parent psycho-education teaches parents to set reasonable expectations for their child or youth. It also teaches parents to understand their role as parents, especially in collaborating with their children's therapists. Further, parents learn how to better work with their child's condition (Minnesota Department of Human Services, 2013).

Support groups: Support groups are a group of people who share common interests or health concerns. Support groups usually will focus on a specific condition or situation (Mayo Clinic, 2013).

Multicultural Relevance

ADHD affects diverse children. ADHD occurs in all cultures; however, it is more often diagnosed in Western cultures. Dwivedi and Banhatti (2005) stated that little importance has been placed on cultural differences and diversity variables in research on ADHD. As social workers, it is important to be culturally sensitive and to seek to understand cultural and diverse family values when working with families impacted by ADHD. Dwivedi and Banhatti reported that a cultural environment may impact a child's behavior. Attitudes and expectations of parents, clinicians, and society also play a significant role towards interpreting acceptable behavior when diagnosing ADHD

(Dwivedi & Banhatti, 2005). Professionals need to understand the effects of culture, ethnicity, age, and gender, in order for a child with ADHD to receive effective treatment. It is also important to be able to understand the cultural context of the individual within the environment he or she lives. For example, in families with limited income, the child's family may lack the resources needed to assist with their child's treatment (Dwivedi & Banhatti, 2005).

The limited research available states that Latino children are at a higher risk for developing ADHD (when compared to Whites and African Americans) but are less likely to be identified by their parents as showing behaviors that are problematic (Haack, Gerdes, Schneider, & Hurtado, 2011). Research shows that Latino children with ADHD are less likely to receive proper assessment and treatment, due to several practical and cultural factors (Haack et al., 2011). According to Haack et al. (2011), more research is needed that includes an examination of functional impairment related to ADHD when working with Latino children and their families. The Latino population is an undeserved population that is rapidly growing in our country that requires more research to provide appropriate services (Haack et al., 2011).

Social Work Relevance

The proposed program will adhere to the National Association of Social Workers (NASW; 2013) Code of Ethics. The core values of social work are service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence (NASW, 2013). The proposed program has relevance to social work practice given that families of children with ADHD often seek the help of social workers to aid in treating their children. Social workers are often at the forefront, advocating on behalf of

children with mental health conditions such as ADHD, collaborating with service providers, and promoting social justice to ensure the well-being of children and their families.

Children with ADHD may have been stigmatized and shamed about their condition and misbehavior (Mayes et al., 2009). Parents may have also been judged and blamed for their children's behaviors; parents' may be faulted for having poor parenting skills (Charach, Skyba, Cook, & Antle, 2006). It is important to advocate for justice and provide services for these children and their families. As noted by Mattox and Harder (2007), "ADHD is a chronic disorder, that has a negative impact on daily social, emotional, academic, and work functioning of children" (p. 196). Most often, these children are referred to as problematic children and are faced with challenges in the home, school, and community environments. Mattox and Harder found that children with ADHD are at higher risk (when compared to non-ADHD diagnosed children) of facing challenges such as learning disabilities, rejection from peers, and parent-child conflict. Children with ADHD can face grade retention, low graduation rates, and low grade point averages (Mattox & Harder, 2007). More programs that are rich in activities are needed to enrich and empower this population (Mattox & Harder, 2007). Children with ADHD need more programs that will help them release their energy in a positive and productive way (Salmeron, 2009). With treatment, people with ADHD can live meaningful lives and be successful in school and daily social functions (NIMH, 2008). Social workers can provide programs and form interdisciplinary teams to help insure these children's needs are met.

CHAPTER 2

LITERATURE REVIEW

Introduction

The following literature review examines existing literature on topics related to children with ADHD. This review will cover the definition, causes, consequences, symptoms, and treatment options for ADHD, as well as the demographics of children with ADHD. In addition, the complex challenges of parents of children with ADHD will also be explored.

What Is ADHD?

Attention Deficit Hyperactivity Disorder (ADHD) is described as a neurobehavioral disorder that is most commonly diagnosed in children (Centers for Disease Control and Prevention [CDC], 2010). ADHD is the most common disorder diagnosed in childhood that is a lifelong disorder (Mattox & Harder, 2007). According to the *Diagnostic and Statistical Manual of Mental Disorders (DSM; APA, 2013)*, ADHD is a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning and development. Inattention is characterized as wandering off task, having difficulty focusing, and being disorganized, and this behavior is not due to being defiant or lacking comprehension (APA, 2013). Hyperactivity is described as excessive motor activity that is not appropriate such as a child running about uncontrollably, excessive fidgeting, continuous tapping, or excessive talkativeness (APA, 2013). Impulsivity is referred to as quick and spontaneous actions that can be harmful to the individual and be

intrusive in social settings such as excessively interrupting others and making important decisions without processing and/or considering long-term consequences (APA, 2013).

Children with ADHD have difficulty concentrating and staying on task (Woliver, 2008). It has been found that children with ADHD, have difficulty awaiting turns, playing quietly, and sustaining attention. They are easily distracted, will interrupt or intrude in others' conversations, avoid tasks requiring sustained mental efforts, and make careless mistakes (Willoughby, Peck, & Greenberg, 2012). Children with intellectual and developmental disabilities are at a greater risk for mental disorders (Neece, Baker, Blacher, & Crnic, 2011). People diagnosed with ADHD as children often have functional impairments as they reach young adulthood (Biederman, Mick, & Faraone, 2000). Hyperactivity and over activity are more often seen in young children and these symptoms tend to decline over time (von Stauffenberg & Campbell, 2007). Conversely, problems with inattention usually appear later in development and become more noticeable with age (von Stauffenberg & Campbell, 2007).

ADHD significantly affects not only the child but also the child's family and peer relationships (Salmeron, 2009). Children with ADHD often perform poorly in school due to aggressive behaviors that often are disruptive. Children who have repetitive aggressive behaviors, which can cause social and emotional rejection by peers and family members, often suffer from low self-esteem, academic failure, and school dropout (Ray, Schottlekorb, & Tsai, 2007). These aggressive behaviors combined with any type of childhood psychopathology can lead to delinquency in adolescence (Mayes et al., 2009). It is important to identify these factors during a child's early development in order to create effective interventions.

Symptoms and Diagnoses of ADHD

In the *DSM-V*, the subtypes of ADHD are: inattentive, hyperactive-impulsive, and combined (APA, 2013). Children undergoing the assessment process for ADHD must meet six or more of the nine symptoms for each type. These symptoms include difficulty sustaining attention, difficulty organizing tasks and activities, being easily distracted, being forgetful, being fidgety, being unable to play or engage in leisure activities quietly, often interrupting, and being overactive (APA, 2013). The diagnostic criteria must be persistent for at least 6 months (APA, 2013). In addition, symptoms must be present prior to the age of 12 and must occur in at least two or more settings that cause impairment with functioning or development (APA, 2013). Children with ADHD can exhibit a wide range of other symptoms such as poor self-control, minimal foresight, anxiety, depression, and conduct problems, which can contribute to family stressors (Kutscher, 2003). Often, children with ADHD will tend to lose focus and tune out activities that are boring, not interesting, and non-stimulating (Fowler, 2002). Fowler (2002) noted how children with ADHD often cannot sustain attention long enough for activities that are tedious or repetitious. They have a hard time resisting distractions, and they do not pay enough attention to detail and organization, causing their school performance to be poor (Fowler, 2002). According to Fowler, many times their performance in school and home is inconsistent. Children's inability to listen to others, follow directions, and attend to conversations causes problems in social situations (Fowler, 2002).

Children with ADHD exhibit problems in the social realm and lack social skills (Woliver, 2008). They have difficulty keeping up with peers and are disinterested.

Children with ADHD often are in need of stimulation, which manifests itself in inappropriate behaviors that can make them have discipline problems and feel excluded (Woliver, 2008).

According to Spencer (2009), people with ADHD display a range of symptoms that are related to functional impairment. Psychiatric comorbidities have also been related to ADHD from an early age and continuing and/or reoccurring into adulthood (Conway, Oster, & Szymanski, 2011; Spencer, 2009). Gillberg et al. (2004) illustrated that more than 60% of individuals with ADHD also present one or more comorbid disorders. The types of co-occurring illnesses that are most common in children and adults with ADHD are, disruptive behavior disorders such as oppositional defiant disorder and conduct disorder, mood disorders, anxiety disorders, depression, tic disorders, and substance use disorders (Czamara et al., 2013; Mattox & Harder, 2007; Spencer, 2009). Interestingly, 20-60% of children with ADHD are also affected by learning disorders (Langberg, Vaughn, Brinkman, Froehlick, & Epstein, 2010). Disruptive behaviors are the most prevalent symptoms found in children with ADHD (Neece et al., 2011). The ADHD diagnostic criteria require that symptoms be present and cause impairment before age 12 (APA, 2013). The age of onset for ADHD may vary by subtype (Neece et al., 2011). Symptoms need to be present in two or more settings such as the home and school, with friends or relatives (APA, 2013). Symptoms also need to interfere with social, academic, or occupation functioning (APA, 2013). Some children by nature are restless and impatient and sometimes act without thinking. However, it is when a child's hyperactivity, impulsivity, distractibility, and poor concentration begin to affect the child's school performance, family relationships and peer relationships, and

there is disruptive behavior at home and in school, that ADHD becomes suspected (Mattox & Harder, 2007).

Associated problems that often co-occur with ADHD are mild delays in language and deficits in motor and social development (APA, 2013). Additional characteristics associated with ADHD include low frustration tolerance, irritability, or mood swings (APA, 2013). Children with ADHD also may exhibit cognitive problems on tests of attention, executive function, or memory (APA, 2013). ADHD is diagnosed by a clinical professional, who is either a developmental pediatrician, child psychologist, or pediatric neurologist, using observable data provided by families and school personnel (Al-Yagon et al., 2013).

Those involved in determining ADHD may not always consider factors, such as gender, in describing symptoms observed in children during the assessment phase of the diagnosis process (Woliver, 2008). For instance, boys who are rowdy and hyperactive or girls who are quiet and shy can be given a wrong diagnosis by a doctor who only refers to gender role stereotypes when determining criteria for ADHD. Fewer studies have been conducted on girls, and the disorder is less understood in girls (Woliver, 2008). Girls are more inattentive and display fewer overactive symptoms. These characteristics make them less noticeable, causing them to be under diagnosed (Woliver, 2008). Consistency in behavior is required for an accurate diagnosis (Woliver, 2008).

Developmental Theory

According to Neece et al. (2011), children with intellectual and developmental disabilities are at a higher risk for mental disorders and disruptive disorders. In Neece et al.'s (2011) study of ADHD children with and without intellectual disability, it was found

that ADHD was over 3 times as prevalent in the intellectual disability group as in the typical development group of children ages 5 to 8.

Toddlers may exhibit excessive motor activity, but symptoms are difficult to differentiate from what is considered normative behaviors before the age of 4. Therefore, ADHD is more likely to be identified during elementary school years due to inattention being more noticeable and consequential (APA, 2013). During preschool years, hyperactivity is more noticeable and common for children with ADHD. It decreases as the child enters adolescence, when the symptoms are replaced by fidgetiness, inner jitteriness, restlessness, or impatience (APA, 2013).

Powers and Bierman (2013) asserted that connections with aggressive friends might affect aggression development at a young age. Aggressive preschool children and schoolchildren are more likely to befriend each other and model non-compliant behavior and rule-breaking behaviors at an early point of development (Powers & Bierman, 2013). Studies have shown that peer influences can be affected by characteristics of the peer ecology at the classroom level, especially in the occurrence of aggressive behaviors (Dishion & Tipsord, 2011; Henry et al., 2000). A study on a large, diverse sample of 4,096 children in 27 schools by Powers and Bierman (2013) demonstrated the importance of the classroom ecology. Their study found that classrooms that were described as having a higher number of children who were aggressive encouraged the development of child aggression (Powers & Bierman, 2013).

Van der Kolk (2005) stated that children experience neural pathways and social interactions in early development that are very complex. Children, who experience complex trauma in early childhood may develop psychological impairment that prohibits

the development of internal models for effective cognitive interpersonal experiences (van der Kolk, 2005). Von de Kolk (2005) also explained that children who are exposed to trauma experience developmental trauma disorder, which is characterized by a repetitive pattern of dysregulation in response to trauma signals.

Sagvolden, Johansen, Aase, and Russell (2005) explained developmental theory within ADHD as various functions of impulsiveness caused by lack of reinforcement and impaired motor control. Their theory describes how the interference of dopamine functioning in the brain may affect learning processes and motor functions (Sagvolden et al., 2005). The developmental theory also predicts “adaptive as well as maladaptive behavioral outcomes of the core deficits interactions with medication, parenting, and societal styles” (Sagvolden et al., 2005, p. 400).

Causes of ADHD

Causes and risks for ADHD are not entirely known, but current research states that genetics play a large role (NIMH, 2013b; Todd et al., 2008). Children with biological relatives of ADHD have a higher risk for developing ADHD (APA, 2000; Mattox & Harder, 2007; NIMH, 2013b). In Rowland, Lesesne, and Abramowitz’s (2002) study, it was found that 34-40% of patients with ADHD reported having family history of ADHD, compared to only 8% of the control sample. Further research is needed to support the heritability of ADHD (APA, 2000).

Other factors may also contribute to the cause of ADHD. These additional factors consist of environmental factors such as time spent in front of the TV, single-parent household, parental education, young age at birth, consumption of alcohol during pregnancy, and maternal smoking (Czamara et al., 2013; Ruckinger et al., 2010; Sagiv,

Epstein, Bellinger, & Korrick, 2012). Other environmental factors include very low birth weight (that shows a 2-3 fold risk for ADHD), possible brain injuries, poor nutrition, and the social environment (APA, 2013; NIMH, 2013b).

Interestingly, preschoolers who are exposed to high levels of lead may have higher risks of developing ADHD (Mattox & Harder 2007; NIMH, 2013b). According to Rowland et al. (2002), research done with animals found that animals that were dosed with lead became more aggressive, distracted, and agitated. Reducing environmental factors can be preventative along with continued treatment and care (Mattox & Harder, 2007).

A history of child abuse, neglect, multiple foster placements, neurotoxin exposure, infections, or alcohol exposure in utero may be correlated with ADHD (APA, 2013). Additional modifiers, such as family interaction patterns in early childhood, may influence ADHD or contribute to secondary development of conduct problems (APA, 2013).

Consequences of Attention-Deficit/Hyperactivity Disorder

According to Spencer (2009), ADHD is often complicated by psychiatric comorbidities that make it challenging to diagnose and manage. ADHD is also associated with neurological disorders (Czamara et al., 2013). Psychiatric morbidity has shown to have negative effects on life outcomes if it goes undetected and/or untreated (Spencer, 2009). There is an increased risk for unemployment, disability, unstable relationships, and in some cases legal complications in adulthood if symptoms are ignored (Spencer, 2009). A study conducted at Massachusetts General Hospital found that compared with age-matched controls, psychiatric comorbidity was more common in

boy's ages 6-17 years (Spencer, 2009). The study also found that patients with ADHD have a significantly higher risk for global and chronic pathology from an early age (Spencer, 2009). According to the CDC (2013), symptoms may improve as the child ages.

Children with ADHD have difficulty concentrating; however, they also have the ability to focus on things that interest them (Woliver, 2008). Children with ADHD have difficulty in school because schoolwork is not always a preferred activity, and therefore they often face academic challenges (Woliver, 2008). Many times, children with ADHD have the inability to stay organized which affects them both in the home and school environments, making it difficult to complete homework, chores, or simple tasks (Woliver, 2008).

Accidental injuries are more common in children with ADHD. According to Shilon, Pollack, Aran, Shaked, and Gross-Tsur (2011), injuries are the leading cause of mortality in children older than 1 year. Children with ADHD are often characterized as impulsive, participating in risk-taking behaviors that put them at an increased risk for injuries (Shilon et al., 2011). A controlled study of 29 school-aged children with ADHD and their same-sex, similar age, and non-ADHD affected siblings concluded that school-aged children with ADHD are at higher risk of accidental injuries than their siblings without ADHD (Shilon, et al., 2011). This is despite ADHD subtype, comorbid psychiatric conditions, developmental co-ordination problems, and environmental/family conditions (Shilon et al., 2011).

Children with ADHD have difficulty with educational, social, and family functioning (APA, 2013; Todd et al., 2008). Children with ADHD face difficulties with

peer rejection, parent-child conflict, and educational difficulties (Mattox & Harder, 2007). Children with ADHD often face grade retention, low graduation rates, and low grade point averages (Mattox & Harder, 2007).

In their study involving 3,097 children, Czamara et al. (2013) determined that 8.1% of those children presented with ADHD symptoms. Of those children with ADHD symptoms, it was found that they had higher risks (25% more) of showing reading and spelling disorders, as well as math difficulties, compared to children without ADHD symptoms. Their results concluded that ADHD and learning disorders are comorbid and share the same fundamental process (Czamara et al., 2013). The study also found that reading disability was significantly correlated with inattention in both girls and boys, but with hyperactivity/impulsivity only in boys. The authors asserted the following: ADHD facilitates the development of learning disorders; genetic predisposition factors for ADHD vary from risk variants for comorbid ADHD. ADHD alone and comorbid ADHD are thus genetically/environmental distinct, and comorbidity may be associated with environmental factors (Czamara et al., 2013).

Traumatized children have been found to exhibit symptoms that resemble ADHD (Conway et al., 2011; van der Kolk, 2005). Common symptoms of trauma and ADHD are poor emotion regulation and impulsivity. The lack of emotion regulation may be attributed to the parents of children with ADHD feeling responsible and creating a dysfunctional environment that interferes with the parent/child relationship during early childhood (Conway, et al., 2011). Conway et al. (2011) found that parents of children with ADHD experience more stress and more dysfunctional interaction styles compared to parents of children without ADHD. Similarly, children who experience child abuse

and neglect can exhibit hyper-arousal symptoms that sometimes mimic symptoms of children with ADHD (Dwivedi & Banhatti, 2005). Traumatic events interfere with children's sensory, emotional, and cognitive responses, resulting in stress and lack of focus (Conway et al., 2011).

Demographics

ADHD is a disorder that continues to affect more than 5.2 million (8.4%) children 3-17 years of age in the United States (CDC, 2013). Boys (12%) were twice as likely as girls (5%) to have ADHD (CDC, 2013). Children living in single-parent homes primarily with single mothers were found to be more likely to have learning disabilities (10%) and ADHD (10%) than children in two-parent families (6% and 8%; Mattox & Harder, 2007). Mattox and Harder (2007) indicated that 25% of children with ADHD were found to have conflict and fight with peers, and 30-45% were more likely to receive formal special education. Children with good health compared with children with fair or poor health were 4 times as likely to have ADHD (27% and 7%). The National Survey of Children's Health reported that there was an increase of 7.8% to 9.5% of children diagnosed with ADHD ages 4-17 years during 2003-2007 (CDC, 2013). The results also showed that there were higher rates of ADHD among multiracial children and children covered by Medicaid (CDC, 2010). According to the NIMH (2013), the number of children being diagnosed with ADHD is increasing.

Treatment

The treatment of children with behavioral and emotional problems has become a widespread issue in the United States (Timmer et al., 2006). According to Spencer (2009), ADHD is often complicated by psychiatric comorbidities that include

oppositional defiant disorder, major depressive disorder, and two or more anxiety disorders that often lead to disruptive behaviors and emotional problems. Azrin et al. (2006), explained how repetitive, and non-preferred tasks might be the most challenging activities for children with ADHD. Children with ADHD require immediate rewards to reinforce good behavior as a result of their impulsivity (Azrin et al., 2006). These rewards should be predictable, frequent, and meaningful (Azrin et al., 2006).

There are several treatments available for ADHD. There is no cure for ADHD; however, through the use of treatments, symptoms may be reduced, which helps to improve functioning (CDC, 2013; NIMH, 2008). Some of the treatments for ADHD include various types of psychotherapy, education, medications, training, and/or combinations of treatments. It is recommended for parents to seek a psychiatrist to monitor progress and any changes in treatment recommendations. It is also recommended to use a multimodal approach that includes behavior interventions, teacher interventions in the classroom, and consultations from other professionals who work with the child.

Among the many psychosocial treatment approaches for ADHD, parent training in child behavior management and teacher training in classroom management have been found to be an effective treatment combination supported by research findings (Antshel & Barkley, 2008). According to Franklin, Harris, and Allen-Meares (2006), the most successful interventions in school settings for ADHD have been the use of a multimodal approach consisting of pharmaceutical interventions, cognitive-behavioral training, parent training, and teacher training in classroom management techniques and special

education methods. Children with ADHD can be successful in school and have productive lives with treatment (NIMH, 2013b).

Mayes et al. (2009) have reported that variety of treatments are generally used to help improve ADHD symptoms. Children are often given stimulant medications as the main form of treatment, in particular methylphenidate that is also known as Ritalin (Chowdhury, Elsworth, Viljoen, & Stein, 2003). Stimulants have an effect on the central nervous system that helps increase its activity, alertness, and arousal (Mayes et al., 2009). Stimulants have calming effects that help decrease some symptoms of ADHD like hyperactivity and impulsivity (NIMH, 2013a). Medications have also been shown to improve children's ability to focus, work, and learn as well as their physical coordination (NIMH, 2013). Different types of stimulant medications have been used to treat ADHD. These include methylphenidate (Ritalin), dextroamphetamine (Dexedrine), and mixed amphetamine salts (Adderall; NIMH, 2013a). Approximately 70-80% of children with ADHD are treated with pharmacological interventions. Stimulants have been found to reduce excessive motor activity and impulsive behaviors, characteristics of those diagnosed with ADHD (Franklin et al., 2006). A study conducted by the NIMH and the U.S. Department of Education's Office of Special Education Programs demonstrated how core interventions have been found to reduce ADHD symptoms (Fowler, 2002). These interventions consist of education about the disorder for the patient, parent, and teacher; medication; behavioral therapy; and other environmental supports including an appropriate school program (Fowler, 2002).

In a longitudinal study conducted on 158 young children diagnosed with hyperactivity, it was found that stimulant therapy for ADHD children is not associated

with increased risk of adolescent experimentation with substance use (Fischer, & Barkley, 2003). The study concluded that there was no correlation between stimulant therapy for ADHD and increased risk for substance use in adolescence or adulthood (Fischer & Barkley, 2003). Conversely, the study demonstrated that stimulant therapy in high school may be a protective factor against the use of hallucinogens in adulthood (Fischer & Barkley, 2003).

Giving immediate feedback has been found to be effective in behavioral approaches to improve children's attention (Clay, 2013). There are several behavioral interventions that continue to be developed to aid parents, teachers, and others assist children's abilities to focus and control their impulses (Clay, 2013). Children who display ADHD symptoms are often prescribed medications by pediatricians without any other alternatives (APA, 2013). Professor Neef from Ohio State University stated that stimulant medications are the most common treatment for ADHD without knowing a lot about the long-term side effects (Clay, 2013). In addition, stimulant medications do not address problems that are related to academic performance, social interaction, and family relationships (Clay, 2013). According to Clay (2013), healthy living can help children with ADHD maintain their focus organically. Research conducted by Pontific, from Michigan State suggested that exercise is an intervention that can help children with ADHD focus and improve their academic performance (Clay, 2013). Pontific's research found that children who spend at least 20 minutes a day in a recreational activity or quietly reading performed better on math and reading comprehension tests after exercising (Clay, 2013). It has been reported that 2.7 million youth ages 4-17 years (66.3%) were reported to be on medication treatment for ADHD (CDC, 2010).

Dance/Movement Therapy (DMT)

Studies have shown that prescribing medication for ADHD is necessary, but not sufficient (Charach et al., 2006; Chronis, Jones, & Raggi, 2006; Salmeron, 2009). The child needs to be viewed holistically and not just by the symptoms he or she displays (Mattox & Harder, 2007). Tools to cope with ADHD need to be provided to families (Hack et al., 2010). A study conducted by Singer (2006) on children affected by the war in Serbia demonstrated that DMT might support the psychosocial development of children by allowing them to express their emotions and experiences thereby transforming them. A study completed by Capello (2008) on DMT with children in different parts of the world (Israel, Spain, Germany, Japan, Korea, Argentina, France, Finland, Egypt, Sierra Leone, India, Norway, and Haiti) found that this therapy has a beneficial impact on children's development, regardless of cultural and societal norms that affect raising children. Children with ADHD have trouble with body tension, poor body image, self-regulating, and uncoordinated movement (Zilius, 2010). According to Zilius (2010), DMT is a possible treatment to address these issues (Zilius, 2010).

Azrin, Ehle, and Beaumont (2013) found that age-appropriate reinforcers are effective in increasing attentiveness and calmness in children with ADHD. The study concluded that engaging in physical activity was an effective reinforcer for treating children with ADHD (Azrin et al., 2013). Children with ADHD can benefit from exercise, because movement and exercise have been found to increase dopamine in the human brain, similar to what the stimulus does (Gronlund, Renck, & Weibull, 2005). DMT can be an alternative to movement and exercise alone. ADHD treatment includes medical treatment and a variety of psychotherapy methods alone or in combination.

Alternative treatments consist of art therapies, dance, drama, and music therapy (Gronlund et al., 2005). According to Gronlund et al. (2005), dance therapy is an effective creative art therapy given that it involves both the body and emotions as instruments of change.

A study conducted in the Uppsala University in Sweden investigated children's understanding of emotions in dance movements (Lagerlof & Djerf, 2009). Lagerlof and Djerf (2009) stated that communication of emotions is important for personal development; it helps regulate behavior in relation to peers and others. A study conducted on the effects of dance therapy for young girls diagnosed with depression concluded that dance therapy is psychotherapeutic and effective (Kock & Brauning, 2006).

DMT consists of several levels of body awareness, affect, use of space, and relationships (Kock & Brauning, 2006). It involves a definite learning of different aspects of self and relationships (Kock & Brauning, 2006). DMT uses different approaches such as expressive movement, creative dance, role-playing, and gross motor activities (Erfer & Ziv, 2006). It also uses perceptual motor activities and a combination of structured and improvised movement experiences (Erfer & Ziv, 2006). The goal of DMT is to develop group awareness, interaction, and cohesion. According to Erfer and Ziv (2006), the development of body image and group awareness are important elements of dance/movement therapy when working with children.

A study conducted with children ages 5-8 years old on a short-term inpatient psychiatric unit found that dance/movement therapy was a valuable treatment for creating unity in groups of children who have been labeled as disorganized and chaotic (Erfer &

Ziv, 2006). Within this group, changes in behavior were observed and impulse control, frustration tolerance, gratification delay, and the ability to get along with others improved (Erfer & Ziv, 2006). The study concluded that DMT is a therapeutic treatment that is effective in promoting group cohesion (Erfer & Ziv, 2006). DMT is a form of communication where children learn about the world through body experiences that express their emotional, social, physical, and cognitive development (Erfer & Ziv, 2006). Dance/Movement therapy is described as “a process that enables children to engage in meaningful exploration of the self, the environment, and others” (Erfer & Ziv, 2006, p. 240). Further research is needed to support dance therapy work with children who have behavioral problems.

ADHD and Diverse Populations

African American and Latino populations have been found to have lower rates of ADHD than Caucasian populations (APA, 2013). In a national survey of U.S. health statistics, it was found that Hispanic children (6%) were less likely to have ADHD than non-Hispanic white (10%) and non-Hispanic black (9%) children (CDC, 2013). According to the APA (2013), ADHD occurs in most cultures in about 5% of children and 2.5% of adults, based on population surveys. Limited research has been performed with individuals with ADHD from diverse ethnic, gender, age, and socio-economic status groups (Mattox & Harder, 2007). Many studies have been done on white, male individuals, but little emphasis has been put on diversity and cultural differences (Dwivedi & Banhatti, 2005; Mattox & Harder, 2007). Mattox and Harder (2007) explained that in the past, diversity variables have been overlooked for the most part in assessment, diagnosis, and treatment of children with ADHD. Mattox and Harder (2007)

argued that even though the person is treated within his/her environment, it is important to consider culture, ethnicity, age gender, and socio economic status. Considering these variables is important in order to provide appropriate evaluations and treatment (Mattox & Harder, 2007).

According to Mattox and Harder (2007), very few studies have been conducted among ADHD culturally diverse groups in the United States. According to the CDC (2005), prevalence does not seem to vary by race in the United States. Further research is needed to address the influence of ethnicity on ADHD. According to Dwivedi and Banhatti (2005), cultural environment may affect a child's behaviors due to different cultural views of parents and society. Culture also affects many issues related to mental health, such as behavioral expectations and patience, language, emotion, attention, attachment, traumatic experiences, conduct, personality, motivation, and setting limits (Dwivedi & Banhatti, 2005). Parenting style and child rearing is also important in understanding how culture plays a role (Dwivedi & Banhatti, 2005). Research by Bokhari, Heiland, Levine, and Ray (2008) illustrated that African American, Hispanic, and Asian children are about 39% more likely to discontinue drug therapy in a given month compared to White children.

The Latino population is one of the fastest growing ethnic minorities in the United States (U.S. Census Bureau, 2000). Practical and cultural barriers are important in understanding the reasons many Latinos do not seek mental health services (Haack et al., 2011). Practical barriers consist of lack of insurance, low socioeconomic status, limited parental education, and transportation problems (Alegria et al., 2007). Cultural barriers include immigration and citizenship status, stigma and negative beliefs towards mental

health treatment, unfamiliarity with and lack of trust of providers, and lack of appropriate bilingual/bicultural providers (Haack et al., 2011). Language barriers are the most reported barriers that prevent the Latino population from receiving mental health services (Alegria et al., 2007). The lack of English fluency makes it difficult for Latino parents to advocate for appropriate services for their children and communicate with professionals (Alegria et al., 2007). The language barrier makes it challenging to understand and read assessments and treatment procedures (Haack et al., 2011). Many parental/family functioning measures are not available in Spanish and culturally and linguistically appropriate assortments have not yet been created (Haack & Gerdes, 2011). Haack and Gerdes (2011) noted that this work is necessary to begin providing culturally appropriate services. In addition, many Latinos value cultural traditions and family closeness over the needs of an individual. Latino families that have these values may be more understanding and accepting of their children's behaviors and less likely to view their behaviors as problematic. They may view the behaviors as a typical part of their development (Haack & Gerdes, 2011).

African American children with ADHD who are living in poverty are less likely to receive mental health services in the United States despite being the most likely to be referred to mental health agencies for services (Tucker & Dixon, 2009). According to Stevens, Harman, and Kelleher (2005), African American children are less likely to receive ADHD treatment through medical interventions than their peers. African Americans continue to experience disadvantages that do not allow them upward mobility and achievement of socioeconomic equality (Harris, 2010). African Americans continue to demonstrate disadvantages across socioeconomic and educational measures (Harris,

2010). According to Cuffe, Moore and McKeown (2005), diverse factors may impact differences in ADHD diagnoses among ethnic and gender groups, such as accurate assessment and diagnosis for African Americans and cultural differences in views of children's behavior. Additional factors include the impact of poverty on children's access to care and possible bias and discrimination among school personnel and mental health professionals (Cuffe et al., 2005). A study conducted by Miller, Nigg, and Miller (2009) found that African American boys have higher rates of problem behaviors compared to European American boys despite the socioeconomic status. The study found that African American boys are less likely to receive a diagnosis of ADHD (Miller et al., 2009). This may be due to the inaccessibility of mental health care as well as different parental views of mental health treatment and risk factors (Miller et al., 2009). Ayalon and Alvidrez (2007) reported that African American parents/caregivers not always access mental health care due to the cultural stigma and discrimination by mental health care personnel.

Nguyen et al.'s (2004) study of psychiatric diagnoses and clinical characteristics of Asian American children and adolescents enrolled in children's services found that Asian Americans were more likely to have severe functional impairment within role performance, self-harm behavior, and thinking when compared to children of other races and ethnic backgrounds within the child welfare system. Few studies are available on mental health disorders and mental health service usage among Asian American children. Nguyen et al. (2004) stated that attention disorders and conduct disorders are less reported among Asian Americans compared with other ethnic minority groups. Asian

Americans continue being underrepresented in the public mental health services (Nguyen et al., 2004).

Parent support groups/psycho-education

Educating parents about ADHD is beneficial. Family psychoeducational interventions were created to help support families and help them cope with the challenges of mental illness (Murray-Swank et al., 2007). Psychoeducation provides education and therapeutic interventions from trained professionals. Psychoeducation provides various types of psychotherapeutic interventions and psychosocial treatment strategies that allow the individual to be part of their own healing process (Bauml, Frobose, Kraemer, Rentrop, & Pitschel-Walz, 2006). Psychoeducation includes elements of client-centered therapy in several ways (Bauml et al., 2006). Psychoeducation can provide individual behavioral therapy, self-assertiveness training, problem-solving training, communication training, and additional family therapy interventions (Bauml et al., 2006). It also provides communication of information, reciprocal exchange of information among those involved, and education about the treatment and illness (Bauml et al., 2006).

According to the National Alliance of Mental Illness (2013), the focus of family psychoeducation is based on patient's outcomes and family members well being. According to Lukens and McFarlane (2006), psychoeducation provides several benefits for social functioning and well-being. According to Murray-Swank et al. (2007), family psychoeducation is highly effective in treating schizophrenia and other mental illness, but it is not used enough. Family psychoeducation interventions support families coping with the challenges of mental illness of a family member (Murray-Swank et al., 2007).

There are several models for family psychoeducation, but all models share essential fundamentals. These include being empathic, non-blaming, having an educational focus, and helping improve family communication and problems solving skills (Murray-Swank et al., 2007).

A review of literature showed that family psychoeducation is an evidence-based practice that supports the treatment of mental illnesses, including bipolar disorder and depression (McFarlane, Dixon, Lukens, & Lucksted, 2003; Murray-Swank et al., 2007). Family involvement has shown to be beneficial in psychoeducation. Outcomes associated with family psychoeducation include increased treatment participation, satisfaction with care, hope, knowledge, and empowerment among consumers (Murray-Swank et al., 2007; Prince, 2005).

A group of parents of children with ADHD, who participated in a quantitative study at the Dunstable Child and Adolescent Mental Health Service, found that group work was beneficial (Chowdhury, Elsworth, Viljoen, & Stein, 2003). Factors that parents felt were beneficial were learning from other parents, being able to express how they individually felt, realizing that they are not alone, and being able to receive practical advice about ADHD (Chowdhury, 2003). According to Corey, Corey, and Corey (2013), groups have a great impact and are powerful work to move people in a more creative and purposeful direction.

Group psychotherapy is an effective tool that is used as a form of therapy in treating a variety of psychological problems (Corey et al., 2013). Groups are being created for different settings and different client groups (Corey et al., 2013). Most groups are short-term groups and are aimed to assist specific client populations (Corey et al.,

2013). In Chowdhury et al.'s (2003) study, they found that it was important to offer parents behavioral management skills to assist their children with ADHD. Groups provide a natural setting that help people feel supported and not alone, giving them a sense of hope (Corey et al., 2013). Groups also provide a sense of community that help provide a solution and relief to those who have felt alienated and isolated in the community in which they live (Corey et al., 2013).

For children, group play has been found to be helpful in assisting children manage their anger. Groups are also used in areas such as substance misuse, social skills, friendship, peer mediation, activity groups, and crisis intervention (Swefach & Laporte, 2012). Groups can help children interact with other children and build relationships while learning about themselves and others (Corey et al., 2010). Many insurance companies are encouraging the use of groups rather than individual therapy due to cost-effectiveness and efficiency (Swefach & Laporte, 2012).

Conclusion

ADHD is a prevalent problem in the United States that continues to affect many children (Hawthorne, 2010; Mattox, & Harder, 2007; Salmeron, 2009). ADHD is one of the most common childhood disorders that continue through adolescence and adulthood (Haack, Gerdes, Schneider, & Hurtado, 2010; Spencer, 2009). Symptoms include difficulty controlling behavior, staying focused, and paying attention, as well as hyperactivity (NIMH, 2008). Behavioral treatments have been shown to help children with ADHD to manage disruptive behaviors and inattention, build social skills, and improve academic performance (Bagner, & Eybert, 2007; Chronis, Jones, & Antle, 2006; Erk, 2000).

It has been shown that children with behavior problems are susceptible to experience serious mental health problems if they go untreated (NIMH, 2013). ADHD cannot be cured; however, it can be managed with treatment (CDC, 2013). There are several treatments available including medication, psychotherapy, behavioral services, and education (NIMH, 2008). Psychoeducation has also been found to be highly effective to assist family members to cope with everyday challenges due to having a family member who lives with a mental illness (Murray-Swank, 2007). DMT uses movement as an alternative therapeutic approach to treating ADHD symptoms (ADTA, 2013). DMT is a creative-art therapy that has been found to be helpful for patients with a variety of medical and psychological issues (Zilius, 2010). Extended research is needed to address culturally diverse groups in the United States regarding ADHD (Mattox & Harder, 2007).

CHAPTER 3
METHODOLOGY
Needs Assessment

The grant writer communicated with families whose child is diagnosed with ADHD at the agency Step by Step Edu-Play in order to seek out information about their needs and concerns. This information was important in obtaining data that will be used in the planning and implementation of the parents' and children's program. The parents' program will be translated into Spanish for Spanish speaking parents. Other sources of information and feedback were collected from the agency workers and the people at the Regional Center working directly with this population to create the program.

A comprehensive review of the literature and research on evidence-based practices regarding working with ADHD children and their families was used in order to understand the problem and support the need for this proposed program. The CDC (<http://www.cdc.gov/ncbddd/adhd/data.html>) and the NIH (www.hhs.gov) websites provided an extensive amount of information on demographic data, parental involvement, and economically disadvantaged and at-risk populations affected by ADHD. This information was useful in demonstrating the need for resources and the types of programs that are appropriate for this population. Scholarly journal articles also provided statistics and data that demonstrated the need.

Target Population

The target population for this proposed program will be school-aged children who are diagnosed with ADHD along with their parents or caregivers. ADHD affects children from diverse ethnicities (Haack et al., 2010). This proposed program will focus on children with ADHD of a diverse population residing in the Westside area of the city of Los Angeles and its surrounding communities. The program will include children ages 6 through 10 diagnosed with ADHD served at the agency Step by Step Edu-Play and/or referred by the Westside Regional Center. In addition to the children with ADHD already served by the agency (approximately 25 children), schools in the community and the regional center will also refer children.

According to the 2010 Census report, the Westside region of the city of Los Angeles had a total population of 529,427 (United States Census Bureau, 2010). It consists of 101.28 square miles, divided into 23 neighborhoods (“The Westside,” 2013). The ethnic/racial demographics for the Westside of the city of Los Angeles are as follows, Hispanic/Latino 15.7%, Asian 11.5%, White 63.3%, African American/Black 5.1%, and other 4.4% (“The Westside,” 2013). Step-By-Step Edu-Play serves school-aged children from the Los Angeles Unified School District (LAUSD), primarily from Brentwood Elementary, Brockton Elementary, Castle Heights Elementary, and Walgrove Elementary. According to Kidsdata.org (2012), the public school enrollment in Los Angeles County for 2012 is as follow, African American/Black 8.6%, Asian/Asian American 7.8%, Hispanic/Latino 63.8%, and White 15.0%. The agency’s clients come from a diverse background of African American, Hispanic, Asian, White, and mixed racial/ethnic people. They are of diverse socioeconomic statuses.

Identification of Potential Funding Source

Several approaches were used to identify potential funding sources. Grant databases and Internet searches were used to collect information about possible funding sources. Selecting and identifying possible funding sources were aided by Internet search such as Google, Google scholar, and Yahoo. Key terms such as grants, children, ADHD, parent groups, support groups, education, psycho-education, children's mental health, developmental disabilities, and families were used in locating possible grant funding databases.

One of the many potential websites used for locating possible funding sources was grants.gov, which provides access totaling approximately \$500 billion in annual awards, and provides over 1,000 grant programs and resources to numerous funding programs (http://Grants.gov/aboutgrants/about_grants_gov.jsp). Grants.gov is managed by the U.S. Department of Health and Human Services, which provides several federal grants (<http://www.grants.gov/>). The California Department of Mental Health (DMH), the ADDA, and the NIMH were also examined to identify potential funding sources.

The grant writer also contacted the Westside Regional Center. They provided some guidance in regard to federal and state funding sources that could be useful to fund ADHD programs. According to the Westside Regional Center staff, currently there are no funding opportunities for ADHD programs due to ADHD not meeting the eligibility requirements for funding purposes.

The Main Library of Santa Monica, California was used to search for potential funding sources. The Main Library of Santa Monica provides access to the Foundation Center, which is an online database that provides access to several grant makers and

companies for grant seekers (foundatiocenter.org). The Foundation Center's directory maps grants for grant seekers worldwide, and allows for an analysis from 150 different need-based data sets. The data set gives a detailed description of foundations.

Accessing the Foundationcenter.org website returned a large amount of foundations that fulfilled the grant writer's requirements. Additional key terms had to be used as well as combined. Search limitations consisted of geographic restrictions. Grants awarding more than \$100,000 were considered and kept as potential funding sources. The grant writer was more successful when accessing the power search tool using several combined key terms. Through this search, there were several possible grant-funding sources taken into consideration, the Ahmanson Foundation, the Atlas Family Foundation, the California Endowment Foundation and the Weingart Foundation. After researching and examining these funders, the Ahmanson Foundation, the Atlas Family Foundation, the California Endowment Foundation, and the Weingart Foundation were found to not be a match for the purpose of this grant program. Many factors were considered such as geographical location, age restrictions, deadlines, agencies' profit/non-profit status, and the amount of money the foundation was willing to fund. The Hearst Foundation was the grant funder that was found to be the most appropriate for this project proposal. Their main goal is to ensure that people of all backgrounds have the opportunity to build healthy, productive, and inspiring lives (the Hearst Foundation, 2013).

The Hearst Foundation

The Hearst Foundation's purpose matched with this proposed project and best met the needs for this project. William Randolph Hearst founded the Hearst Foundation, Inc.

in 1948. The Hearst Foundation is known to be a national philanthropic resource for organizations working on culture, education, health, and social services. Throughout its history, the foundation has made over 19,000 grants that have totaled more than \$925 million. Currently, the Hearst Foundations assets are approximately \$825 million. The Hearst Foundation's goals are: to work towards increasing academic achievement and affordable educational options for youth, improve health and quality of life in the United States, ensure the role of the arts and sciences, provide access to and training for employment and careers for adults, and stabilize and support families (The Hearst Foundation, 2013).

The Hearst Foundation (2013) granted 269 grants in 2011 totaling \$34,15,000 and 241 grants in 2010 totaling \$24,515,00. The Hearst Foundation has a high priority of addressing the needs of low-income populations. The Hearst Foundation focuses on strengthening families and funding cultural institutions that offer meaningful programs in the arts and sciences. The foundation also focuses largely on higher education and funding innovative models of early childhood and K-12 education. The foundation is committed to help grow and impact programs that will create long-term, wide-scale improvements in the nation.

Host Agency

Step by Step Edu-play serves a diverse population of children and their families in an effort to provide services for special needs children and children facing global developmental delays (Step By Step Edu-play, 2013). The total number of families served is more than 200 (Step by Step Edu-play, 2013). The age range of the children is

from birth to 18 years of age. Step By Step Edu-Play receives many referrals from the Westside Regional Center.

The special needs population that is served at Step by Step Edu-Play includes children with ADHD, autism, speech delay, motor delay, Down's syndrome, and cerebral palsy. Step by Step Edu-Play's funding derives from fees for rendered services, fundraising, and financial support from various organizations such as Tools for Intervention and Practical Strategies (T.I.P.S.). T.I.P.S. is a foundation that raises funds to support programs and projects that enhance opportunities for prevention and intervention related to developmental disabilities (Step-By-Step Edu-play, 2013). Step by Step Edu-Play's major source of funding is directly through the Regional Center. The Regional Center provides services for and supports individuals with developmental disabilities throughout the Westside of Los Angeles. Step by Step Edu-Play is a contracted agency that provides services for the Regional Center (Step by Step Edu-play, 2013). These services and supports are provided through a combination of federal, state, county, and local government funding. Step by Step Edu-Play provides services by their professionals and volunteers (Step by Step Edu-play, 2013).

The owner, Shelley Cox, Executive Director, founded Step by Step Edu-Play in 1999. The emphasis of her practice is on the "growth and development of families who have children with developmental delays" (Step by Step Edu-play, 2013, p. 1). Her overall vision for all children with disabilities and their families is that they are provided resources to be able to become as independent as they can be and be active participants in their community with their friends and family (Step by Step Edu-play, 2013).

Step by Step Edu-Play provides an array of services. These include prenatal and perinatal parenting, early childhood classes, early intervention, social skills training, behavior intervention, the behavior respite program, occupational therapy, speech therapy, psychological assessment and counseling, adult education, parent education groups, and resources for providers and services (Step by Step Edu-play, 2013). Specialized services include in-home services, agency-based services, and community programs (Step by Step Edu-play, 2013).

Step by Step Edu-Play's mission statement endorses collaborative partnerships, creative programming, education, and enjoyable activities (Step by Step Edu-play, 2013). The organization helps to increase children's motivation to succeed and advocates for positive inclusion of children with disabilities as well as developing children (Step by Step Edu-play, 2013, p. 4). Step By Step Edu-Play's purpose is to provide an environment where children can have the opportunity to learn and play whether they are developmentally delayed or gifted. Step by Step Edu-Play believes that their intervention programs and services are an addition to programs in the community and family involvement. The agency strives for collaborative partnerships and integrated programming (Step by Step Edu-Play, 2013).

CHAPTER 4
GRANT PROPOSAL
Background and Needs

According to the NIMH, ADHD affects about 9.0% of United States children (NIMH, 2013). According to the CDC (2013), about 1 in 10 children in the United States, ages 4-17, have been diagnosed with ADHD. ADHD continues to be one of the most common disorders among children and the symptoms can continue through adolescence and adulthood (NIH, 2013). Pastor and Reuben (2008) reported that 4.5 million children between the ages of 5 and 17 were diagnosed with ADHD in 2006. These numbers have risen over the past decade as well as the number of children taking psychotropic medications for this mental disorder (Pastor & Reuben, 2008).

ADHD has become an important economic and social issue that needs to be addressed. Pelham, Foster, and Robb (2007) reported that in 2005, children diagnosed with ADHD had an economic impact on educational and medical services of \$36-\$52 billion (Pelham et al., 2007). The CDC (2013) reported that the costs associated with ADHD and children are approximately \$38 billion or more annually.

Children with ADHD are affected in several ways. It may cause difficulty in school, home, and socially with friends (CDC, 2013). Children with ADHD may have more conflicts with family and peers, more rejection by peers, and fewer friendships (Taylor & Kuo, 2011). Children with ADHD have difficulty in school because school requires children to pay attention and control behavior and impulses. These reactions are

very hard to control for children affected by ADHD symptoms (NICHCY, 2012). Having ADHD makes it very difficult for children to learn due to the inability to pay attention, listen, and follow directions (CDC, 2013).

The U.S. Food and Drug Administration reported that a combination of behavioral therapy and medication for ADHD was found to be more helpful to manage and modify some of the problem-causing behaviors than using only one method (FDA, 2011). According to the FDA (2011), if ADHD goes untreated, it can have serious consequences such as falling behind in school, difficulties sustaining friendships, and conflict with parents/family. Children who have ADHD and go untreated have more visits to the emergency rooms and are more likely to have self-inflicted injuries than those who are treated for ADHD (FDA, 2011). According to Zilius (2010), Dance Movement Therapy (DMT) is a creative-art therapy that is found to be helpful for patients with medical and psychological issues. The mind–body connection is a foundation of DMT. It is a creative-art therapy designed to improve bonding, reduce behavioral issues, and increase self-regulation (Zilius, 2010). Children with ADHD are often shamed about their behavior and impulsivity. DMT allows children with ADHD to release energy productively while working with their feelings and emotions (Zilius, 2010).

Proposal

The purpose of this grant is to acquire funding for a DMT class for children, ages 6-10, diagnosed with ADHD. The goal of the program is to provide children living with ADHD a positive alternative to release energy productively and help address issues related to ADHD. The DMT group will incorporate a type of support group for children

through a Dance/Movement class. The DMT, used in groups, will assist the children with releasing negative feelings in a positive outlet. It will help children process their feelings associated with having ADHD and give them the opportunity to build healthy relationships with other children who are also dealing with ADHD. A Dance/Movement therapist and one Licensed Social Worker with group work experience who are both culturally competent and fully trained will co-facilitate the DMT group.

In addition, this project will include a psycho-education support group for the parents/caregivers of the children in the program. The psychoeducational support group is to educate parents/caregivers about ADHD and give them resources in their community. The psychoeducational support group will help parents/caregivers learn about ADHD, learn strategies for managing their child's behavior, educate them about diagnosis and treatment, give them information about medication and school programming and supports, and most importantly, give them an opportunity to talk to other parents/caregivers for support.

The period of the program's implementation will be 1 year. The program (children's and parent's/caregiver's) will run for 8 weeks, six times per year. The DMT class and concurrent parent psychoeducational support group will be held one day a week for an hour. The group will consist of 8 children between the ages of 6 and 10. The DMT class will take place once a week for a one-hour session for a total of 8 weeks. Parents/caregivers will be able to attend a psychoeducational support group facilitated by an MSW while their child is attending the DMT class. Childcare will be provided for additional siblings. After the completion of 8 weeks, the children's group and support

group for parents will be available for new families. The DMT and parent psycho-education support group will serve individuals and families at Step By Step Edu-Play.

Step By Step Edu-Play is a community-based agency that provides clinical and educational programs for a diverse population that. It was established in 1999 by Shelley P. Cox, MA, Executive Director. Step By Step Edu-Play serves children from birth to adulthood as well as their families. The program includes home-based early intervention services from birth-18 months (“infant stimulation”); center-based intervention programs that incorporate occupational therapy, speech therapy, social skills training; and inclusion programs, after school programs; behavioral intervention; behavioral respite; and adult community integration.

Objectives and Outcomes

The overall goal of the program is to help children diagnosed with ADHD decrease ADHD symptoms of hyperactivity/impulsivity and/or inattentiveness. The goal is to increase attention through a positive outlet and educate parents/caregivers about how to best support their children.

The specific objectives for the DMT group are:

1. Effectively communicate emotions
2. Improve attention and focus
3. Release energy appropriately and encourage positive outlets for negative

feelings

4. Improve self-esteem

The projected outcomes for the DMT group are:

1. Children will explore their feelings through dance and music. They will

communicate their feelings and emotions more effectively. Children will identify and express their feelings and have a better understanding of themselves and others. Children will feel better about themselves as measured by the parents'/caregivers' posttests. A 50% improvement will be demonstrated.

2. Children will have the ability to learn how to improve their attention and focus by the structured and calm environment that the DMT class offers. Children will be able to practice these techniques by using soft tones, maintain relaxed postures, and follow movement patterns. Parents/caregivers will report a 50% improvement in their child's behavior as demonstrated on the parents/caregivers' post-tests.

3. Through DMT, children will have the opportunity to release energy productively. Therapists will work towards helping children connect to their emotional and physical selves. Through DMT, children will have the opportunity to release any negative feelings in a positive outlet. The therapist will work with the children to help them process their feelings through creative ways using DMT, in order to decrease disruptive behaviors and increase their ability to work with their emotions through DMT. Parents/caregivers will report a 50% improvement in their child's behavior as demonstrated on the parents/caregivers' post-tests.

4. Children will gain self-esteem and feel empowered. Children will gain confidence in their ability to work together in the DMT group. Children will gain confidence in learning how express their feelings and being able to release any negative feelings in a positive outlet. Children will learn coping skills through DMT. Children will feel more positive about themselves as measured by the parents'/caregivers' posttests. A 50% improvement will be demonstrated.

The specific objectives for the psychoeducation support groups for parents/caregivers are:

1. Educate parents/caregivers about ADHD
2. Learn about strategies for managing children's behaviors
3. Educate about treatment options
4. Build support among group members and provide additional resources in the

community.

The projected outcomes for the psychoeducational support groups are:

1. Parents/caregivers will learn about the symptoms and signs of ADHD. They will also learn about the comorbid diagnoses that are often associated with ADHD. In addition, parents/caregivers will learn how to differentiate normal developmental milestone behavior from what is not developmentally appropriate. Parents/caregivers will improve their knowledge from pre-to post-test at a significant level.

2. Parents/caregivers will learn intervention tools to help build on their children's abilities, strengths, and talents. They will also learn strategies for managing their children's behaviors (e.g., praising, setting clear rules, charting, rewarding, ignoring behaviors, giving natural consequences, etc.). Parents/caregivers will improve their behavioral management skills from pre-to post-test at a significant level.

3. Parents/caregivers will learn about the several treatments available for ADHD along with parent training in child behavior management. They will be educated about the various types of psychotherapy, psychosocial treatment, and or a combination of treatments. Parents/caregivers will also be educated on the use of stimulant medications used to treat ADHD, along with the risk factors associated with those medications. A psychiatrist will attend one session to educate parents about medications and how

medication use should be monitored for progress or to detect any problems. The psychiatrist will educate parents on stimulant medications and the myths about this type of treatment. Parents/caregivers will improve their knowledge about several treatments for ADHD as measured by pre-to post-test improvement at a significant level.

4. Parents/caregivers will be able to build a support system with the group members. The group will provide emotional and practical support to parents/caregivers raising children with ADHD. The group will give the members an opportunity to discuss their concerns and learn coping skills to deal with everyday challenges of raising a child with ADHD. Parents will express satisfaction with the group experience at post-test.

Evaluation

In order to verify the influence and the effectiveness of the program, an assessment will be conducted. For the parent/caregivers in the psychoeducation support group, a pre-test will be given in the beginning of the group. The pre-test will assess the parents' knowledge of ADHD and their behavioral management skills. It will also measure children's behavior from the parents' perspective. A post-test will be given at the end of the group session. The evaluator will help monitor members' progress and group success. Verbal feedback from members and children at the end of each session will also be solicited in order to make necessary changes to improve the quality of the program. A final verbal evaluation will also be conducted to measure all variables as well as satisfaction with the group experience.

Budget Narrative

The estimated budget for the proposed program for 1 year will be \$158,240, which includes in kind support of \$55,000. Therefore, the amount sought from the

Hearst Foundation is \$103,240. The budget includes staff salaries as well as other direct and indirect costs. Beside staff salaries and benefits, direct program costs will include supplies, such as yoga balls and other instructional materials for the DMT class. The direct operating costs will allow for the purchase of refreshments, office supplies, handouts (printing materials), a projector, a laptop, and advertising for the program. Administrative costs and evaluations will be covered under indirect costs. The space for the children's group, the parents' group, and the childcare room are in-kind contributions by the agency.

The Program Director will be a part-time employee who will be paid \$70.00 per hour for 20 hours per week for 48 weeks, totaling \$67,200. There will be no benefits provided for the part-time staff, including the Program Director. The Program Director will be a Licensed Clinical Social Worker (LCSW) who is bilingual (English and Spanish). A further requirement that the Program Director will have to meet is a minimum of 4 years of professional experience in group work with families and children in the mental health field. The Program Director will be responsible for implementing the overall structure of the program and will facilitate the parent psycho-educational support group. He/she will be responsible for the management of the team and run supervision meetings.

The Dance and Movement Therapist, a part-time therapist with a Masters in Expressive Therapies: Dance Therapy with a specialization in Mental Health Counseling, will be paid \$60.00 per hour for 4 hours per week for 48 weeks, totaling \$11,520. The Dance and Movement Therapist will have experience in working with

ADHD children 6-10 years of age from diverse backgrounds. The Dance Movement Therapist will be responsible for running the DMT group class.

The social group worker will have a Masters in Social Work (MSW) and 2 years experience facilitating groups with a specialization in children and families. The social group worker will be a part-time employee who will be paid \$60.00 per hour for 4 hours per week for 48 weeks, totaling \$11,520. The social group worker will also have experience in working with ADHD children and families from diverse backgrounds. The social group worker will support the Dance Movement Therapist and incorporate group work with the population being served.

The proposed budget allows for the hiring of two teacher aides with a background in early child-development to provide childcare for additional siblings. The salary will be \$30.00 an hour for 1.5 hours a week for 40 weeks, totaling \$3,600.

The budget will support contracting with a bilingual psychiatrist (English and Spanish) to provide a psychoeducational lecture that will include information about the use of medications that are commonly prescribed. The psychiatrist will guest lecture during one session of the psychoeducational parent support group. The group will take place six times per year. The consulting Psychiatrist will be paid \$150.00 per presentation.

Timeline

Month 1:

1. Recruit Program Director and program staff.
2. Program staff meet to coordinate the structure of the program
3. Create Registration packets

4. Distribute of flyers
5. Recruit members
6. Develop pre- and post-test and evaluation forms
7. Purchase supplies, equipment, and materials.

Months 2 and 3:

1. First DMT group class and parent/caregiver psychoeducation support group will be held.
2. Group goals and purpose will be established for both DMT group and parent/caregiver psychoeducational support group.
3. Weekly supervision meetings will be held with staff.
4. Children will complete 8 weeks of DMT and parent/caregivers will complete 8 weeks of parent psychoeducation support group.
5. Distribute and collect all pre-and post-tests.
6. Pre-and post-tests will be evaluated by the Program Director.
7. Celebrations will be held upon completion of first groups.
8. Recruitment for second groups will be conducted.

Months 4 and 5:

1. Based on evaluations from previous class, changes will be implemented.
2. Begin Second DMT group class and parent/caregiver psychoeducation support group.
3. Group goals and purpose will be established for both DMT group and parent/caregiver psychoeducational support group.
4. Children will complete 8 weeks of DMT and parent/caregivers will

complete 8 weeks of parent psychoeducation support group.

5. Distribute and collect all pre-and post-tests.
6. Pre-and post-tests, will be evaluated by the Program Director.
7. Weekly supervision meetings will be held with staff.
8. Celebrations will be held upon completion.
9. Recruitment for third set of groups.

Months 6 and 7:

1. Begin third DMT group class and parent/caregiver psychoeducation support group.
2. Continue recruiting new members.
3. Same steps as in months 4 and 5 will take place.

Months 8 and 9:

1. Begin fourth DMT group class and parent/caregiver psychoeducation support group.
2. Continue recruiting new members and creating changes based on evaluations.
3. Same steps as in months 4 and 5 will take place.

Months 10 and 11:

1. Begin fifth DMT group class and parent/caregiver psychoeducation support group.

Month 12:

1. Begin sixth DMT group class and parent/caregiver psychoeducation support group.
2. Classes and groups will be held twice a week rather than one a week.
3. Group goals and purpose will be established for both DMT group and parent/caregiver psychoeducation support group.
4. Distribute and collect all pre-and post-tests.
5. Pre-and post-tests evaluated by the Program Director.
6. Weekly supervision meetings will be held with staff.
7. Children will complete eight sessions of DMT and parent/caregivers will complete eight sessions of parent psychoeducation support group.
8. Celebrations will be held upon completion.
9. A report will be sent to the foundation regarding the year's progress.
10. Apply for a new grant for sustainability.

TABLE 1. Line-Item Budget

Budget Request--Fiscal Year July 2014-June 2015

Dance Therapy and Psychoeducational Groups for ADHD

EXPENDITURES	AMOUNT	IN-KIND SUPPORT
PERSONNEL		
Program Director (LCSW) – PTE	\$67,200	
DMT Therapist (MA) – PTE	\$11,520	
Social Group Worker (MSW) – PTE	\$11,520	
Teacher Aides (2, BA) – PTE	\$3,600	
Psychiatrist (contracted only)	\$900	
Total Personnel	\$94,740	
NON-PERSONNEL		
DMT equipment (yoga ball, iPod)	\$1,500	
Refreshments	\$1,000	
Office supplies (paper, pens, staples)	\$1,500	
Printing (handouts, flyers, advertising)	\$2,000	
Projector	\$1,000	
Laptop	\$1,500	
Total Non-Personnel	\$8,500	
OTHER COSTS		
Rent and utilities		\$50,000
Telephone and fax		\$5,000
Total Other Costs		\$55,000
SUBTOTAL PROJECT EXPENSES	\$103,240	\$55,000
TOTAL BUDGET REQUEST	\$103,240	

CHAPTER 5

LESSONS LEARNED

Looking for a Funding Source

The grant identification process was challenging due to the writer having no grant writing experience. The writer gained knowledge through this grant writing process. Several sources were utilized to find potential funders for this grant. The grant writer used grant databases and Internet searches to locate information about possible funding sources. The grant writer used Google Search, Google Scholar, and Yahoo search engines. One of the websites that the grant writer used to locate possible funding sources was grants.gov. The grant writer learned that this website only funds federal grants, primarily for large research projects.

The grant writer learned that it is challenging to locate possible grant funders online without a subscription. The grant writer found it difficult to search online due to her lack of knowledge and difficulty navigating web pages. There were several difficulties that the grant writer also faced while searching for potential grant funders. It was difficult to understand some of the terminology used for program development. Another difficulty was evaluating each grant to verify that the proposal met with the grant funder's requirements and also that the grant funder met the writer's requirements. The requirements of the grant funders were difficult to fulfill due to limitations. Several grant funders had to be eliminated because they did not match the grant writer's criteria, making it difficult to find a perfect match.

The grant writer found it beneficial to use the Main Library of Santa Monica to access their online database, the Foundation Center (foundationcenter.org). This database gave a detailed description of foundations. The database was useful for the grant writer because it provided a large amount of foundations that fulfilled the grant writer's requirements.

The grant writer gained knowledge about strategies for identifying and selecting potential funding sources. Through this process, the grant writer learned about several types of grant applications. The grant writer also learned about the process required for grant funding. Most grants require an initial letter of intent. Most grant applications ask information about how the project will be sustained, the expected results of a program, a statement of the problem, population to be served, information about the sponsoring organization, geographic location, and how the project will be evaluated.

Challenges

The grant writer experienced several challenges while writing this grant proposal. The grant writer had to learn step by step how to create a successful grant. Creating the program goals and objectives along with the timeline and budget for the grant was challenging due to her lack of knowledge of program development and budgeting. The program's goals and objectives had to be realistic and measurable, which developed the writer's critical thinking skills.

Lastly, personal challenges were associated with having to multitask and manage time effectively. Creating a thesis along with other schoolwork and sustaining family responsibilities were the most challenging aspects of the grant writing process.

Implications for Social Work Practice

An overarching goal for social workers is to help those in need and address social problems (NASW, 2013). The primary mission of the social work profession is to enhance the well-being of all people by ensuring that basic needs are met. The profession especially works to assist those who are most vulnerable and oppressed (NASW, 2013). ADHD is a social problem that affects many children and their families. Children diagnosed with ADHD are a vulnerable population that are often misunderstood and stigmatized. Due to the high number of children being diagnosed with ADHD, it is important to have programs available to help this population. Families also need to have access to more services and information regarding their child's mental health condition.

Social workers can support children with ADHD and their families in order to prevent school and social failure. Children with ADHD often have poor self-esteem and a poor sense of autonomy. Helping children with ADHD at a young age and their families with effective interventions can prevent delinquency, including drug and alcohol misuse. Social workers can offer ways to support children and their families through creative activities that are meaningful and supportive. This program will allow participants to learn how to release negative feelings effectively while learning coping skills to manage their behaviors and be successful. Parent/caregivers will become educated about ADHD and learn strategies to help manage their child's behaviors. This program will help build healthier and more positive relationships.

Relevance to Social Work Policy

Children with ADHD are often inadequately served, or are inappropriately served, in our communities. Social workers can be advocates for this population in order to

provide access to services. Grant writing can be challenging, but the needs for funding and services are high. Grant funding can help with the implementation of programs that will create social change for the most vulnerable and oppressed. Grant writing can help create effective programs that not only help children with ADHD but also help treat other mental health disabilities. It can also contribute to creating programs for social problems and economic hardships for the most vulnerable populations. This grant was created to provide services for children with ADHD and their families in a creative and productive way that is not stigmatizing. Social workers need to know the policies affecting this population in order to advocate for this population and their rights. Future grants can help social workers develop several programs for children with ADHD and their families to help break the stigma of receiving mental health services.

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