

THE IMPACT OF PARENT EDUCATION ON
PARTICIPATION AND SATISFACTION
IN MULTIDISCIPLINARY MEETINGS
FOR SPECIFIC LEARNING
DISABILITIES

By

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CHAPTER 1

INTRODUCTION

Parents are increasingly being seen as partners in special education (Sacks, 2001). The National Education Goals Panel (1998) also addresses parental participation, stating that all schools need to promote partnerships that will increase parental involvement and participation so as to promote the social, emotional, and academic growth of students. When students are suspected of having a disability, home-school collaboration is even more critical. Under Public Law 94-142 and the Individuals with Disabilities Education Act, initiatives to increase parent participation have been enacted (Fagan & Warden, 1996; IDEA, 1997). This parental participation is meant to go beyond attendance of classification meetings and Individualized Education Plan meetings, and giving permission to endorse school personnel decisions (Hoff, Fenton, Yoshida, & Kaufman, 1978; IDEA, 1997; Shriver & Kramer, 1993; Vaughn, Bos, Harrel, & Lasky, 1988; Wise, 1995). Rather, parents are seen as valuable members of the multidisciplinary team that makes important eligibility and IEP planning decisions (IDEA, 1997; Sacks, 2001). Parents are also seen as integral within regular education and the reasons for this importance pertain to parents in special education as well.

Parents as partners in education is an important concept for increasing student success in regular education (Dunst, Johanson, Rounds, Trivette, & Hamby, 1992). Collaboration through partnership empowers all parties involved (Rappaport, 1981; Whaley & Swadener, 1990). Partnerships with parents in education improve

student learning because parents view their child's success as directly related to the parents' participation (Rich, 1987). High achievement was associated with active, interested parents that provided educational experiences, helped with school work, developed their children's interest in reading, and took the initiative in contacting schools (Rankin, 1967). Parent involvement has been associated with better long-term achievement, and improved attendance and attitudes about school (Henderson, 1989; Kagan, 1984; Sattes, 1985). Parent involvement results in improved child functioning and improved school functioning (Henderson 1981; 1987). The importance of parental involvement for regular education students is strong evidence that involvement of parents is even more critical for students with difficulties.

Educators are encouraged to communicate with parents on a regular basis about successes and weaknesses of students in order to form partnerships (O'Shea et al., 2001). Face to face communication, phone communication, notes home, parent newsletters, and frequent parent conferences are suggested methods of maintaining the partnership. This communication establishes a precedent for further parent involvement. A negative standard may be set if the only time a parent is invited to school is to discuss difficulties. This is especially important when communication occurs with a parent who has a child in special education. These parents need consistent information about both strengths and areas that need improvement. Improved communication between school and parents could result in parent involvement prior to a school decision to do an evaluation for special education. This involvement could lead to better academic pre-referral interventions and decrease the number of special education referrals, particularly when learning difficulties are noted.

The most common referral concern that leads to a formal evaluation and special education classification is that of students displaying academic difficulties (Salvia & Ysseldyke, 1998). The number of students identified as having a disability during the academic year 1999-2000 reached 5,683,707 or 8.92% of the total population of school age children. Students who were identified under the category of specific learning disability numbered 2,871,966 or 4.5% (23rd Annual Report to Congress, 2002). Of the school aged population in Oklahoma 77,072 or 9.5% of children were identified as having a disability and students identified with a specific learning disability (SLD) totaled 43,502 (5.36%). Out of the school age population in Texas 457, 771 (9.0%) were identified as having a disability and students identified with a specific learning disability totaled 265,189 (4.45%). Since SLD is a high incidence disability it is important that schools develop partnerships with parents to ensure future success.

Unfortunately, the future for students with specific learning disabilities does not seem as promising as compared to regular education students (Capella, Roessler, & Hemmerla, 2002; Kavale, 1988; Reif & DeFur, 1992; Sacks, 2001; Shessel & Reiff, 1999; Spreen, 1988). Thirty-five percent of students with learning disabilities do not finish high school. Less than 2% who graduate from high school attend a 4-year college, despite that many are above average in intelligence. Only 14% of students with learning disabilities attended a post-secondary school program within 2 years of leaving high school. Sixty-two percent of students with learning disabilities were not fully employed one year after graduating from high school (Capella, Roessler, & Hemmerla, 2002; Reif & DeFur, 1992). Of the population of students with learning disabilities, 50-60% of adolescents were in treatment for substance abuse. Of eighth graders who were asked

about their educational aspirations, 17.8% expected to complete high school or graduate, 35.6% expected to have some post-secondary education, and 46.6% expected a bachelor's degree or higher. Approximately 29% of students with learning disabilities who received bachelor's degrees applied to graduate school compared to 40% in the overall population. Adults with learning disabilities experienced difficulties in daily living, social isolation, and damage to emotional health (Shessel & Reiff, 1999).

Parent Participation

A special education eligibility determination is required by law to be multidisciplinary, including the participation of parents (Fagan & Warden, 1996; IDEA, 1997). In practice though it becomes simplified to expedite matters and quickly move a student into special education (Bocian, Beebe, MacMillan, & Gresham, 1999; Frankenberger & Harper, 1985; Gartner & Lipsky, 1992; Gresham & Witt, 1997; Ysseldyke & Algozzine, 1982). Although on the face of it, this seems to be for the best interests of the student and parent, due process and thorough understanding may be compromised during the classification process. Proper classification procedures that effectively involve parents may not be used. Although the expedited method may be efficient for providing special education services, the comprehensive element is missing.

Parents are increasingly encouraged to take an active role in the classification and Individual Educational Plan meeting (Hoff, Fenton, Yoshida, & Kaufman, 1978; IDEA, 1997; Shriver & Kramer, 1993; Vaughn, Bos, Harrel, & Lasky, 1988; Wise, 1995). A critical question to be asked is whether parents truly are influential members of the multidisciplinary team because this may determine their level of participation in meetings (Gilliam, 1979). However, it is not known whether parents have enough knowledge to be

effective members of the multidisciplinary team. There is no dispute that the knowledge and information that parents provide for the evaluation of the child is important (O'Shea, O'Shea, Algozzine, & Hammitte, 2001). However, their role as child advocate could be enhanced if their knowledge of meeting procedures, parental rights, and criteria for eligibility was increased.

It is not until recently that parents were even required to attend classification and IEP meetings (Shriver & Kramer, 1993). Few studies have focused on classification meetings (Hoff, Fenton, Yoshida, & Kaufman, 1978; Vaughn, Bos, Harrell, & Lasky, 1988). Thus a dearth of information regarding parental knowledge of special education classification procedures and effective participation in classification meetings exists. Understanding parent involvement in classification meetings is of utmost importance as it sets the stage for parents' perceptions and expectations regarding their role during future Individual Education Plan (IEP) meetings. Parents who assume an active role can advocate so that their child receives the best and most appropriate services available.

More research has focused on parents attending IEP meetings (Gartner & Lipsky, 1992; Goldstein, Strickland, Turnbull, & Curry, 1980; McKinney & Hocutt, 1982; Polifka, 1981; Shriver & Kramer, 1993; Vacc, Vallecorsa, Parker, Bonner, Lester, Richardson, & Yates, 1985; Witt, Miller, McIntyre, & Smith, 1984) and these findings may generalize to classification meetings because important decisions regarding the outcome of the child are made at both meetings. The classification meeting and IEP meeting generally have the same members present and follow a similar procedure. Parents should have more involvement in special educational programming and should be given guidelines about scope and construction of general IEP goals prior to the meetings

in order to be more effectively involved (Polifka, 1981). More involvement and information could assist parents to be more effective in regard to classification procedures as well.

Findings from the few studies regarding classification meetings suggest parents tend to display a lack of understanding about eligibility decisions despite attending the classification meeting (Hoff et al., 1978; Vaughn et al., 1988). Even though parents attend meetings, the likelihood that parents have been actively involved in the process seems minimal. Parents have demonstrated they are unaware of their rights (Hoff et al., 1978; Lynch & Stein, 1982; McKinney & Hocutt, 1982; Vaughn et al., 1988). Parents also seem to have misconceptions regarding special education, such as how the classification process works and what their roles are in the proceedings. Some parents do not realize that they have the role of child advocate, information source, and important individual for the implementation of parts of a determined intervention (Goldstein et al., 1980; Vaughn et al., 1988; Witt et al., 1984). They often take the passive role of information recipient. They may also feel intimidated by the process, as they are usually the only non-professionals in attendance (Gartner & Lipsky, 1992; O'Shea et al., 2001; Wise, 1995). The use of unfamiliar terms and professional jargon does not add to the parent's perception that they can be a competent team member. Some parents have felt that the professionals made decisions prior to meeting and without them (Gartner & Lipsky, 1992). Increased training could assist parents in becoming more cognizant of what constitutes a special education eligibility determination and placement, and become more active participants so that they may be better advocates for their child and make informed decisions.

Parallels to the Medical Model

Medical, mental health and behavioral health settings employ multidisciplinary team meetings so that multiple contributions are made when diagnosing and forming treatment plans for patients (Stone, 1988). Parents have an increased ability to participate in the treatment of their child when they have substantive knowledge regarding the disorder that has been diagnosed. Informed consent is necessary for parents to actively participate in their child's treatment. Informed consent in this setting is seen as more than just a voluntarily made decision. Precautions are taken so that the patient is not coerced to make certain decisions (Roberts, 1995). These same precautions are taken for special education placement (IDEA, 1997). However, in special education there may be gray areas concerning covert pressure on the parent to make a decision that agrees with the team (Hoff et al., 1978). In special education an eligibility decision is made in the span of a one-hour meeting (Goldstein et al., 1980; Vaughn et al., 1988). Valdez (2002) suggests that an integral aspect of informed consent in the school setting is the inclusion of a prognosis for specific learning disabilities both with and without treatment. Parents who make program demands are often parents who are educated about the characteristics and the prognosis for the disability. These parents have a better understanding about the needs of their child. Increased training for parents whose child has been referred for an evaluation could lead to parents being better advocates.

When informed consent for an evaluation is obtained parents are usually alerted to the specific reason school personnel feel an evaluation is needed (Hoff et al., 1978). When the parent participates in the assessment process, they should be informed again about the purpose, course, and goal of the evaluation (Bailey & Wolery, 1992; Hawkins,

1979; O'Shea et al., 2001). Discussion with parents during the assessment process is important because the parent is probably aware of the possible classification for a specific learning disability and they are certain to have questions and concerns about learning disabilities (Hawkins, 1979; O'Shea et al., 2001). Parents with increased knowledge can give better information about their child as well as give input into their perception of appropriateness of the referral. This is important because minority children are often misclassified and inappropriately placed into special education (De Leon, Medina, & Ortiz, 1998; Duffy, Salvia, Tucker, & Ysseldyke, 1981; Finlan, 1992; Kavanaugh, 1994; Nagler, 1972; Ortiz & Maldonado-Colon, 1986; Talbert-Johnson, 2001).

Overrepresentation of Minorities

The reoccurring topic of overrepresentation of minorities in special education is a relevant factor in special education classifications (Artiles, Aguirre-Munoz, & Abedi, 1998; Bersoff, 1980; Jacobs, 1991; MacMillan & Reschly, 1998; Maheady, Algozzine, & Ysseldyke, 1984; Patton, 1998; Talbert-Johnson, 1998). At the root of this problem is the misclassification and inappropriate placement of minority students (De Leon, Medina, & Ortiz, 1998; Duffy, Salvia, Tucker, & Ysseldyke, 1981; Finlan, 1992; Kavanaugh, 1994; Nagler, 1972; Ortiz & Maldonado-Colon, 1986; Talbert-Johnson, 2001). Increased training and education for parents may decrease the likelihood of this occurrence (Nagler, 1972). Parents could act as informal regulators of the classification process given the proper training. This active participation could have a positive relationship with increased school personnel accuracy and accountability (Talbert-Johnson, 2001). Parents could dispel teacher misperceptions and demand equitable learning environments. Other

problems with classification also exist and an understanding of Special Education guidelines is needed to bring about positive change.

Special Education Guidelines and Problems

The Individuals with Disabilities Education Act outlines regulations for special education procedures (IDEA, 1997). These regulations specify types of disabilities, parent rights, evaluation policies, eligibility criteria and determination procedure, due process, and IEP policy. Even with detailed regulations in place, problems and misconceptions can impact eligibility determination (Salvia & Ysseldyke, 1998). Many students who often do not meet criteria for eligibility are referred and ultimately classified as learning disabled (MacMillan & Forness, 1998). Students who are difficult to teach and manage are often classified with a learning disability even if they don't meet classification criteria (Gerber, 1984). Decisions regarding eligibility seem to be more a factor of referral information rather than assessment information (Ysseldyke & Algozzine, 1982). Special education placement may be biased by the reason given for referral (O'Reilly, Northcraft, & Sabers, 1989; Salvia & Ysseldyke, 1998). Individuals displaying learning difficulties as well as overt behavior difficulties may be referred and ultimately classified learning disabled, whereas individuals displaying the same learning difficulties without marked disruptive behavior may not be referred. Educators form a hypothesis about what a child's classification should be and collect data to support their ideas. Alternative causes for a child's difficulties such as the educational environment may not be considered. Parents may play a role in reducing the amount of inappropriate placements if they are knowledgeable about what constitutes a specific classification being made.

It is also important to understand the specific components that influence a special education classification by a multidisciplinary team since criteria may vary or be disregarded, at least when making SLD classifications (Salvia & Ysseldyke, 1998). Research indicates that increased training and knowledge of professionals does not correlate with better decisions (Potter, Ysseldyke, Regan, & Algozzine, 1983). Parents could provide alternate views of the child's difficulties that the team would have to consider. Therefore parents with increased knowledge may play a significant role in the team exploring multiple hypotheses about the child's difficulties by serving as active members of the multidisciplinary team.

Even though multidisciplinary teams and conferences are required by law, there is wide variation in how these are constructed and function. Often professionals serving on a multidisciplinary team make subjective judgments about who is eligible and who is not eligible for SLD labels (Bocian, Beebe, MacMillan, & Gresham, 1999; MacMillan & Forness, 1998). Frequently low achieving girls without problem behaviors were not placed into a special education category, while boys who did not meet discrepancy criteria (a significant discrepancy between cognitive ability and achievement ability) for a SLD were placed (Bocian et al., 1999). Multidisciplinary teams are making eligibility classification decisions based on perceived educational need rather than discrepancy between test scores and other relevant information from extensive assessments by a school psychologist (Gresham, MacMillan, & Bocian, 1998; Gresham & Witt, 1997). Thus, many professionals tend to make classifications based on variables other than the actual criteria for the exceptionality and fail to classify when students do meet the criteria (Potter et al., 1983). Parents, who have more knowledge about the process and the

specific label that may be given to their child, may be able to serve more effectively on the team. Parents who have received training will have a better understanding of eligibility criteria and the types of information needed to make this determination may help to ensure decision making based on the relevant data. With increased knowledge parents may also push for alternative options to special education placement.

Educators with the benevolent desire to help students who do not meet eligibility criteria and who are unaware of alternative interventions, such as instructional consultation, sometimes overlook the regulations and place the student anyway (Salvia & Ysseldyke, 1998). This situation may occur due to vaguely written regulations. The imprecise nature of the regulations permits various interpretations that result in inconsistent practice (Salvia & Ysseldyke, 1998). This imprecision and inconsistency is most prominent when determining eligibility for a learning disability (Salvia & Ysseldyke, 1998). Parents are bound to have difficulty understanding eligibility criteria when even educators cannot come to a clear consensus. This lack of consensus may result in high referral rates and bias when classifying students.

High referral and placement rates, as well as overrepresentation and bias, have raised concern about the test-and-place models, in particular (Graden, Zins, & Curtis, 1988; Mamlin & Harris, 1998). Intervention-based assessments have recently been used as a feasible option to test-and-place models (McNamara & Hollinger, 1997; McNamara, Telzrow, & DeLamtre, 1999; Mamlin & Harris, 1998). Parent satisfaction for Intervention-Based Assessment (IBA) is related to amount of parent involvement (McNamara, Telzrow, & DeLamtre, 1999). This involvement included parents' opportunity to aid in the planning of the intervention. Parents who were involved at the

beginning of the IBA rated the intervention plans more favorably suggesting plan ownership and investment.

The classification of a student with a special education label, such as a Specific Learning Disability (SLD), is a significant event that will have long lasting effects on his or her academic career. Many people will define the student by his or her label when making important educational decisions regardless of other relevant information (Clark & Artiles, 2000; Clifford, 1986; Falk, 2001; Fox & Stinnett, 1996; Gillung & Rucker, 1977; Johnson & Blankenship, 1984). Therefore it is of utmost importance that the classification process be accurate, comprehensive, and be completed in a beneficent manner.

Previous studies on classification and IEP meetings have been descriptive in nature (Hoff et al., 1978; Polifka, 1981; Shriver & Kramer, 1993; Turnbull & Leonard, 1980; Vaughn et al., 1988; Witt et al., 1984). Describing the classification and IEP meeting procedures aided in the identification of areas for improvement, such as increased parental knowledge and education. The next phase of research could investigate different methods for improving this process. Experimental studies are needed to determine how best to increase parent knowledge and participation. With increased knowledge and participation, parent satisfaction may be affected.

Parent satisfaction with the classification process is important. A parent may not feel like a competent or valuable member of a team if they are dissatisfied with the process (Gartner & Lipsky, 1992; Shriver & Kramer, 1993; Wise, 1995). There has been a significant positive correlation between parent satisfaction and whether they were asked to give input in preparing their child's IEP as well as whether they felt that their child's

classification was appropriate (Gartner & Lipsky, 1992; Polifka, 1981). Parent satisfaction with special education staff meetings might also be mediated by input from many people, blame for the child's difficulty being placed on sources other than the parents, and the amount of parent participation (Witt et al., 1984).

Increased parental involvement during the classification process could lead to more positive outcomes for parent and child at future IEP meetings (Christenson & Conoley, 1992). In promoting effective parent involvement from the beginning of the special education process (classification decision), many future problems could be prevented. For instance, intervention compliance may result if the precedent is set for active parental involvement. Increased parental knowledge could lead to parents feeling competent and comfortable enough to give input without needing to be asked to by staff members. Thus parents may take a proactive role in their child's education versus a passive role. For example, they might be more accepting of recommended interventions and maintain them in the home environment. However, a parent's reaction to the possibility that their child may have a disability may negatively impact their ability to take an active role in their child's education.

Parents may go through stages of grief when they learn their child may have a disability (O'Shea, O'Shea, Algozzine, & Hammitte, 2001). Responses of parents might include uncertainty, bewilderment, and guilt. In pediatric psychology settings parental distress regarding the diagnosis of a disorder or disease can impact the child's distress (Chaney, Mullins, Frank, Peterson, Mace, Kashani, & Goldstein, 1997; Thompson, Gustafson, Hamlett, & Spock, 1992). This distress stems from uncertainty about the

disease. Increased knowledge regarding the disorder or disease tends to reduce this distress.

Parents of children who are suspected to have a SLD may also go through stages of grief when they learn their child may have a disability. They too might have feelings of uncertainty, bewilderment, and guilt. The parents' distress may impact the child's distress. Increased knowledge about SLD's may decrease parents' uncertainty and distress if they have a better understanding of this disability. Changing parent perceptions and preconceived notions about this label may have positive outcomes for children (O'Shea et al., 2001). It is also important to change negative perceptions and increase knowledge about classification procedures because special education policy regarding learning disabilities may change in the near future.

Changes in Special Education Policy

The reauthorization of the Individuals with Disabilities Education Act (IDEA, 1997) further illustrates the need for parent training and education regarding classification. A recommendation to discontinue the use of test score discrepancies was made at a recent National Joint Committee on Learning Disabilities (NJCLD) roundtable (2002). As the requirements for eligibility determination change, the need for parent education will increase. Guidelines and training aids could be initiated so that parents can clearly follow along with current and new procedures. These training aids could include understandable definitions of learning disabilities, prognoses, question prompts for use during meetings, and checklists to easily organize the information that is received (Anderson-Inman, 1986; Costello, Dulcan, & Kalas, 1991; Fagley, 1984; Hawkins,

Mathews, & Hamdan, 1999; Kratochwill and Roseby, 1988; Mattison, Lynch, Kales, & Gamble, 1993; Moss, Prosser, Costello, Simpson, Patel, Rowe, Turner, & Hatton, 1998).

Summary

Parents are seen as partners in education. A special education eligibility determination is legally required to be multidisciplinary and include the participation of parents. Parents are not only supposed to be present but are encouraged to take an active role in the classification process. Children displaying academic difficulties represent the most common referral and children identified under the category of specific learning disability make up the largest population in special education.

Problems with the special education exist. The Individuals with Disabilities Education Act outlines regulations for eligibility decisions and IEP meetings. Despite these regulations, ambiguity about eligibility remains, and high referral and placement rates, as well as overrepresentation and bias have remained as concerns for minority and non-minority children alike. Alternatives to the test and place model, such as pre-referral interventions continue to be an under-utilized resource. The impending reauthorization of IDEA concerning specific learning disability classifications also demonstrates a need for parent training. The classification of a student with a special education label, such as a Specific Learning Disability (SLD), is a serious undertaking that will have long lasting effects.

Parent satisfaction with the special education process may also impact their participation. Active participation by parents may lead to positive outcomes for students. For example, intervention compliance could be maintained with active parental involvement and parent satisfaction. Parents might serve as influential members on the

multidisciplinary team and improve the decision making process. The medical model for diagnosing and treating disabilities and IDEA parallel each other. Integral to both are multidisciplinary teams, informed consent, and an alliance with clients and parents. Parents suffer distress and grief after learning their child has a disability, which may be lessened by decreasing the amount of uncertainty parent feel. This may best be facilitated by parent education and parent training.

There is a shortage of empirical research regarding parental knowledge of special education classification procedures and effective participation in classification meetings. However, the literature available suggests parents lack an understanding about eligibility decisions despite being in attendance at the classification meeting (Hoff et al., 1978; Vaughn et al., 1988). More research has focused on parents attending IEP meetings. Previous research has also been descriptive in nature.

Current Study

This research project is designed to investigate parental factors that are present during a Specific Learning Disability classification process in children ages 6 to 16 years of age. The study will attempt to (a) examine whether increased information provided to parents increases the amount and quality of their participation in the process (e.g., number of verbalizations and questions), (b) determine the amount of knowledge parents have about the specific label (SLD) and procedure prior to the classification meeting, and(c) examine parent satisfaction with the classification process and interaction with other team members.

It is hypothesized that (a) parents who participated in the training would have higher amounts of actual and perceived participation, (b) parents who participated in the

training would have higher amounts of knowledge about specific learning disabilities and the special education process, and(c) parents who participated in the training would have higher levels of satisfaction with the special education process.

Ultimately if parents become more effective as multidisciplinary team members, the likelihood of their participation in the child's education from the start through the end of the child's academic career will increase. Through increased amounts of knowledge, parents may truly make an informed decision regarding their child's education. The best method intuitively would be face-to-face training of parents by a school psychologist. However, due to school psychologists with too large a case load and parent factors, such as not being able to make time for both training and attending the meeting, in-person training may not always be practical (Dunst et al., 1992). Therefore this study will attempt to provide adequate training through the use of informational handouts. A worthwhile goal is that with increased education and training learning disabilities would be better understood and effectively managed.

CHAPTER 2

REVIEW OF THE LITERATURE

The initiative to increase the partnership between school and parents in the education of children has been a long-term goal that has been given even greater prominence in the special education process (Christenson & Conoley, 1992; O'Shea et al., 2001). Active parent participation in special education classification meetings is one step in achieving a partnership. Parents' understanding of disabilities, their parental rights, and their role in eligibility determination are necessary to bring about greater parental involvement (Hoff et al., 1978; O'Shea et al., 2001; Vaughn et al., 1988). Parents' satisfaction with classification meetings may also be related to type and amount of involvement they undertake (Polifka, 1981; Witt et al., 1984).

The goal of an eligibility classification meeting is to make a decision that is in the best interest of the referred student (Mash, 1998). To meet this goal a theoretical model that focuses on a child's success in all areas should be at the core of the individual's beliefs who are making decisions (Hibbs & Jensen, 1996; Kazdin, 1997; Mash, 1998). The child's success in all areas includes academic, social, future career goals, and positive contribution to society. Decisions about placement and intervention need to be based on multiple types of empirical data that were collected from a variety of sources (Kazdin, 1997). A systems approach that calls on different knowledge bases, including that of parents, is important for effective decision making (Kanfer & Schefft, 1988).

Many factors can influence whether a child is diagnosed with a special education label. There are criteria for determining eligibility of a student for special education. Originally Public Law 94-142 the Education for All Handicapped Children Act, and presently the Individuals with Disabilities Education Act (IDEA) and state guidelines specify these criteria (Fagan & Warden, 1996; IDEA, 1997). The current regulations and laws provide authorized procedures. However, with the call for a reauthorization of IDEA and trend in using pre-referral intervention-based assessment some of these guidelines may change (McNamara & Hollinger, 1997; McNamara, Telzrow, & DeLamtre, 1999; Mamlin & Harris, 1998; NJCLD, 2002). These changes will impact how multidisciplinary teams function to make eligibility decisions.

Multidisciplinary teams meet to make classification decisions (Fagan & Warden, 1996; IDEA, 1997). The compositions of these teams and the manner in which they operate may have an influence on parent satisfaction and involvement (McNarmara, Telzrow, & DeLamtre, 1999; Rosenfield & Gravois, 1996; Shaw & Swerdik, 1995; Thousand & Vialla, 1992). Current practices are not precise and teams may be influenced by factors such as “group think” (Castona et al., 2002; Hart, 1990; Hogg 2001). Inappropriate classifications may occur if team members make subjective judgments based on limited amounts of assessment data (Bocian et al., 1999; Gresham, MacMillan, & Bocian, 1998; Gresham & Witt, 1997; MacMillan & Forness, 1998; Potter et al., 1983).

The widespread problem of overrepresentation and misclassification of minorities in special education is one result of invalid classification approaches (Artiles, Aguirre-Munoz, & Abedi, 1998; Bersoff, 1980; Jacobs, 1991; MacMillan & Reschly, 1998;

Maheady, Algozzine, & Ysseldyke, 1984; Patton, 1998; Talbert-Johnson, 1998).

Labeling studies illustrate the negative outcomes that occur when erroneous classification decisions are made (Clark & Artiles, 2000; Clifford, 1986; Falk, 2001; Fox & Stinnett, 1996; Gillung & Rucker, 1977; Johnson & Blankenship, 1984).

A review of mental health and medical diagnoses procedures is beneficial in that the educational diagnosis model has its foundation in the medical model (Stone, 1988). Topics of particular interest include informed consent and patient preferences for participation in medical decision-making, as well as decreasing uncertainty about a diagnosed disease or disorder (Arora & McHorney, 2000; Chaney et al., 1997; Rae, Worchel, & Brunnequell, 1995; Thompson et al., 1992). These topics are important because they parallel components involved in special education decision making. Another important aspect is the mechanism or mechanisms that are useful for increasing parent participation in the treatment of their child (La Greca & Schuman, 1995). This information could be adapted and used in school settings.

Parent participation in special education is especially important considering the number of students who are referred for learning difficulties. The number of students identified with disabilities during the 1999-2000 academic year reached 5,683,707 (8.92%) of the total population of school age children and students who were identified under the category of specific learning disability numbered 2,871,966 (4.5%)(23rd Annual Report to Congress, 2002). Of the school age population in Oklahoma 77,072 (9.5%) children were identified as having a disability and students identified with a specific learning disability totaled 43,502 (5.36%).

The prognosis for students with specific learning disabilities is not as promising as compared to students within regular education (Cappella et al., 2002; Kavale, 1988; Reif & DeFur, 1992; Sacks, 2001; Shessel & Reiff, 1999; Spreen, 1988). Over a third of students with learning disability do not graduate from high school. Of the students who do graduate from high school, very few attend a 4-year college. Of the few students who do graduate from a 4-year college, do not attend graduate school at the same rate as the overall population. Students with learning disabilities have difficulty finding full-time employment. Almost half of the students with a specific learning disability have substance abuse difficulties.

Parent Participation

Although the intent of the Public Law 94-142 was for active parent participation, this topic received little notice until IDEA was enacted (Shriver & Kramer, 1993). A general lack of empirical data regarding parent knowledge and involvement in the classification process exists. A few researchers began cursory investigations shortly after the inception of Public Law 94-142; however there is a deficit of current information (Hoff et al., 1978; Vaughn et al., 1988). More research has been conducted in regard to IEP meetings (Gartner & Lipsky, 1992; Goldstein et al., 1980; McKinney & Hocutt, 1982; Polifka, 1981; Shriver & Kramer, 1993; Vacc et al., 1985; Witt et al., 1984).

Hoff et al. (1978) investigated parental involvement in the initial placement and IEP meeting. Specifically parental understanding of eligibility meetings and the goals of the IEP meetings were explored. Parents were interviewed on three separate occasions: prior to the placement meeting, two weeks after the meeting, and months after the meeting. The first interview explored communications between the school and parents,

how parents were informed of the placement meeting, parents' preparation for the meeting, and their expectations about participating. The second interview explored parents' understanding about the decision made, the placement of their child, the goals of the IEP, and the review date of the IEP. In the final interview, program changes for the coming year, communications with the school after implementing a new program, and whether parents had given permission for changes in this program were explored. The principal in each school completed a questionnaire regarding the reason for referral, the history of parental contacts, and the method of notifying parents about placement meetings. Personnel in attendance at the meeting completed a questionnaire immediately after the meeting indicating their contacts with parents including information discussed, and instructional and placement preferences brought up by the parents. Each meeting was also videotaped and transcripts were produced. Parents typically were informed of the date and time of the placement meeting but were not informed of what decisions might be made. Only 40% of the sets of parents reported giving consent to the placement meeting decisions. Clear eligibility, placement, program goals, and review dates, were only reported by 50% of the parents. The other 50% were confused about these different aspects. Amazingly 45% of parents did not realize that eligibility had been decided in the meeting. Seventy-five percent of parents lacked knowledge about the implications of being classified. Parents also reported that educational programs had not changed for their children when in fact the IEP had changed these programs dramatically. Many parents also did not understand the IEP objectives. When asked about the review date of the IEP only 35% of parents knew when this would occur. This study clearly

demonstrated a lack of parental knowledge about special education proceedings and a need for procedural safeguards.

The state of affairs prior to Public Law 94-142 illustrates why this law is so important. Many areas of administrative communication with parents such as informing parents about decisions that would be made in placement meetings, informing parents of due process safeguards, and documenting proceedings in writing were overlooked (Hoff et al., 1978). Descriptive studies regarding classification practices were important in order to identify problems with the process. Now that problem areas have been identified steps can be taken to improve this process. Experimental manipulations can be done to ascertain how best to involve parents and thus serve children in the schools.

A study of parent participation and parent perceptions focused on initial placement meetings (Vaughn et al., 1988). The primary focus of the study was to ascertain whether parents had assumed an active role as mandated by Public Law 94-142 as well as what parents' perceptions were of the process. This study utilized an observer who continuously recorded parent participation. The number and duration of questions, comments, and responses made by the parents during the meeting was recorded. Parents' participation was low and thus their verbalizations were recorded in seconds. The observer immediately interviewed the parents after the meeting. To ensure consistency a structured interview was used and it consisted of open-ended questions. The questions focused on the following areas: school contacts prior to the classification meeting; parents' feelings about their child's learning problems; student awareness of his/her learning problem; parents' and school personnel's roles in educating children; parent satisfaction with and knowledge about the meeting; and parent satisfaction and

knowledge regarding decisions made during the meeting. Parent verbalizations accounted for only 14.8% of the conference. Twenty-seven percent of the parents thought that learning disabled meant slow learner and 23% did not know the meaning of the term. Sixty-nine percent of the parents reported satisfaction and appreciation for the classification meeting, however. Sixty-five percent also indicated their questions had been answered and they did not have any other questions. This study demonstrated that parents had a lack of understanding about their child's classification and what decisions needed to be made during the IEP meeting.

The Vaughn et al. (1988) study set a good foundation for the investigation of classification meetings. However, this study was descriptive in nature. Observations and interviews certainly give information about these meetings but there is still some subjectivity involved. An optimal situation would be to have objective data collection methods and to add an experimental component.

The small amount of empirical information regarding classification meetings warrants a review of research concerning IEP meetings (Gartner & Lipsky, 1992; Goldstein et al., 1980; McKinney & Hocutt, 1982; Polifka, 1981; Shriver & Kramer, 1993; Vacc et al., 1985; Witt et al., 1984). Vacc et al. (1985) found that parents did not participate much and were often passive. Goldstien et al. (1980) found that resource teachers were found to talk twice as much as parents. However, on average parents talked more than the rest of the participants (regular education teacher, counselor, principal, examiner, speech therapist, and reading teacher) but one of the parents was a psychologist who was quite familiar with IEP meeting proceedings (Goldstein et al., 1980). Curriculum, behavior, and performance were the most discussed topics;

placement, evaluation procedures, and parent rights and roles were discussed less (Goldstein et al., 1980). Goldstein et al. (1980) suggested that parents need an advocate at these meetings; an alternative suggestion would be that parents need training in order to be their own advocates for their children.

Parents felt that the decision about planning had already been made prior to the IEP meeting and that their input is not valued (Gartner & Lipsky, 1992). Polifka (1981) found a significant positive relationship between reported parent satisfaction with their child's special education program and whether they were asked to give input in regard to many issues. These issues included the IEP planning, whether they felt an appropriate classification had been made, and whether they were informed of their right to appeal if they did not agree with the placement. Parents reported high levels of satisfaction with the meeting despite their low level of participation (Goldstein et al., 1980). Parent satisfaction with staff meetings was found to be influenced by allowing enough time for the staffing, having input from a number of people, not feeling blame for their child's problem, and participating as much as they had wanted (Witt et al., 1984). Preparing parents for what to expect at staff meetings had a minor impact on parent satisfaction. Satisfied parents had been encouraged to participate and their ideas have been sought and used in developing the IEP. Parents of high socioeconomic status have been shown to be less satisfied with their input during the evaluation process and with their involvement as multidisciplinary team members in making decisions (Shriver & Kramer, 1993; Witt et al., 1984). They felt undervalued as members of the multidisciplinary team.

Although the Witt et al. (1984) study seems to refute other findings regarding parent participation, such as whether preparing parents in advance really improves the

process, the study should be interpreted with caution. This study requested that parents complete a questionnaire about their perceptions of meetings that had occurred in the past. Many of the parents who participated did so at a special education workshop they were attending. This preparation variable was not clearly defined. Thus one is left guessing what kind of expectations parents had due to “parent preparation”.

A comparison study was conducted in order to describe the nature and extent of involvement of parents with children classified as learning disabled and parents with children in regular education (McKinney & Hocutt, 1982). They also investigated the involvement of parents with children with LD in developing and implementing education programs. Both sets of parents felt involvement was important. Parents of children with LD did not report much involvement in the planning and implementation of educational programs. They also could not remember much of what occurred at the IEP meeting and what goals were determined.

A similar study was conducted to describe parent participation and attitude toward their children’s special education program (Lynch & Stein, 1982). Interviews were completed in the parent’s home using a 64-item questionnaire. When asked about active involvement in the development of the IEP, 71% of the parents felt they had been adequately involved. They listened to information and agreed with recommendations. Parents did not offer many suggestions and were not aware of the services listed on the IEP. Many parents felt the needs of their children were not identified early enough. Overall parents were satisfied with the process.

Parent satisfaction with special education staff meetings might be mediated by input from many people, blame for the child’s difficulty being placed on sources other

than the parents, and the amount of parent participation (Witt et al., 1984). Allowing enough time for the meeting also resulted in parent satisfaction (Witt et al., 1984). There has been a significant positive correlation between parent satisfaction and whether they were asked to give input in preparing their child's IEP as well as whether they felt that their child's classification was appropriate (Gartner & Lipsky, 1992; Polifka, 1981). Higher socioeconomic parents felt less satisfied with their participation in the process (Shriver & Kramer, 1993; Witt et al., 1984). Parents are often passive during meetings while resource teachers do all the talking (Goldstein et al., 1980; Vacc et al., 1985).

Parent involvement in special education necessitates that parents take on the role of child advocate (Turnbull & Leonard, 1980). For parents to find success in this role, they need knowledge and decision making skills. This knowledge base must include information about the particular needs of a child with a SLD, location and availability of resources, and parental rights and responsibilities. Effective communication styles will also lead to success for the parent in the role of advocate. Parent advocates will need training and/or devices to aid in their decision-making (Anderson-Inman, 1986; Costello, Dulcan, & Kalas, 1991; Fagley, 1984; Hawkins, Mathews, & Hamdan, 1999; Kratochwill and Roseby, 1988; Mattison et al., 1993; Moss et al., 1998).

A family centered approach to special education could promote increased parent involvement. Principles such as viewing the family as the primary unit of service delivery, focusing on child and family strengths, responsiveness to family identified priorities, flexibility and responsive action to the changing needs of families, and encouragement of parent participation set the foundation for a family centered approach (McWilliam, Winton, & Crais, 1996). Parents who were asked to describe the most

helpful aspects of their early intervention experience described parent education as one of the major components (Wehman & Gilkerson, 1999). These parents valued knowledge about what to do for their children and their child's development and disability. They wanted professionals to answer their questions and model activities for them. These parents cited that one of the major barriers to early intervention was lack of clear communication between parents and professionals. Parents did not feel listened to, did not feel they had input about what their child needed, and felt the time allotted for their questions to be answered was inadequate. These parents suggested that public awareness of early intervention services needed to occur.

In Britain parent satisfaction with early intervention services (called portage for the British) has also been studied (Clare, 1995). Parents found that the most helpful aspects about early intervention included advice from professionals, information, and ideas as well as a family approach versus an individual child approach. Suggested improvements to early intervention included more input on how parents could help and more training for parents.

Effective and consistent training is needed to ensure that parent roles and competency as a multidisciplinary team member are upheld and maintained. While parents may have gained recognition as team members who could make decisions, their ability to do so has been overlooked (Simpson, 1982). The skill level of many parents is still low (Goldstein et al., 1980). Parents need training about the procedures of each type of meeting (classification or IEP). They need to be familiarized with the type of information that will be discussed. Active participation needs to be promoted by training parents about how to prepare and be assertive. Guidelines for evaluating meetings could

also guide parents. Suggestions for how to provide training include educators, professionals, or other parents providing workshops (Simpson, 1982).

Another avenue of training may be providing a checklist that will aid them in participating and evaluating meeting outcomes (Anderson-Inman, 1986; Costello, Dulcan, & Kalas, 1991; Fagley, 1984; Hawkins, Mathews, & Hamdan, 1999; Kratochwill and Roseby, 1988; Mattison, Lynch, Kales, & Gamble, 1993; Moss, Prosser, Costello, Simpson, Patel, Rowe, Turner, & Hatton, 1998). A behavioral checklist has been used to assist educators in the assessment of treatment needs for schoolboys labeled Emotionally Disturbed (Mattison et al., 1993). Mattison et al. (1993) investigated the usefulness of teacher and parent checklists in determining placement and treatment. The participants in the placement meeting were blind to the scores of these checklists so as to compare the effectiveness of the checklists. The Child Behavior Checklist was selected for the teachers and the parents use (Achenbach & Rescorla, 2001). The checklists were found to be an excellent method of identifying boys at risk for emotional disturbance and the lists complimented the classification decisions.

A tool used to identify mental health problems in people with intellectual disabilities is the PAS-ADD checklist (Moss et al., 1998). This checklist contains every day language so that anyone can understand the items and agreement on case identification has been found to be excellent. Costello, Dulcan, and Kalas (1991) endorse a twelve-item checklist of criteria for psychiatric hospitalization of children. This checklist was able to correctly predict whether a patient had been hospitalized by a skilled intake counselor, demonstrating that it was a great guide for decision making for inexperienced workers. Self-monitoring checklists have been found to alter the role and

responsibility of special education students without changing the teacher's role (Anderson-Inman, 1986). This could generalize to parents and school personnel in classification meetings. Checklists are practical methods for using data in order to make decisions (Fagley, 1984; Hawkins, Mathews, & Hamdan, 1999; Kratochwill & Roseby, 1988). Checklists utilized by parents could be used in a similar fashion for evaluating learning disability classification meetings.

Parents can be great advocates for their children if trained in advocacy skills. Many factors have been identified for developing parent advocacy skills (O'Shea et al., 2001). Understanding the rules of the process is one of the most important skills for being an effective advocate (O'Shea et al., 2001). Parents who are knowledgeable of the laws and regulations schools abide by are in a better position to receive appropriate services for their children (O'Shea et al., 2001; Valdez, 2002). The specific criteria schools use vary from state to state, further supporting training opportunities for parents (Salvia & Ysseldyke, 1998). Asking questions is another skill that parents need to have and part of asking the right questions is having a good understanding of what to ask (O'Shea et al., 2001; Valdez, 2002). Parents also need to be aware that they have a right to ask questions and keep asking until their level of understanding has been achieved (Salvia & Ysseldyke, 1998). Parents who gather information on the disability and become familiar with jargon can better participate in the classification meeting. Parents who come prepared for the meeting with specific goals in mind will be able to communicate more effectively. A good advocate is one that possesses the knowledge and skills to negotiate the best educational outcome for their child (O'Shea et al., 2001).

In a best case scenario parents would meet with a school psychologist at the time of referral to discuss the reason for the referral, the procedures that will be followed, the ultimate outcome that may occur after the assessment, and parent's rights and responsibilities (Wise, 1995). Parents would also be given the opportunity to ask questions and gain further understanding. It would also be beneficial if parents were given information prior to the classification meeting regarding the specific special education label (e.g. SLD) that their child may be given. Although it is best practice for school psychologists to meet individually with parents to give them information, many times this is not practical and does not occur (Wise, 1995). Therefore, parents need to be provided with resources such as information handouts about specific special education disabilities. This would enable parents to be even more valuable resources for the educational success of their children. This would also enable them to make informed decisions about their child's education.

Parallels to the Medical Model

Multidisciplinary team meetings for case conferences in psychiatric departments and hospitals have become routine and an integral part of practice (Stone, 1988). These meetings in the past have been recorded and this has been included in the case record. The main goal of team meetings has been to allow multiple contributions from various professionals to tentatively diagnose and formulate a treatment plan.

Informed consent is essential for patient's rights to be protected when professionals make mental health diagnoses and recommendations for treatment. Informed consent is more than just a decision that is made voluntarily (Rae, Worchel, & Brunnequell, 1995). The patient needs to be able to make decisions concerning their

health without feeling coerced or that there is a “right” choice to make. The patient also needs to have enough knowledge in order to be informed. Working with child patients also means working with their parents. Parents’ increased knowledge about their child’s disorder may increase their ability to maintain adherence to treatment (La Greca & Schuman, 1995). Enhancing informed consent in the schools could come from including a prognosis for an SLD during the classification meeting (Valdez, 2002).

Parents may have various perceptions about their child having a disability (O’Shea et al., 2001). The types of perceptions that parents have may impact the way in which they approach special education. Parents who have positive perceptions are likely to have positive experiences in dealing with their child’s disability (O’Shea et al., 2001). The Beach Center on Families with Disabilities (1997d) have identified four perceptions that may well functioning parents maintain. The perception that the disability has specific causes is beneficial. Parents feel they have better control of the situation when they have identified specific reasons their child may have a disability (The Beach Center on Families with Disabilities, 1997d). Parents who feel they can control aspects of the disability are more likely to accept and be involved in recommended interventions (The Beach Center on Families with Disabilities, 1997d). Parents can cope better when they have someone to compare their situation with who has effectively dealt with the disability (The Beach Center on Families with Disabilities, 1997d). Parents who focus on their child’s strengths and not just their disability also function better (The Beach Center on Families with Disabilities, 1997d). Through appropriate training and education parents will be better equipped to take a positive role in advocating for their child.

Parents in pediatric psychology settings often experience uncertainty and distress upon the diagnosis of a disease for their child (Chaney et al., 1997; Thompson et al., 1992). Increasing parental knowledge regarding expectancy has been helpful in alleviating this distress. Parents may pass through various stages of grief upon being informed their child may have a disability (O'Shea et al., 2001; Paul, 1981). These stages might include denial and depression, anger and guilt, and bargaining and acceptance. Parents may need aid in changing their perceptions and misconceptions about disabilities. Increased parent education is one solution. Parents facing an educational placement decision may also find relief of distress as their knowledge increases, as well. They might be able to realize that children with disabilities can still live a successful life with the appropriate interventions in place.

A parent's initial reaction to the diagnosis of a disability may be one of denial (O'Shea et al., 2001). Parents have the tendency to believe a mistake has been made and may delay treatment. At the realization and acceptance of the disability parents may experience depression. A side effect of their depression may be socially isolating themselves from much needed support. Parents may be able to avoid the denial and depression stage or in the very least progress swiftly past this stage if they have assurance and support. This may be in the form of parental education.

Another reaction parents may have regarding the diagnosis of a disability is one of anger and guilt (O'Shea et al., 2001). Parents may blame themselves or they may blame others such as a teacher. They might attribute the disability to a genetic defect they must have passed on to their child. Parents in poverty often fault themselves for not providing better for their child. Overall a parent's self-esteem and ability to deal

effectively with the disability may suffer. Through increased education parents can better understand the disability and not succumb to negative, false information.

Parents may also go through a period of finding alternative interventions for their child's disability (O'Shea et al., 2001). Thus a parent may realize their child has a disability but they attempt to cure the disability, not wanting to admit the gravity of the disability. Parents may be able to cope better with their child's disability if they have an understanding of the nature and course of the disability. They will be able to deal with the disability if they understand the methods that will enable their child to succeed despite the disability.

Patient preferences for participation in medical decision making has been explored (Arora & McHorney, 2000). Many of the patients desired a passive role in the decision making. Characteristics of passive patients included people who placed a high value on their health believing the best outcome is one achieved by professionals, people who had a significant amount of trust in their doctor, and older and less educated people. Active patients had more education, were younger, had less severe illnesses, and an active coping style. Women were also more active than men, which shows consistency in that they are more active in seeking care in general. These preferences may generalize to parents who have a child referred for a special education as well; however this preference for passivity may result in inappropriately classified students with a specific learning disability.

Overrepresentation of Minorities

Prior to the Public Law 94-142 many court cases highlighted the problem of overrepresentation of minorities in special education (Bersoff, 1979). Cases such as

Hansen v. Hobson, Larry P. v. Riles, Diana v. State Board of Education, and Covarrubias v. San Diego Unified School District ended in rulings against biased assessment and misclassification (Salvia & Ysseldyke, 1998). These court cases caused ability grouping and standardized tests to receive legal inspection. Judges ruled that test scores were misleading and inaccurate for minority students. Schools were required to evaluate students in their primary language if it was not English. African American children who were identified as having mental retardation were reevaluated for placement without using standardized intelligence tests. Some students who were misclassified were even awarded monetary damages.

The number of minority students placed in special education seems to be increasing steadily (O'Shea et al., 2001). This alarming trend may be due to bias and misclassification due to insensitivities to cultural differences. Inappropriate use of discrepancy scores between IQ and achievement tests has been implicated as the root of the problem (Bardon, 1980; Bersoff, 1980; MacMillan & Forness, 1998; Maheady et al., 1984; Reschly, 1981). Other contributors that may perpetuate this problem include teacher biases and assumptions, differing cultural expectations, and unfavorable learning environments (MacMillan & Reschly, 1998; Maheady et al., 1984; Patton, 1998). Greater parental involvement may be one method for combating this, in that they can serve as the cultural expert and reduce insensitivities.

Parents also need to be aware of the factors that contribute to an appropriate evaluation of their child. Assessment materials should include a representation of items that include individuals from diverse backgrounds, because not doing shows bias toward minority groups (Salvia & Ysseldyke, 1998). Test materials should also account for

differing experiential opportunities of individuals from diverse backgrounds (Artiles, Aguirre-Munoz, & Abedi, 1998). The language and concepts within an individual assessment device should not be racist in any way (De Leon, Medina, & Ortiz, 1998). Parents need to realize that some assessments utilize subjective scoring (Jacobs, 1991). Normative comparisons are not always appropriate (Talber-Johnson, 1998). Students need to be tested in their native language to extent feasible or nonverbal tests need to be utilized (Kavanaugh, 1994). School personnel conducting evaluations need to either have training or supervision when working with an unfamiliar cultural group (Talbert-Johnson, 2001). Parents and students are entitled to Protection in Evaluation Procedures (PEP) (Salvia & Ysseldyke, 1998). Minority parents who have knowledge about appropriate evaluations will be able to ensure that their child has been treated fairly. They and non-minority parents also need information about appropriate evaluations because other problems with specific learning disability classifications also exist.

Special Education Guidelines and Problems

Public Law 94-142 was passed in 1975 and the benefits of this law included the improvement of parental involvement in special education procedures (Fagan & Warden, 1996). For a student to be eligible for special education he or she must have a disability which interferes with his or her educational success. Some students may have a disability and not require special education, whereas some students may have special learning needs but not be eligible for a classification (Salvia & Ysseldyke, 1998). The disabilities specified in IDEA (1997) include specific learning disability (SLD), mental retardation, autism, emotional disturbance, hearing impairment, visual impairment, speech/language impairment, orthopedic impairment, traumatic brain

injury, multiple disabilities and other health impairment. It is intended that eligibility determinations for special education are based on a multi-factored evaluation that is fair and unbiased (Salvia & Ysseldyke, 1998). Parental rights include consenting to the evaluation, attending the classification meeting, accepting or rejecting the evaluation results and placement, and if accepted attending the IEP meeting (IDEA, 1997). Parents also have the right to an independent evaluation and due-process hearings if a disagreement occurs (IDEA, 1997).

Under the Individuals with Disabilities Education Act (IDEA, 1997) parents of a child suspected of having a disability must be given the opportunity to inspect and review all educational records as well as participate in meetings with respect to the identification, evaluation, and educational placement of the student. Each public agency is to provide notice to parents to ensure that parents have the opportunity to participate in meetings (IDEA, 1997). Each public agency needs to ensure that the parents of a child who may have a disability are members of any group that makes decisions on the educational placement of their child (IDEA, 1997). The public agency needs to make reasonable efforts to ensure that the parents understand, and are able to participate in any team decisions related to the educational placement of their child (IDEA, 1997).

IDEA (1997) specifies that a group of qualified professionals and the parent(s) of the child evaluated must determine whether the child has a disability. The public agency must provide a copy of the evaluation report and the documentation of determination of eligibility to the parent (IDEA, 1997). For a child to be considered eligible for a specific learning disability a team must consider several criteria. Criteria one indicates that the child does not achieve commensurate with peers his or her age by displaying impaired

performance levels in one or more academic areas, despite being provided with learning experiences appropriate for the child's age and ability levels (IDEA, 1997; Salvia & Ysseldyke, 1998). Criteria two is that the child has a severe discrepancy between achievement and intellectual ability in one or more of the following areas: oral expression, listening comprehension, written expression, basic reading skill, reading comprehension, mathematics calculation, and mathematics reasoning (IDEA, 1997; Salvia & Ysseldyke, 1998). A child may not be diagnosed with a specific learning disability if the discrepancy is primarily a result of a visual, hearing, or motor impairment; mental retardation; emotional disturbance; or environmental, cultural or economic disadvantage (IDEA, 1997; Salvia & Ysseldyke, 1998). The severity of the disability must be assessed to determine whether school success is possible without classification (Salvia & Ysseldyke, 1998).

When a disagreement between team members and parents result, parents have a right to go through an impartial due process hearing (IDEA, 1997; Salvia & Ysseldyke, 1998). Parents may also appeal decisions reached during due process hearings, through civil action (IDEA, 1997; Salvia & Ysseldyke, 1998). Cases such as *Mills v. Board of Education* (1972) illustrated the importance of due process to protect against exclusion of classified students (Salvia & Ysseldyke, 1998). In the case *Pennsylvania Association for Retarded Children v. Commonwealth of Pennsylvania* parents were guaranteed the right to inspect and challenge educational records (Salvia & Ysseldyke, 1998).

Wise (1995) describes an all too frequent situation of "worst practices" in which, parents are likely to feel uncomfortable from the moment they walk into the meeting room with school personnel. They may feel anxiety regarding the fate of their child

(O'Shea et al., 2001). They usually are the only non-school professionals present (O'Shea et al., 2001; Salvia & Ysseldyke, 1998; Wise, 1995). A report is given to them and discussed using professional jargon they often do not understand (O'Shea et al., 2001; Wise, 1995). Usually the school professionals are all in agreement about the eligibility placement and a parent may not feel competent enough to participate, thus they agree with whatever the professionals decide (Wise, 1995). These factors often promote intimidation instead of active participation.

Problems with determining eligibility for special education have resulted from ambiguous regulations and policies (Salvia & Ysseldyke, 1998). Many educators and parents have the misconception that special education services should be provided for students who might benefit from them rather than students who meet the specific classification criteria (O'Shea et al., 2001; Salvia & Ysseldyke, 1998). Educators may have a desire to bend regulations to serve a child who is having problems even when they would not qualify legally (Salvia & Ysseldyke, 1998). This practice may occur as a result of humanitarian beliefs or the erroneous belief that students having difficulty can only be helped through special education (O'Shea et al., 2001). Individual States have the freedom to interpret federal regulations in a variety of ways. This causes inconsistent practices across states. This imprecision is most significant in defining specific learning disabilities (Salvia & Ysseldyke, 1998). The severe discrepancy criterion is interpreted differently by individuals. Parents may have difficulty grasping eligibility criteria when there is not a clear consensus as to what comprises the disability. Informational handouts and decision making aids, such as a checklist may help parents have a better understanding of eligibility criteria. A parent's grasp of what constitutes a specific

learning disability and their informed consent for their child to receive special education services is important because being given a special education label carries serious consequences.

Labels such as attention deficit disorders, learning disabled and emotionally disturbed are prevalent in today's schools. Researchers have found that people generally make negative judgments about labeled individuals (Palmer, 1983; Rolison & Medway, 1985; Fox & Stinnett, 1996; Johnson & Blankenship, 1984; Gillung & Rucker, 1977; Foster, Algozzine, & Ysseldyke, 1980). Negative judgments about labeled individuals tend to lead to discrimination and stigmatization. This discrimination can occur in the academic arena and the social arena. Fox and Stinnett (1996) found that children given the label seriously emotionally disturbed were judged as less likely to be successful with interpersonal relations than students without this label. In comparing two students who are doing poorly on an academic task, a student with a learning disabled label might be judged as lacking in cognitive ability, whereas a student with no label might be judged as lacking in motivation (Palmer, 1983). The academic expectation for the two students is likely to differ drastically.

A stigmatized student will experience the cost of being labeled (Falk, 2001). These costs could include, depending on the label, lowered expectations, misconceptions about appropriate behavior, and false attributions about the causes of behavior. Just recently the term inclusion has entered schools, in which an individual should be given an appropriate education in the least restrictive environment possible (Santrock, 2001). Before inclusion, children given a special education label were segregated from the “normal” students. Even with this new term, the spirit of inclusion has yet to be

understood by many teachers. A majority of teachers may still hold the notion that a special education student needs to be served in a separate special education room.

Stigmatization occurs when people have little or no experience with a population of people, such as special education students (Falk, 2001). However, despite this lack of experience with special education students' teachers still tend to make negative generalizations about them leading to stereotypes. Perceiving others who are different negatively often occurs. Once people gain experience with a certain group, the negative stereotypes tend to subside. Unfortunately, stigmatized students may take the victim role and display traits such as defensiveness and impaired self-esteem. This could lead to manufactured academic helplessness and perpetuates their learning problems. Thus, a vicious cycle may begin in which the teacher perceives the labeled student negatively, the student becomes a victim and acts accordingly, and the teacher feels justified in having negative perceptions.

Attributional processes, the processes that influence the way a person perceives an event or other people, have a role in labeling bias (Clark & Artiles, 2000). Teachers may assign various attributions in order to explain the cause of a situation, such as low achievement. Teacher attribution patterns were investigated in an effort to determine the reasons teachers' responses are so stable regarding perceived low achievers (Clark & Artiles, 2000). The three factors identified were locus, stability, and controllability. Humans possess fragile psyches and have a natural tendency to assign the locus of a problem to someone else. Many teachers assume that a child's low achievement is due to an internal problem. Teachers also might presume the low achievement of a student is stable and will not change over time. Teachers may also believe the student is in control

of their ability to achieve. These three factors enable the teacher to pass all the responsibility onto the student. A teacher, who believes a student is a low achiever, because they are learning disabled for example, does not have to explore other reasons why a student might be having difficulties. These other reasons could be external to the student, such as classroom environment or instructional style. A teacher would most likely not perceive external reasons for a learning disabled student's low achievement because this might be admitting something wrong with them. Thus, teacher attributions may effect their expectations for labeled students.

Rolison and Medway (1985) found that classroom teachers' expectations are influenced by a student's previous special education label. Typically a teacher will have lower expectations for a student with a special education label versus a student with no label. Undergraduate students in either a special education or elementary education program were found to rate labeled students more negatively on the Behavior Problem Checklist (Johnson & Blankenship, 1984). Gillung and Rucker (1977) found that both special education teachers and regular education teachers had lower expectations of labeled students and perceived these students as having severe behavior problems. The consequences of a teacher's attributions are immense (Clifford, 1986). Once a teacher has decided that the low achievement of a student is due to factors within that student, they place the student at a greater risk for academic failure and the student's self-esteem may be damaged.

Multidisciplinary Teams

Social theory in regard to group dynamics, group processes, and group decisions is at the core of parents serving as team members on a multidisciplinary team and

becoming more involved (Ahlfinger & Esser, 2001; Castona, Yzerbyt, Bourguignon, & Seron, 2002; Cropanzano & Schminke, 2001; Hogg, 2001; Hogg & Hains, 1998). Parents may be influenced by “group think” factors. These “group think” factors may be a potentially damaging factor for effective group decision making (Hart, 1990). Influence depends highly on social categorization by group members (Hogg, 2001). Group identification may impact the acceptance of parents as multidisciplinary team members (Castona, Yzerbyt, Bourguignon, & Seron, 2002). Social attraction is related to whether a group of people will go along with each other’s ideas (Hogg & Hains, 1998). Leaders of groups who promote their own preferences discuss fewer facts and reach decisions more quickly, at the cost of evaluating other problem solving alternatives (Ahlfinger & Esser, 2001).

Accurate decision making techniques include group identification, knowledge of group needs, and loyalty to group goals (Geist & Chandler, 1984). Sound decision-making occurs when individuals and points of views are fairly represented (Foss, 1976). When team members are invested in group procedures there is group harmony and productivity (Cropanzano & Schminke, 2001). Groups with cooperative goals are able to discuss opposing views openly and constructively, which results in effective team performance (Apler, Tjosvold, & Law, 1998). Decisions made in regard to special education classification occur within multidisciplinary teams (Gutkin & Nemeth, 1997). These teams need outcome criteria in order to assess group decision making.

A requirement of Public Law 94-142 is the utilization of multidisciplinary teams for the evaluation and educational planning for children with learning disabilities (IDEA, 1997). Individual decision making was seen as unreliable and fallible (Salvia &

Ysseldyke, 1998). The purpose of the multidisciplinary team was to prevent biased or inappropriate classifications by having a group of professionals agree on a diagnosis (Fagan & Warden, 1996; Yoshida, 1983). In the past, multidisciplinary teams were at minimum to be made up of two members (Federal Register, 1977). Personnel comprising multidisciplinary teams varied among states (Frankenberger & Harper, 1985). Despite the requirement that regular education teachers should participate as a team member, their participation was not consistent in all states. On the other hand, special education teachers were present 100% of the time in most states. Psychologists' and parents' participation was inconsistent as well. These teams varied in number of team members as well. Most of the teams consisted of five to nine members. Currently IDEA (1997) requires a group of qualified professionals and the parent of the child evaluated to comprise the multidisciplinary team. The very nature of this process has strong family school collaboration underpinnings (Muhlenhaupt, 2002).

Active parental roles such as monitoring IEPs and involvement in IEP planning were rejected by educators serving on multidisciplinary teams (Yoshida, Fenton, Maxwell, and Kaufman, 1978). Two parental roles endorsed by these team members were presenting and gathering basic information. Both activities were very passive. Multidisciplinary teams involved in the classification of students indicated on a survey that 79% of them were unaware and unclear that communication with parents was one of the goals (Fenton, Yoshida, Maxwell, & Kaufman, 1979). Gilliam (1979) found that parent contributions in team meetings were cited as ninth on the list of importance.

The construction and operation of multidisciplinary teams can vary a great deal, despite federal guidelines. Subjective judgments are made often regarding special

education eligibility (Bocian et al., 1999; MacMillan & Forness, 1998; Potter et al., 1983). Students who are low achieving but do not display behavior problems are placed less often where as students who are not low achieving but are disruptive are placed more often (Bocian et al., 1999) Discrepancy between Intelligence Quotient (IQ) and achievement scores also do not seem to be extremely influential in determining eligibility; instead low achievement in itself becomes more of a determining factor (MacMillan & Forness, 1998). These findings show evidence that the proper classification procedures are not being followed by professionals.

Three major team models have surfaced in special education to better serve students (Albano, Cox, York, & York, 1981; Hart, 1977; Lamorey & Ryan, 1998; Orelove & Sobsey, 1996). The terms multidisciplinary teams, interdisciplinary teams, and transdisciplinary teams have been used interchangeably but they actually denote three separate models. Multidisciplinary teams have been described as specific to each discipline. For example, a team made up of educators in which all had equal status would be considered a multidisciplinary team. Interdisciplinary teams have been described as specific to each discipline as well, however a case manager would handle the flow of information and decisions that were made as a group. In this example a team would be made up of educators with one person, perhaps the school psychologist, assigned as the case manager. Transdisciplinary teams might be comprised of parents and various professionals across disciplines (Albano et al., 1981; Baine & Sobsey, 1983; Orelove & Sobsey, 1996; Rainforth & York, 1987; Sears, 1981).

Most team members saw themselves as part of a transdisciplinary team (31%), many saw themselves as part of an interdisciplinary team (25%), some saw themselves as

part of multidisciplinary team (19%), and the remainder identified as a mix of the three teams (Lamorey & Ryan, 1998). Parents were not present in this sample. Members included educators, therapists, administrators, and nurses. Team sizes ranged from one member to thirty members, with an average team size of five. The teams meeting frequencies were from weekly meetings to quarterly. There were no significant differences in team demographics between the three types.

Team members from all three types indicated various influences on team effectiveness including adequate time spent on team construction and maintenance; effective team leadership; effective follow-up services; resolution of role, turf, and status issues; and increased skills across disciplines (Lamorey & Ryan, 1998). Other important factors for team effectiveness included team objectives that were clear and applicable; equality of involvement in team decisions; clear, applicable decision-making guidelines; sense of mutual respect among team members; and effective communication across disciplines. Team members also indicated various reasons for team ineffectiveness including overworked staff; lack of administrative support; philosophical differences among members; resistance to change; and inequitable distribution of workload. Various other factors were also identified as barriers to effectiveness including unorganized dissemination of information; lack of communication due to specialized terminologies; unclear team objectives; unequal levels of involvement among team members; perceived status differences; and territory and role confusion (Lamorey & Ryan, 1998). Again no significant differences were found among the three types of teams in regard to effectiveness.

Teams provided a variety of services including screening, assessment, programming, outpatient therapy, classroom intervention, home-based intervention, consultation, in-services, counseling, and support groups (Lamorey & Ryan, 1998). Teams used a variety of tools for assessment including standardized tests, criterion referenced tests, Curriculum Based Assessments (CBAs), checklists, observations, interviews, medical evaluations, and special testing. Parent participation was high in the assessment process in the form of completing home inventories and parent interviews. Parent participation was low in direct assessment such as parent observations. Parent involvement was also reported as low in developing IEP goals. Teams reported a moderate amount of parent participation in providing direct interventions. Once more there were no significant differences between the three types of teams.

A Secondary Student Instructional Support Team (ASSIST) is touted as a great alternative to traditional pull-out programs (Gable, Manning, Hendrickson, & Rogan, 1997). These teams generally consist of regular education teachers who teach various subjects and one or more specialists. Team members meet during a common planning period to support one another. This team also constructs an instructional plan for the individual students. These team members use curriculum-based assessments, use motivation strategies, and teach learning strategies. This approach has many positive components. However, parents are not included on these teams.

Pre-referral teams could serve as an alternative to multidisciplinary teams (McNamara & Hollinger, 1997; McNamara, Telzrow, & DeLamtre, 1999; Mamlin & Harris, 1998; Salvia & Ysseldyke, 1998). A regular education teacher generally implements a variety of teaching alternatives for students demonstrating academic or

behavioral difficulties (Salvia & Ysseldyke, 1998). Many state mandates require regular education teachers to provide pre-referral interventions prior to referring students for a formal evaluation. Parent satisfaction for the Intervention-Based Assessment (IBA) was related to amount of parent involvement (McNamara, Telzrow, & DeLamtre, 1999). Parents reported a desire to participate in the IBA process. While parent satisfaction with the IBA process was high, satisfaction with the intervention outcomes did not necessarily follow. Parents who were involved at the beginning of the IBA rated the intervention plans more favorably suggesting plan ownership and investment. In schools in which pre-referral teams have not yet been established, parents who are aware that other schools utilize such teams may act as change agents.

Family involvement will require school personnel to operate within a collaborative-consultative orientation with parents (Dunst, Johanson, Rounds, Trivette, & Hamby, 1992; O'Shea et al., 2001; Rappaport, 1981; Whaley & Swadener, 1990). Collaboration is defined as working cooperatively with others (Merriam-Webster, 1985). Collaboration through partnership enables school personnel and parents to act in the best interest for the student (Rappaport, 1981; Whaley & Swadener, 1990). Parents and teachers can share in a common goal and responsibility of success for learners (Seely, 1985).

When parents are made partners in education they tend to relate their child's success to their involvement and become invested in their child's education (Rich, 1987). High achievement was associated with active, interested parents who provided educational experiences, helped with schoolwork, developed their children's interest in reading, and took the initiative in contacting schools (Rankin, 1967). Parent involvement

has been associated with better long-term achievement, and improved attendance and attitudes about school (Henderson, 1989; Kagan, 1984; Sattes, 1985). Parent involvement results in improved child functioning and improved school functioning (Henderson 1981; 1987). The importance of parental involvement for regular education students is strong evidence that involvement of parents is even more critical for students with difficulties.

Effective collaborating includes frequent, consistent communication (O'Shea et al., 2001; Vosler-Hunter, 1990). The relationship should be one of mutual respect (O'Shea et al., 2001; Rosenfield & Gravois, 1996). Teachers and parents need to maintain their individual roles, while working in a cooperative manner (Christenson & Conoley, 1992). A lack of these factors may result in obstacles to collaboration.

However, school personnel, school psychologists, and parents have differing views that may hinder the collaborative process (Christenson & Conoley, 1992; O'Shea et al., 2001). Barriers to collaboration may include parents with the belief that they are not intelligent enough to discuss issues with teachers, parents who have had bad experiences with teachers, and parents with the belief that they will not be treated fairly by school personnel (O'Shea et al., 2001). Time constraints, role confusion, lack of structure, lack of training, and unclear boundaries are also problematic (Christenson & Conoley, 1992). Another barrier could include parents' beliefs that their child does not have a problem and thus see no point in participating in problem solving (O'Shea et al., 2001).

It has been suggested that most multidisciplinary teams will experience increased creativity, productivity, and satisfaction if a collaborative approach is implemented

(Thousand & Vialla, 1992). A collaborative approach includes face-to-face communication, joint leadership, effective communication, and individual as well as group accountability. Teacher empowerment may be increased through participatory decision making (Schlechty, 1990). Multidisciplinary teams whose purpose is to make special education classifications have faced many problems (Shaw & Swerdik, 1995). A major problem is the lack of equal participation of team members in decision making. Teams also suffer when other problems surface such as hidden agendas, lack of trust, and active or passive participants.

Teachers and parents alike may not have the adequate knowledge and training about team processes (Rosenfield & Gravois, 1996). A foundation of understanding regarding essential team procedures could enable team members to work effectively toward the unified goal of providing the best service for the student in question. Key elements of team functioning could include keeping the focus on the individual student and critically evaluating instructional environments and previous intervention designs. Team members should be concerned with the instructional match and not necessarily where the instruction will take place. The realization that responsibility is shared among the members is essential for active involvement of all participants. School personnel and parents who understand the goals and responsibilities of the team will be able to communicate more effectively. This effective communication will be imperative with the changes called for in specific learning disability classification procedures.

Changes in Special Education Policy

Policy recommendations for the reauthorization of IDEA were discussed at a recent National Joint Committee on Learning Disabilities (NJCLD) roundtable (2002).

Active parent participation and collaboration with professionals was recognized as a key procedural safeguard because this puts the focus on the individual student. A change in the way of identifying children with specific learning disabilities was suggested. This change called for students to be evaluated on an individual basis comparing intra-individual differences. The rejection of the IQ-Achievement discrepancy model was also suggested. This current method of identifying students with disabilities has been labeled antiquated and ineffective (Nealis, 2002). Aspects of a new model would include early identification, and intervention and accountability and parent empowerment. Parents who are actively involved will invest in the process and feel responsibility to have a positive influence versus passively receiving information. The use of parent satisfaction surveys is one of the recommendations for accomplishing this.

Summary

Previously Public Law 94-142 and currently IDEA provide regulations for special education classification and a major aspect of this is parent involvement (Fagan & Warden, 1996; IDEA, 1997). However, these regulations are vague which has lead to inconsistent practices (Salvia & Ysseldyke, 1998). This vagueness has the biggest impact on classifying students with learning disabilities, which are the most common referral and placement (Salvia & Ysseldyke, 1998). Another problem with the classification process is the over representation of minorities placed in special education, specifically in the learning disability category (Artiles, Aguirre-Munoz, & Abedi, 1998; Bersoff, 1980; Jacobs, 1991; MacMillan & Reschly, 1998; Maheady, Algozzine, & Ysseldyke, 1984; Patton, 1998; Talbert-Johnson, 1998). The reauthorization of IDEA will result in policy

change in the classification process, thus eligibility criteria may become even more confusing for parents (NJCLD, 2002).

Parents may feel unprepared and intimidated at classification meetings, as they are the only non-professionals (Wise, 1995). A collaborative-consultative style will need to be followed for proper family involvement (O'Shea et al., 2001). Previous studies on parent involvement were descriptive in nature and did not attempt to manipulate variables (Hoff et al., 1978; Gartner & Lipsky, 1992; Goldstein et al., 1980; McKinney & Hocutt, 1982; Polifka, 1981; Shriver & Kramer, 1993; Vacc et al., 1985; Vaughn et al., 1988). Parent satisfaction is positively associated with parent involvement (Polifka, 1981; Witt et al., 1984).

Effective parent training and education is necessary to enable parents to be competent in their role as a team member (O'Shea et al., 2001). This training needs to include training about procedure and the nature of learning disabilities (Goldstein et al., 1980; Simpson, 1982). This training could include the use of a checklist for eligibility criteria (Anderson-Inman, 1986; Costello, Dulcan, & Kalas, 1991; Fagley, 1984; Hawkins, Mathews, & Hamdan, 1999; Kratochwill and Roseby, 1988; Mattison, Lynch, Kales, & Gamble, 1993; Moss, Prosser, Costello, Simpson, Patel, Rowe, Turner, & Hatton, 1998). Parents with positive, realistic perceptions of their child's disability can advocate for their child's needs to be met (O'Shea et al., 2001). Parents also need additional advocacy training so that they can gain skill such as appropriate questioning (Valdez, 2002). A good advocate has the skills to negotiate in the best interest of their child.

CHAPTER 3

METHODOLOGY

Multidisciplinary special education eligibility team meetings for initial classification were audio taped for 46 elementary and secondary students suspected of having a Specific Learning Disability (SLD). The IEP meetings of the 14 students who were classified as SLD were also audio- taped. The amount and types of verbal participation of parents during the meetings was recorded. The number of questions asked, responses to school personnel, acknowledgments (e.g. okay, yeah), and interjections were recorded. Prior to the meetings one third of the parents were given informational handouts and training regarding SLD's and one third of the parents were given informational handouts regarding developmental milestones; while another third of the parents were not given any additional information. All parents were given a prior knowledge questionnaire. Parents were also asked to complete a perception and satisfaction questionnaire regarding the proceedings and decision following the meetings. Regular education teachers who attended the meeting were also asked to complete a similar perception and satisfaction questionnaire regarding the proceedings and their perceptions of parent participation.

Participants

Participants ($N=45$) included parents of children who were suspected to have a Specific Learning Disability (SLD) and had been referred for an initial psychoeducational evaluation to determine special education eligibility. Parents of children attending

elementary and secondary schools, in three separate school districts within two Southwestern states, participated in this study. The regular education teachers of the children who attended the classification and IEP meetings also participated by completing a questionnaire after the meeting. These three school districts were selected because their student populations were representative of urban, small city, and rural student populations.

Participants met the following criteria to participate in the study: (a) have a child attending kindergarten through seventh grade, (b) have a child who had not previously been evaluated and found eligible for a specific learning disability, and (c) endorse they are proficient in the English language. The third criterion was designed to limit possible confounds that might be present if participants differed considerably in language comprehension and expressive communication skills. Each participant also agreed to be randomly assigned to the different conditions of the study, participate in training activities, answer questionnaires, have the regular education teacher answer a questionnaire, be audio taped during the classification and IEP meetings, and release special education documents to the researcher. These documents included the initial evaluation report, the referral for testing form, and any IEP goals and objectives.

The demographic characteristics of the participants and their families are shown in Table 1. Seventy eight percent of the parent participants were mothers, followed by fathers (19.6%), and one grandmother who was a legal guardian (2.2%). The majority of parents, both mothers and fathers, were between 36 to 45 years of age (mothers 58.7%, fathers 47.8%). Yearly incomes were reported in the range of below \$5,000 (2.2%), \$5-\$10,000 (4.3%), \$11-\$20,000 (15.2%), \$21-\$40,000 (39.1%), and \$40, 000 and above

(39.1%) annually. Half of the participants had 2 – 3 children in their family (50.0%). Many of the mothers had partially completed college or technical training (39.1%), 26.1% graduated from college, 21.7% graduated from high school, 8.7% completed grade school and had some high school and 4.3% had graduate training or a graduate degree. Similarly, the educational level of many fathers was completion of partial college or technical training (32.6%), 23.9% graduated from college, 21.7% graduated from high school, 10.9% completed grade school and had some high school and 8.7% had graduate training or a graduate degree. The majority of mothers and fathers were Caucasian (mothers 71.7%, fathers 69.6%). Most participants were married (67.4%). Of the parents who were divorced (23.9%) or separated (2.2%) the student spent a majority of their time with their mother (86.7%). Most participants reported no previous experience with the special education process (84.8%) and did not have other children receiving special education services (89.1%).

Table 1
Demographic Characteristics of Participants

Characteristic	<u>n</u>	Percent of Total
Relationship to Student		
Mother	36	78.3%
Father	9	19.6%
Legal Guardian	1	2.2%
Age of Mother		
18-25	2	4.3%
26-35	14	30.4%
36-45	27	58.7%
46 or older	3	6.5%

Age of Father		
18-25	0	0.0%
26-35	13	28.3%
36-45	22	47.8%
46 or older	11	23.9%
Yearly Income		
Below \$5,000	1	2.2%
\$5-10,000	2	4.3%
\$11-20,000	7	15.2%
\$21-40,000	18	39.1%
Above \$40,000	18	39.1%
Number of Children in Family		
1	9	19.6%
2-3	23	50.0%
4-5	10	21.7%
6-7	3	6.5%
8 or more	1	2.2%
Educational Level of Mother		
Grade School/ Some High School	4	8.7%
High School Graduate	10	21.7%
Partial College/ Technical Training	18	39.1%
College Graduate	12	26.1%
Graduate Training or Degree	2	4.3%
Educational Level of Father		
Grade School/ Some High School	5	10.9%
High School Graduate	10	21.7%
Partial College/ Technical Training	15	32.6%
College Graduate	11	23.9%
Graduate Training or Degree	4	8.7%
Ethnicity of Mother		
African American	2	4.3%
Caucasian/White	33	71.7%
Hispanic/Latino	11	23.9%
American Indian/ Alaska Native	0	0.0%

Ethnicity of Father		
African American	2	4.3%
Caucasian/White	32	69.6%
Hispanic/Latino	11	23.9%
American Indian/ Alaska Native	1	2.2%
Marital Status of Parents		
Single	3	6.5%
Married	31	67.4%
Separated	1	2.2%
Divorced	11	23.9%
If Divorced, Child Spends Time w/		
Mother	13	86.7%
Father	2	13.3%
Previous Experience w/ Special Ed		
No	39	84.8%
Yes	7	15.2%
Any Other Children in Special Ed		
No	41	89.1%
Yes	5	10.9%

Note. Some groups do not sum to 100% due to rounding

The characteristics of referred students are shown in Table 2. Referred students consisted of both male (54.3%) and female (45.7%) children. The average age of referred students was 9.3 years. Overall, a majority of these students (69.6%) did not meet the eligibility criteria to qualify as a student with a specific learning disability.

Table 2
Characteristics of Referred Students

Characteristic	<u>n</u>	Percent of Total
Age		
7 years	3	6.5%
8 years	14	30.4%
8.5 years	1	2.2%
9 years	12	26.1%
10 years	5	10.9%
11 years	6	13.0%
12 years	3	6.5%
13 years	2	4.3%
M = 9.29		SD = 1.57
Gender		
Male	25	54.3%
Female	21	45.7%
Qualified w/SLD		
No	32	69.6%
Yes	14	30.4%

Note. Some groups do not sum to 100% due to rounding.

School Districts

Three separate school districts in Oklahoma and Texas agreed to participate in this study. These school districts were selected because their student populations were representative of urban, small city, and rural student populations; and their willingness to be involved in the study (see Tables 3-5 for descriptive information). Schools were given the incentives of direct benefits to parents and students, a master set of SLD

informational packets so that they could make and distribute copies to parents, and the opportunity to contribute the professional literature regarding ways to better inform parents about special education procedures.

Table 3
Size of School District

School District	Student Population
Urban	74,736
Small City	13,517
Rural	1,268

Table 4
Ethnicity of Districts' Student Population

School District	Students	Percent
Urban		
African American	8,296	11.1%
Asian	6,128	8.2%
Caucasian/White	38,863	52.0%
Hispanic	21,374	28.6%
Native American	75	0.2%
Small City		
African American	1,379	10.2%
Asian	730	5.4%
Caucasian/White	8,867	65.6%
Hispanic	1,243	9.2%
Native American	1,298	9.6%
Rural		
African American	60	4.7%
Asian	0	0.0%
Caucasian/White	1,096	86.5%
Hispanic	44	3.4%
Native American	68	5.4%

Table 5
Size of Districts' Special Education Population

School District	Students	Percent
Urban	7,100	9.5%
Small City	1,379	10.2%
Rural	157	12.4%

Instrumentation

The *Specific Learning Disability (SLD) informational packet* (see appendix F) was compiled to provide understandable and helpful information for the parent to be more active during the meeting. This packet contained a SLD symptom and prognosis sheet, a handout highlighting specific parent rights regarding classification, a question prompt sheet combined with a SLD eligibility check sheet, an informational handout about being a member of a multidisciplinary team, and an IEP guide and check sheet. The question prompt sheet portion gave the parents examples of questions they could ask to facilitate better understanding. The SLD eligibility check sheet portion contained items parents could check off if that information was presented in the meeting. This enabled parents to keep track of the eligibility criteria for their child's SLD placement decision. The multidisciplinary handout defined the role of multidisciplinary teams and its members, as well as gave tips on being an effective team member. The IEP guide outlined the primary functions an IEP should serve and gave examples of clearly written IEPs. The IEP check sheet provided an outline of the items an IEP should include so that

the parents could check these off during the meeting as the IEP goals and objectives were reviewed.

The *Parent Knowledge Questionnaire (PKQ)* (see appendix E) was developed to measure the parent's knowledge about parental rights, SLDs, IEPs and classification meeting procedures. These questions were taken directly from the Individuals with Disabilities Education Act (IDEA) regulations for special education procedures (IDEA, 1997). Parents were instructed to answer yes or no to 42 questions regarding parental rights, specific learning disability eligibility criteria, multidisciplinary teams, and IEPs. The number correct was summed to give a total correct score. The higher the score on the PKQ more parental knowledge of special education procedures was assumed. The PKQ was also used to measure whether parents who were given the *SLD informational packet* assimilated the information it provided. The researcher was able to attend to items the parent was unsure about and use the PKQ as an outline in order to better prepare parents in the treatment group for the classification and IEP meetings during the direct training.

The *Parent Verbalization Coding Form (PVCF)* (see appendix G) was developed to assess parent participation during the classification and IEP meetings. The type and duration of parent verbalizations were coded in 15 second intervals. All verbalizations were placed into four categories: a) questions, b) responses, c) acknowledgments, and c) interjections. These verbalizations were also divided into two quality categories: a) passive and b) active. Active verbalizations were statements that were volunteered or asserted by the parent. Passive verbalizations were statements induced by or in response to statements and questions of the school personnel. Questions were defined as a

subject/expression presented for open discussion, expression intended to seek additional information (examples include requests for clarification or additional information).

Responses were defined as answering/replying to personnel's questions, (examples include answering questions posed by school personnel with a yes or a no or answering questions or responding to statements while adding information to the conversation).

Acknowledgements were defined as recognition of school personnel's statements (e.g. okay, yeah). Interjections were defined as words or statements that interrupt school personnel's statements.

The *PVCF* was used to code parent participation in conjunction with audio-taped recordings of the meetings. This type of recording was used to reduce participant reactivity during the meetings and provide a means to later code the meetings. Audio-taping was selected as the best way to record meetings due to several factors that included maintenance of confidentiality, less reactivity than to a live observer, less reactivity than to a video camera, ability to use multiple coders, increased assurance of accuracy, and it was the most economical. The recordings were coded by the researcher and inter-rater agreement was assessed on every fifth audiotape (11%) by a research assistant. The research assistant was a school psychology doctoral student who was very familiar with educational terminology and special education procedure, thus she quickly learned to discern the different participation types. The research assistant was trained to a reliability standard of 90% agreement with the researcher. To limit rater bias, the research assistant was blind to which group participants were assigned. When comparing researcher and research assistant coding of the meetings an inter-rater reliability of .87 on the *PVCF* was obtained. Due to technical difficulties, one classification meeting had not

been audio-taped, which reduced the data available for analysis of parent participation to 45 cases.

The *Parent Perception & Satisfaction Questionnaire (SPQ)* (see appendix H) was developed based on parent perception and multidisciplinary team studies (Goldstein et al., 1980; Lamorey & Ryan, 1998; Lynch & Stein, 1982; Weham & Gilkerson, 1999; Witt et al., 1984). It measured the parent's perception of how much they participated in the process and various aspects of the process, such as how satisfied they were about their participation and the process and their satisfaction regarding the placement and if applicable the IEP decisions made by the multidisciplinary team. The questionnaire contained 44 items constructed using a five-point Likert-scale consisting of strongly disagree (1), disagree (2), no opinion (3), agree (4), and strongly agree (5) was used; high scores on this scale being more desirable. Parents were also asked to answer open-ended questions regarding barriers to parent involvement, helpful and least helpful aspects of the meetings, suggested improvements, and any additional comments.

The *Teacher Perception & Satisfaction Questionnaire (TSPQ)* (see appendix I) was developed and modeled after the SPQ to measure the regular education teacher's perception of how much parents participated in the special education process, satisfaction about their own participation, satisfaction regarding the placement and if applicable IEP decisions that were made. This questionnaire was used as a check for parent perceptions, as different individuals may interpret the events of the meeting differently. This measure allowed for a comparison between parents' perceptions of their participation and teachers' perceptions of parent participation. If teacher perceptions matched parent perceptions greater weight could be given to findings regarding the effectiveness of the

parent training. The questions pertaining to teacher satisfaction were an aside to this study and included because it matched the parent questionnaire, and the information gathered could be used in future analyses. Regular education teachers were selected to complete the questionnaire so that parent perceptions could be compared to the perceptions of the school personnel. These teachers were best suited to complete this questionnaire because they knew the student best and would consistently be present at classification and IEP meetings. The questionnaire contained 42 items constructed using a 5-point Likert scale format with scores ranging from 1 (strongly disagree) to 5 (strongly agree), with high scores being more desirable. Due to one teacher not completing both sides of the questionnaire the sample size was reduced to 45 for analysis of data about teachers.

Procedure

This study evaluated the effects of the parental training program on parent perceptions of the special education process and their satisfaction, teacher perceptions of parent participation during the special education process, and quantity and quality of parent involvement during initial special education multidisciplinary meetings.

Participants were initially informed about the study by the special education representative at their school to ensure their privacy. Special education representatives were the individuals responsible for obtaining permission for the initial evaluation and included school counselors, assistant principals, and/or special education teachers. At either the time a parent signed permission forms for an initial evaluation or when the classification and IEP meetings were scheduled with the parent, the special education representative reviewed the request to contact form (see appendix A). This form briefly

explained the study, requested the parent's name, telephone number, address, e-mail address, and signed permission for the researcher to contact the parent further. The special education representative within each school informed the researcher about each initial evaluation in which permission to contact was obtained. The researcher contacted parents by phone to briefly explain the study, review the consent form, obtain informal consent to participate, and inform them that a formal consent form would be mailed to them. During the phone conversation parents were given an explanation of the purpose of the study, requirements for participation, confidentiality procedures, possible benefits and risks, participant rights, that there was no penalty for non-participation, and that they could discontinue participation at any time during the study without penalty. A participant recruitment letter (see appendix B) and informed consent form (see appendix C) was mailed to the parents with a request that they sign the consent form and mail it back using a self-stamped, pre-addressed envelope. The incentive for participation included direct benefits through participation in the study and all parents were given the SLD informational packet by the conclusion of the study. Of the parents who gave permission to be contacted three declined to participate in the study due to time constraints and no participants chose to withdraw from the study.

The regular education teachers who attended the classification and IEP meetings were asked to complete a perception and satisfaction questionnaire after the meetings. It was explained that their participation was completely voluntary and anonymous. All regular education teachers agreed to complete the questionnaire.

Three study conditions were employed to assess differences in the groups and measure the effectiveness of the treatment provided. Using a treatment and control group

would have provided basic information regarding group differences; however a third group, named the attention group, was also included to determine if differences among the groups were due to a true treatment effect or was due to the additional attention parents would receive in the treatment group. Parents in the attention group received an informational handout regarding developmental milestones of school age children (see appendix J), information that appeared neutral in nature and theoretically not related to increased knowledge about the special education process.

Participants ($N = 46$) were randomly assigned to either the control group ($n = 16$), attention group ($n = 15$), or treatment group ($n = 15$). The participants and the school personnel were kept blind to which condition they had been assigned in order to minimize response to treatment expectations and maintain internal validity of the study. The randomization was carried out using a website that generates a randomization plan specific to any study (www.RANDOMIZATION.com, 2003). The program begins by sorting treatment names internally. Randomization.com utilizes a pseudo-random number generator that was conceptualized by Wichmann and Hill (1982), which was modified by McLeod (1985). The generator uses three seeds, in which the first seed is always 12345, the second seed is always 23456, and the third seed can be specified by the researcher. However, the third seed is typically obtained from the local computer's clock as $1 + \text{mod}(1000 * \text{seconds} + 10 * \text{minutes} + \text{hours}, 29998)$; an integer between 1 and 29,998. The randomization in this study was carried out by using three blocks to insure against serious imbalance even if the study was terminated before reaching the expected amount of subjects, which was 60 for the current study (Fleiss, 1986). Thus, 60 subjects were randomized to 3 blocks to insure that the number of subjects on each treatment would be

equal every time the total number entered is a multiple of 60, because the number of subjects per block must be a multiple of the number of treatments. Each block is generated by placing the list of the treatments in reverse alphabetical order, each treatment appears in the block k times, the list starts out as k copies of condition 1, followed by k copies of condition 2, and then k copies of condition 3 for a total of kt treatment names. “A random permutation vector ($P(i): i=1,..,kt$) is generated. Initially, $P(i)=i$. At each step i , as i goes from kt to 2, a random integer is generated between 1 and i , inclusive. The value at that position in the permutation vector swaps places with the value currently in position i .” (Dallal, 1997)

Prior to the classification meeting each parent, or couple if both parents attended, completed a demographic questionnaire (see appendix D) and the *PKQ*. In condition one, the treatment condition, the parent was given the *SLD informational packet* and this was reviewed with the researcher prior to the classification meeting either in person or via telephone. In condition two, the attention condition, the parent received an informational handout on developmental milestones for school age children and this was reviewed before the classification meeting either in person or via telephone. In condition three, the control condition, the parent did not receive any additional information. Every parent involved in the study received all the information their schools normally provided parents during this process, thus all parents regardless of group assignment received at least the minimum information regarding the special education process as specified by IDEA.

The special education representative, usually a school counselor, special education teacher, or diagnostician, responsible for conducting multidisciplinary

meetings audio-taped each classification and IEP meeting. The audio-tape was set to record on side A and only attended to if it needed to be placed on side B due to a lengthy meeting. Immediately following the meetings, the parent completed the *SPQ* and the regular education teacher completed the *TSPQ*. If the student was found to meet the eligibility criteria for a specific learning disability, the parent and teacher were asked to answer the questions pertaining to the IEP meeting after that meeting was completed. A copy of the parent's classification and IEP check sheets were going to be obtained to measure whether they were used by the parents; however none of the parents in the study used them. Thus, making copies was unnecessary. Copies of the referral form, evaluation report, and if applicable IEP goals and objectives were also obtained. Finally, parents were debriefed about the nature of the study and those parents who had not yet been given the *SLD informational packet* received one.

Reliability

The SPQ and TSPQ were researcher developed measures constructed specifically for the purposes of this study. Thus, technical data for these measures had not been previously established. General statistical guidelines for reliability have been provided and a minimum reliability score of .60 has been proposed by researchers for reporting scores of groups of individuals (Salvia & Ysseldyke, 1991, p.142). Of particular concern with researcher developed measures is whether reliable factors can be measured. Internal consistency can be forced when individual items of measures have a theoretical basis. The reliability of SPQ and TSPQ was computed by calculating the internal consistency of individual items using coefficient alpha methodology.

The SPQ measured three separate constructs: parent perception of the meetings, parent satisfaction with the meetings and parent perception of their participation during the meetings. The TSPQ also measured three separate constructs; teacher perception of the meetings, teacher satisfaction with the meetings and teacher perception of parent's participation during the meetings. The internal consistency of all six constructs exceeded the .60 criteria for reliability (Salvia & Ysseldyke, 1991, p. 142). Coefficient alpha for these constructs ranged from .85 to .94. Table 6 displays all the reliability scores for the constructs measured by the SPQ and TSPQ.

Table 6

Internal Consistency of Construct Scores

Cluster	Coefficient Alpha
Parent Perception	0.88
Parent Satisfaction	0.91
Parent Perception of Participation	0.94
Teacher Perception	0.89
Teacher Satisfaction	0.85
Teacher Perception of Participation	0.85

Validity

Once reliability of the SPQ and TSPQ was established, correlations of these items were measured for the general perception constructs and satisfaction constructs. The Parent Perception and Parent Satisfaction constructs were highly correlated (.962) at the 0.01 level. The Teacher Perception and Teacher Satisfaction constructs were also highly

correlated (.918) at the 0.01 level. Thus, although they appeared to be two separate constructs these high correlations indicated that they were actually measuring the same construct; satisfaction. All the questions were asking how parents felt about the meeting asking them to make a value judgment. Actual, objective perceptions were not asked. The Parent Satisfaction construct and the Teacher Satisfaction construct were moderately correlated (.368) at the 0.05 level. The Parent Perception construct and the Teacher Perception construct were moderately correlated (.427) at the 0.01 level. It was expected that at least moderate correlations would exist between parent and teacher constructs. Validity is also strengthened because multiple measures and multiple informants were used.

CHAPTER 4

RESULTS

The effects of parent training on parent participation (quantity and quality), perception of participation (by parent and teacher), and parent satisfaction in regard to multidisciplinary meetings were investigated. The Statistical Package for the Social Sciences version 11.0 (SPSS, 2001) was used to conduct statistical analyses of the data. The SPQ, TSPQ, PKQ, and behavioral observations of the multidisciplinary meetings were used as the dependent variables to determine differences between the experimental conditions.

Treatment Integrity

The integrity of the treatment was paramount in determining whether differences found between experimental conditions were attributed to the parent training. To ensure that parents previewed the informational packet, the researcher reviewed the packet and answered any parent questions prior to their attendance at the initial multidisciplinary meeting. Therefore, the treatment was not merely a packet of handouts; instead one-on-one attention was integral to the parent training.

All parents were asked whether they had prepared for the initial meeting by obtaining information about learning disabilities on the PSQ. Parents in the treatment group answered yes automatically because they went through the training. Thus, this question was asked to determine if parents in the other group had independently gathered information to prepare for the meeting. Parent responses to this question were analyzed

using univariate ANOVA and significant ($p < .001$) differences were found between the treatment and attention and control conditions (see table 7 and table 8). Participants in the treatment condition reported higher rates of preparation than participants in the other two conditions [$F(2, 46) = 9.98, p < .001$].

Table 7

Parent Preparation

Variable	Group (N=46)						Sig.
	Treatment (n=15)		Attention (n=15)		Control (n=16)		
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>	
PPREP	4.27	.70	2.67	1.11	3.0	1.21	.000

Table 8

ANOVA Summary 1

	Sum of Squares	df Square	Mean	F.	Sig.
Between Groups	21.472	2	10.736	9.978	.000
Within Groups	46.267	43	1.076		
Total	67.739	45			

Research Questions

Question 1: Are there differences in quantity and quality of parent participation in initial multidisciplinary meetings between parents who received training and parents who did not?

An analysis of data from audio-taped behavioral observations, the SPQ, and TSPQ was used to examine parent participation differences. The quantity of active verbal behavior of parents was coded in 15 second intervals to yield an overall amount of time. Four items from the SPQ were used to assess parents' perception of their participation during the initial multidisciplinary meeting. Four items from the TSPQ were used to assess teachers' perception of parent participation during this initial meeting. It was hypothesized that parents who participated in the training would have higher amounts of actual and perceived participation.

The three dimensions of parent participation: observed, self-report, and teacher, were analyzed using MANOVA to examine group differences. The dependent variables were the parent participation construct made up of the amount of active verbalizations (total active), parent perception of participation (PPART), and teacher perception of parent participation (TPART). The n for the control was 15, due to one meeting that was not taped as a result of technical difficulties. A significant multivariate main effect for group was noted (Wilk's lambda = .54; $F(2, 45) = 4.807$; $p < .001$). Significant differences were found between the treatment, attention, and control conditions for parent participation during initial multidisciplinary meetings. η^2 values are reported as a way to estimate effect size. Table 9 summarizes the multivariate results.

Table 9

Parent Participation

Variable	Group (N=45)			Sig.	Eta Sq.
	Treatment	Attention	Control		
	(<u>n</u> =15) <u>M</u> <u>SD</u>	(<u>n</u> =15) <u>M</u> <u>SD</u>	(<u>n</u> =15) <u>M</u> <u>SD</u>		
Total Active	273 346.31	41 69.31	32 72.58	.004	.24
PPART	17.20 2.01	11 3.76	13.87 4.75	.000	.34
TPART	16.40 2.20	13.01 3.53	13.67 3.96	.020	.17

Analysis of these data indicated that participants assigned to the treatment condition displayed statistically significantly higher participation during the initial multidisciplinary meetings than the participants assigned to the attention and control conditions for all three constructs; total active, PPART, TPART.

Univariate analysis of variance tests were conducted as a follow-up to the significant multivariate test. There were significant group differences on all three dependent variables. The significant group effects for each dependent variable were also analyzed with post hoc tests.

There was a significant main effect for Treatment [$F(2, 45) = 6.461, p < .01$] on the total active variable. Parents who were in the treatment condition ($M = 273.00, SD =$

346.31) were observed to have significantly higher participation than the parents who did not receive the treatment, both for the attention condition ($M = 41.00$, $SD = 69.31$) and control condition ($M = 32.00$, $SD = 72.58$). Post hoc Tukey HSD indicated that there was a significant mean difference ($Md = 232.00$, $SEM = 76.01$, $p < .05$) between the treatment condition and the attention condition. A significant mean difference ($Md = 241.00$, $SEM = 76.01$, $p < .01$) between the treatment condition and the control condition also occurred. There was not a significant mean difference ($Md = 9.00$, $SEM = 76.01$) between the attention and control conditions.

A significant main effect for Treatment [$F(2, 45) = 10.639$, $p < .01$] on the PPART variable was found. Parents who received the treatment ($M = 17.20$, $SD = 2.01$) rated themselves to have higher amounts of participation than parents who received attention ($M = 11$, $SD = 3.76$) and parents who were in the control condition ($M = 13.87$, $SD = 4.75$). Post hoc Tukey HSD indicated that there was a significant mean difference ($Md = 6.20$, $SEM = 1.35$, $p < .001$) between the treatment and attention condition. A significant mean difference ($Md = 3.33$, $SEM = 1.35$, $p < .05$) between the treatment condition and the control condition also occurred. There was not a significant mean difference ($Md = 2.87$, $SEM = 1.35$) between the attention and control conditions.

There was a significant main effect for Treatment [$F(2, 45) = 4.306$, $p = .02$] on the TPART variable. Parents who were in the treatment condition ($M = 16.40$, $SD = 2.20$) were rated to have higher amounts of participation by the regular education teachers than parents in the attention condition ($M = 13.01$, $SD = 3.53$) and parents in the control condition ($M = 13.67$, $SD = 3.96$). Post hoc Tukey HSD indicated a significant mean difference ($Md = 3.33$, $SEM = 1.21$, $p < .05$) between the treatment condition and the

attention condition. There was not a significant mean difference ($Md = 2.73$, $SEM = 1.21$) between the treatment condition and control condition. There was also not a significant mean difference ($Md = 0.60$, $SEM = 1.21$) between the attention and control conditions.

In order to determine practical significance, the Cohen effect size was measured for each variable (Stevens, 2002, p. 10). When looking at the practical significance of the difference between the treatment condition and attention condition for the total active variable, the Cohen effect size equaled 1.12, which falls into the large range according to Cohen. The Cohen effect size for the difference between the treatment condition and control condition for the total active variable was 1.15, which was also in the large range. The practical significance for the PPART and TPART variables between the conditions also fell within the large range according to Cohen. See Table 10 for all the univariate results and effect sizes. Thus, not only were there clinically significant differences between the treatment condition and the attention and control conditions these differences were also practically significant.

Table 10

Effect Sizes

Variable	Sig.	Effect Size
total active		
treatment vs. attention	.004	1.12
treatment vs. control	.003	1.15
PPART		
treatment vs. attention	.000	1.07
treatment vs. control	.017	.99

TPART		
treatment vs. attention	.009	1.16
treatment vs. control	.029	.89

Question 2: Does parent training account for differences in parents' knowledge about specific learning disabilities and the special education process?

Data from the PKQ were analyzed to determine differences in parent knowledge. Parents' responses on the PKQ were summed to yield a total correct score, named PK. The higher the score the higher the knowledge. Univariate analysis of variance (ANOVA) was used to measure differences between the treatment, attention, and control conditions. It was hypothesized that there would be differences between experimental conditions on amount of knowledge parents acquired about specific learning disabilities and the special education process. Significant ($p < .01$) differences were found between the treatment condition and the attention and control condition [$F(2, 46) = 13.976, p < .01$] on the Parent Knowledge variable. Parents who were in the treatment condition ($M = 40.33, SD = 2.44$) demonstrated more knowledge than parents in the attention condition ($M = 32.73, SD = 5.31$) and parents in the control condition ($M = 32.38, SD = 5.57$). Table 11 and 12 summarizes the results of the analysis of parent knowledge.

Table 11

Parent Knowledge

Variable	Group (N=46)						Sig.
	Treatment		Attention		Control		
	(n=15)		(n=15)		(n=16)		
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>	
PK	40.33	2.44	32.73	5.31	32.38	5.57	.000

Table 12

ANOVA Summary 2

	Sum of Squares	df Square	Mean	F.	Sig.
Between Groups	613.636	2	306.818	13.976	.000
Within Groups	944.017	43	21.954		
Total	1557.652	45			

Post hoc Tukey HSD indicated that there was a significant mean difference ($Md = 7.60$, $SEM = 1.711$, $p < .01$) between the treatment condition and the attention condition. A significant mean difference ($Md = 7.96$, $SEM = 1.684$, $p < .01$) between the treatment condition and control condition also occurred. There was not a significant mean difference ($Md = .36$, $SEM = 1.684$) between the attention and control conditions. It is also important to note that the standard deviation for the treatment condition varied

significantly from those of the attention and control conditions; that is it was much smaller.

Practical significance was also measured and large effect sizes were found for the differences between the treatment condition and attention and control conditions (Stevens, 2002, p. 10). The effect size for the difference between the treatment and attention conditions was 1.96. The effect size for the difference between the treatment and control conditions was 1.99. Thus, statistically and practically significant differences were found for differences between the treatment condition and the other two conditions.

Question 3: Are there differences in parents' satisfaction with the multidisciplinary team meetings and the decisions that were made due to participation in parent training?

Parent satisfaction was measured using the SPQ. The 18 items relating to parent satisfaction composed the satisfaction variable, named PSATIS. It was hypothesized that there would be differences between experimental conditions on the level of satisfaction. Parents who participated in the parent training were expected to have higher levels of satisfaction. Univariate analysis of variance (ANOVA) was used to measure condition differences. A significant ($p < .05$) difference was found [$F(2, 46) = 3.903, p = .028$] between the treatment condition and the attention condition but no significant differences were found between the treatment condition and control condition on the Parent Satisfaction variable. Parents who were in the treatment condition ($M = 74.20, SD = 8.92$) reported more satisfaction than parents in the attention condition ($M = 64.07, SD = 10.49$). Table 13 and 14 summarizes the results of the analysis of parent satisfaction.

TABLE 13

Parent Satisfaction

Variable	Group (N=46)						Sig.
	Treatment		Attention		Control		
	(n=15)		(n=15)		(n=16)		
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>	
PSATIS	74.20	8.92	64.07	10.49	70.25	10.52	.028

Table 14

ANOVA Summary 3

	Sum of Squares	df Square	Mean	<u>F</u>	Sig.
Between Groups	783.145	2	391.572	3.903	.028
Within Groups	4314.333	43	100.333		
Total	5097.478	45			

Post hoc Tukey HSD indicated that there was a significant mean difference ($M_d = 10.13$, $SEM = 3.657$, $p < .05$) between the treatment condition and the attention condition. There was not a significant mean difference ($M_d = 3.95$, $SEM = 3.599$) between the treatment condition and control condition. There was also not a significant mean difference ($M_d = .618$, $SEM = 3.599$) between the attention and control conditions.

Practical significance was also measured and a large effect size of 1.04 was found for the difference between the treatment condition and attention condition (Stevens, 2002,

p. 10). Thus, a statistically and practically significant difference was found for differences between the treatment and attention conditions.

A chi square analysis was calculated on the eligibility rates to compare each group. This could serve as a way to control for whether the child had been ruled eligible to receive special education services as child with a specific learning disability. This additional analysis was conducted to determine if this could have affected parent satisfaction.

Table 15

Chi-Square Test

	Experimental Groups	Did They Qualify
Chi-Square	.043	7.04
Df	2	1
Asymp. Sig.	.978	.008

The results indicated that group differences were significantly better than chance for this variable $\chi^2 (1) = 7.04, p < .01$. Frequencies indicated that more students in the treatment group qualified for special education (6 qualified, $M = .40$) than students in the attention group (4 qualified, $M = .27$) and the control group (4 qualified, $M = .25$).

Summary of Data

Participants in the treatment condition reported higher rates of preparation than participants in the attention and control conditions. Significant differences were found between the treatment, attention, and control conditions for parent participation

during initial multidisciplinary meetings. Participants in the treatment condition displayed statistically significantly higher rates of active participation during the initial multidisciplinary meetings than the participants assigned to the attention and control conditions. Participants in the treatment condition demonstrated that they significantly rated themselves as more active and the regular education teachers rated them as more active statistically than the participants in the other two conditions. These differences in participation between the treatment condition and the attention and control conditions were also practically significant. Parents in the treatment condition demonstrated significantly more knowledge about the special education process than parents in the attention condition control condition. Practically significant differences were also found for differences between the treatment condition and the other two conditions for knowledge. Parents who were in the treatment condition reported more satisfaction than parents in the attention condition, but not the control condition. There was also not a difference in reported satisfaction between the attention condition and the control condition. Practically significant difference was also found for difference between the treatment and attention condition with regard to parent satisfaction. A chi square analysis indicated that group differences regarding whether the student qualified for special education were significantly better than chance. More students in the treatment group qualified than in the attention and control group.

CHAPTER 5

DISCUSSION

Increasing parent participation has been an important objective of special education initiatives set forth by IDEA and the National Education Goals Panel (Fagan & Warden, 1996; IDEA, 1997; The National Education Goals Panel, 1998). It has also been suggested that parents should have more involvement in special educational programming in order to be more effectively involved in implementing strategies at home to support school programming (Polifka, 1981). Parents are valuable members of multidisciplinary teams that make eligibility and IEP planning decisions and their participation is meant to be beyond mere attendance and passively giving permission to school personnel decisions (IDEA, 1997; Hoff, Fenton, Yoshida, & Kaufman, 1978; Sacks, 2001; Shriver & Kramer, 1993; Vaughn et al., 1988; Wise, 1995).

Few studies have focused on parent participation during classification meetings (Hoff et al., 1978; Vaughn et al., 1988). What is known is that parents typically have shown a lack of understanding about eligibility decisions despite attending the classification meeting (Hoff et al., 1978; Vaughn et al., 1988). Parents also have demonstrated unawareness of their rights and misconceptions regarding special education, such as how the classification process works and what their roles are in the process (Hoff et al., 1978; Lynch & Stein, 1982; McKinney & Hocutt, 1982; Vaughn et al., 1988).

In the current study parent training was conducted to determine if parents would become more cognizant of what constitutes a special education placement and become more active during multidisciplinary meetings to become better advocates for their children. This study contributes to the empirical literature regarding parental knowledge of special education classification procedures and factors related to effective participation in classification meetings.

This study investigated the effectiveness of parent training in the special education process. This training consisted of an informational handout and one-on-one attention from a school psychology doctoral candidate. Increased amounts of parent knowledge, parent participation, and parent satisfaction were predicted.

The outcomes of this study suggest that giving parents information about learning disabilities and the special education process can have a positive effect on their actions and perceptions. The training provided was not only effective but also efficient and cost effective.

In order to ensure the soundness of this study, an analysis was conducted to determine if parents not in the treatment group had prepared independently for the classification meeting. The participants in the attention and control condition reported significantly less preparation prior to the classification meeting than the participants in the treatment condition. Thus, it can be concluded the parents typically do not independently prepare for classification meetings.

Research Question 1

Are there differences in quantity and quality of parent participation in initial multidisciplinary meetings between parents who received training and parents who did not?

The results supported the hypothesis that a difference in amount and quality of parent participation would occur between parents who received parent training and those that did not. Participants who received the training exhibited higher amounts of active verbalizations than parents in the attention and control condition. These parents asked questions and interjected their ideas during the meetings. The attention group served as a means to determine whether parents' participation increased because of the training or because they had been given extra attention prior to the classification and IEP meetings. Parent participation did not simply increase because of attention. The participants in the attention and control conditions did not exhibit differences in amount and quality of participation. These parents were more passive. They mainly responded to questions asked by school personnel and made acknowledgments when school personnel spoke. This demonstrates that with training parents can participate more effectively during these meetings.

Participants who received the training not only had increased amounts of participation, but also their perception of how much they participated was significantly different from the other two groups. Participants who received the training perceived themselves as being active during the multidisciplinary meetings. They reported that they asked questions and gave input during the meetings. The regular education teachers who attended the multidisciplinary meetings also perceived the participants who received

training as more active. Their perceptions matched the parents' in the training group. They perceived that parents in the training group asked more questions and gave more input during the meetings. Self-perceptions and teacher perceptions of the participants in the attention and control group were not significantly different. These participants had lower amounts of participation, and perceived themselves as less active during the multidisciplinary meetings. The regular education teachers who attended the meetings perceived these parents to be less active. These results indicated that self efficacy of the parents who received training and teachers perception of their effectiveness was enhanced.

Research Question 2

Does parent training account for differences in parents' knowledge about specific learning disabilities and the special education process?

Parent training also accounted for differences in parents' knowledge about specific learning disabilities and the special education process. Participants who received training had scores on the PKQ that were significantly different from the participants in the attention and control groups. The participants who received training had higher scores and demonstrated a greater awareness of their rights and special education procedure. They also displayed more knowledge about specific learning disabilities. The participants who received training had scores on the questionnaire that did not vary much. Thus, not only did parents in the treatment condition have significantly higher knowledge scores there was also less variance in their scores. Thus, they learned the same information. This is most likely due to their scores being high, as many had perfect scores. This indicates that the training effectively taught parents information about

learning disabilities and the special education process. Participants in the treatment group not only reviewed the information but also retained this knowledge.

Research Question 3

Are there differences in parents' satisfaction with the multidisciplinary team meetings and the decisions that were made due to participation in parent training?

The data regarding parent satisfaction provided mixed results. There were significant differences in parent satisfaction between the participants who received the training and the participants who received the neutral attention. There were not significant differences between the participants who received the training and participants in the control group. There were also no significant differences between the participants who were given neutral attention the participants in the control group. Overall, all parents indicated a high level of satisfaction. Thus, the hypothesis that parent training would increase parent satisfaction does not appear to be supported by the data.

These insignificant findings between the control group and the treatment condition may be due to various reasons. Results indicated that students whose parents were in the training group qualified more than students whose parents were in the other two groups. This alone does not completely explain why these differences occurred but if paired with other factors gives insight into possible reasons for this finding. For instance parents in the control condition may have felt satisfied because they had no background knowledge to know any different, even though their children did not qualify for special education. Parents may also have rated the process favorably because despite the assurances that their questionnaires were confidential and would not be shared with

the school, they may have still felt social pressure to rate their school well knowing the researcher would be reading them

The findings between the treatment condition and the attention condition were unexpected when compared to the findings between the treatment condition and the control condition. It appears the attention given to participants may not have been as neutral as the researcher originally thought. Participants in this condition may have been influenced by priming effects. Participants in the attention condition may have had their expectations set to have information about their child delivered to them from a developmental standpoint since they received developmental information prior to the meeting. This is consistent with social psychology studies in which priming was found to influence participants' impressions of others and every day social interactions (Ikegami, 1993; Philippot, Schwarz, Carrera, Vries, & Yperen, 1991). Thus, participants who were expecting to discuss information from a developmental standpoint may have been less satisfied with the process when this did not happen. This may have been increased when their children also did not qualify for special education. Another possible reason for these unexpected findings might have been that parents in the attention group were expecting to receive specific information about learning disabilities and were disappointed because the meetings generally were spent reviewing test scores and discussing whether their child qualified for special education services. However, again it is important to note that all participants in the study reported high amounts of satisfaction.

When reviewing participant comments on the satisfaction questionnaire for the control and attention group, differences existed. The comments of participants in the

control group were mostly positive. Sample responses included: “no difficulties occurred; I was happy with the results; everyone at the school did an excellent job.” The few negative comments were about the referral process. Parents felt the school did not act soon enough and the steps to get to an evaluation were not included in the classification meeting as meaningful reasons of why the child may need special education services. A lot of participants in the control group did not make any comments and instead wrote “none”. Participants in the attention group comments included: “did not understand what constitutes classification in special education; difficulties understanding the technical terms and tests that were used; scheduling problems for attending the meetings; felt school did not let me make some choices I would have liked to; hearing that my child had a learning disability; not agreeing with the decision that was made; wanting more info about the special education process.” Thus it appears that the participants in the control group may not have had a clear idea of what their role was in the meetings and were satisfied with being passive participants. The participants in the attention group on the other hand appear to have been primed to feel they were being prepared for the meetings and when their perceived preparation did not match the information being delivered they may have been less satisfied than the other participants.

Summary of Results

The results of this study indicate that the parent training was an effective method for informing parents about learning disabilities and the special education process, and helping them become active multidisciplinary team members. Analyses of the data showed that parent training increased the amount of quality participation during multidisciplinary meetings, as well as increased amount of perceived quality parent

participation by parents and regular education teachers. The training also increased the amount of knowledge parents acquired about learning disabilities and special education procedures. Parent satisfaction did not seem to be largely effected by participating in parent training. Parents' ratings of satisfaction with the special education process generally were not significantly different between the parents who received training and those who did not. Other factors may have played a role in the difference found between the treatment condition and the attention condition.

Limitations of Study

Despite the significant findings of this study limitations of this study need to be considered. There might have been limitations in sample size and statistical power. There may also be limitations with sampling bias and generalizing the results to the population. Also, while parents were asked about their previous experience with special education, the question of whether they ever received special education services was not asked.

One limitation is the small sample size, which could have affected statistical power. Although significant findings were present for most of the research questions and the subject numbers were almost equal in all three conditions, the unexpected results concerning parent satisfaction may have been impacted.

Selection bias effects may have been present due to the characteristics of the school districts who agreed to participate in the study. Astonishingly, some school districts were opposed to parents receiving information that might increase their ability to advocate for their children. School personnel actually made statements during proposal meetings that they did not want parents to have knowledge that might make them

adversarial. The districts and schools who agreed to become involved were districts in which research was already being conducted, values of parent participation were already in place, and the school personnel were very enthusiastic about methods to increase parent participation in special education. While this may have been a limitation, random selection of subjects helped control for this factor.

More schools declined to participate in the study than schools who were accepting within the districts themselves. Of the three school districts who agreed to participate, 18 elementary schools out of the 52 eligible elementary schools agreed to participate in the study. Most of the nonparticipating schools either declined or did not respond to the request to meet with the researcher. Schools gave a variety of reasons for not participating. Many schools were concerned that the study would add to the workload of their staff, despite assurances that the researcher would be doing all of the recruiting and distributing of questionnaires, while the school personnel only had to record the meetings. Another reason that was given for not participating was that the special education staff was new and the study may add undue stress to the staff because the meetings were audio-taped.

While selection bias might have occurred, its effects on the current study are not known. This selection bias may also have impacted selection bias in the families who were referred for recruitment. Parents of children attending the schools who agreed to participate may have come into the study with school experiences different from parents in the schools in which the study was not welcomed. Although, random assignment to the study conditions provides substantial support for the validity of the results indicating observed differences between the treatment condition and the other two conditions.

However, these differences may not be able to be generalized to parents of schools that did not want to be part of this study.

The effect of parents having previous experience with special education is not known. Although participants were screened and excluded from the study if their child had been referred previously or was already receiving special education services, the selection criteria did not exclude parents who had other children in special education. Five of the participants in the study had other children already in special education and seven parents reported that they had previous experience with special education. Parents were not asked if they received special education services when they were in school. However, again random assignment to the study conditions increases the validity of the findings.

Another limitation of the study is the threat to the generalizability of the results. While two of the school districts had relatively high amounts of diversity, one school district was small and not diverse. This study was also conducted in two southern states and parents in other geographic areas may have responded differently. Again, this study included schools that were eager to participate, thus school environments of other schools most likely differed. This study also did not investigate student outcomes beyond initial multidisciplinary meetings and therefore it is not possible to determine long-range effects of the intervention. Thus, changes in parent behavior may not have remained active over time and in different settings.

Implications for Future Research

The results of this study provide other possible opportunities for future research. One opportunity would be to repeat this study with added improvements. The current

study could be improved by increasing the sample size. Including other geographic areas could also increase the diversity of the subjects and increase generalizability. Improving the attention condition so that priming effects did not occur would also help to determine differences in parent satisfaction.

Another direction for future research would be to compare multiple training methods. Instead of using only the training method that was employed in the current study other methods could be used and compared. These could be in form of video training, computer CDs, parent classes, or a mixed model. This type of design would enable researcher's to determine the most effective mode of adding to parents' knowledge and effectiveness with the special education process.

School personnel could also be trained to determine if that would make a difference in parent participation. Although, it would be key to have administrator support in order to successfully complete this type of study. School districts that were willing to make the training a part of their procedure would enhance the rates of treatment validity of school personnel. Training could include sensitivity training regarding parent reactions to hearing their child had a learning disability. Procedural training that includes questions and prompts for school personnel during multidisciplinary meetings could also increase parent involvement. For example, making sure they ask parents if they would like to make suggestions at multiple times during the meetings. Thus, training could help school personnel make parents feel comfortable and communicate to parents that they are an important member of the multidisciplinary team.

Long-term parent behavior beyond initial multidisciplinary meetings and the long-range effects of special education decisions could also be researched to determine if changes in parent behavior remained active over time and in different settings.

Implications for Practitioners

Psychologists working in the school can use this information to enhance their ability to effectively communicate with parents about what to expect after their child has been referred. Since results indicated that parents typically do not prepare on their own for classification meetings, practitioners will need to make sure they have done a thorough job of explaining the special education process to them and answering any questions the parents might have prior to the meetings. Psychologists can also take into consideration the comments parents made regarding use of jargon and make sure to either define the jargon for them or make an effort not to use it and encourage others not to use jargon as well.

Conclusion

This research study provided parents with important information about specific learning disabilities and the special education process. Positive changes occurred for parents who participated in the parent training. These changes included increased participation in multidisciplinary meetings, perceptions of increased participation by parents and teachers, and an increase in the knowledge parents acquired about special education. The informational handout paired with one-on-one attention in order to preview the information was an effective mode for training parents. This training enabled parents to feel prepared, effective, and make more informed decisions about their child's education.

The results of this study contribute to the empirical knowledge base regarding factors that influence parent knowledge, parent behavior, and perceptions of their behavior in the special education process. This study suggests further opportunities for future research and possible ways to improve training and increase school districts' likelihood of using training as part of their special education procedures.

References

- 23rd Annual Report to Congress. (2000). Retrieved October 3, 2002, from <http://www.ld.org/advocacy/pdf/OKData.pdf>.
- Achenbach, T. M. & Rescorla, L. A. (2001). Manual for ASEBA School-Age Forms & Profiles. Burlington, VT: University of Vermont Research Center for Children, Youth, & Families.
- Albano, M. L., Cox, B., York, J., & York, R. (1981). Educational teams for students with severe and multiple handicaps. In R. York, S. Schofield, D. Donder, D. Ryandak, & B. Reguly (Eds.), *Organizing and implementing services for students with severe and multiple handicaps*. Springfield, IL: Illinois State Board of Education.
- Arora, N. K. & McHorney, C. A. (2000). Patient preferences for medical decision making: Who really wants to participate? *Medical Care*, 38, 335-341.
- Artiles, A.J., Aguirre-Munoz, A., & Abedi, J. (1998). Predicting placement in learning disabilities programs: Do predictors vary by ethnic group? *Exceptional children*, 64, 543-559.
- Baine, D. & Sobsey, R. (1983). Implementing transdisciplinary services for severely handicapped persons. *Special Education in Canada*, 58, 12-14.
- Bardon, J. I. (1980). School psychology: The post Larry P. era. *School Psychology Review*, 9, 159-167.
- Beach Center on Families and Disabilities. (1997d). How to better cope with a family member's disability. Retrieved October 2, 2002, from <http://www.lsi.ukans.edu/beach/html.1c.htm>.

- Bersoff, D. N. (1979). Regarding psychologists testily: Legal regulation of psychological assessment in the public schools. *Maryland Law Review*, 39, 27-120.
- Bersoff, D. N. (1980). P. v. Riles: Legal perspective. *School Psychology Review*, 9, 112-122.
- Bocian, K.M, Beebe, M.E., MacMillillan, D.L., & Resham, F.M. (1999).Competing paradigms in learning disabilities classification by schools and the variations in the meeting of discrepant achievement. *Learning Disabilities Research & Practice*, 14, 1-14.
- Chaney, J., Mullins, L., Frank, R., Peterson, L., Mace, L., Kashani, J., & Goldstein, D.(1997). Transactional patterns of child, mother, and father adjustment in insulin-dependent diabetes mellitus: A prospective study. *Journal of Pediatric Psychology*, 22, 229 - 244.
- Christenson, S. L. & Conoley, J. C. (Eds.). (1992). *Home-school collaboration: Enhancing children's academic and social competence*. Silver Sprig, MA: The National Association of School Psychologists.
- Clare, L. & Pistrang, N. (1995). Parents' perceptions of portage: Towards a standard measure of parent satisfaction. *British Journal of Learning Disabilities*, 23, 110-117.
- Clark, M. D., & Artiles, A. J. (2000). A cross national study of teachers' attributional patterns. *Journal of Special Education* 34, 77-89.
- Clifford, M. M. 1986. The comparative effects of strategy and effort attributions. *British Journal of Educational Psychology* 56, 75-83.
- Falk, G. (2001.) *Stigma, How We Treat Outsiders*. Amherst, NY: Prometheus Books.

- Fagan, T.K. & Warden, P. G. (1996). *Historical Encyclopedia of School Psychology*. Westport, CT: Greenwood Press.
- Federal Register. (1977, August). *Copy Editor*, 42, 163.
- Fenton, K. S., Yoshida, R. K., Maxwell, J. P., & Kaufman, M. J. (1979). Recognition of team goals: An essential step toward rational decision making. *Exceptional Children*, 45, 638-644.
- Foster, G., Algozzine, B., & Ysseldyke, J. (1980). Classroom teacher and teacher-in-training susceptibility to stereotypical bias. *Personnel and Guidance Journal* 59, 27-30.
- Fox, J. D. & Stinnett, T. A. (1996). The effects of labeling bias on prognostic outlook for children as a function of diagnostic label and profession. *Psychology in the Schools* 33, 143-152.
- Frankenberger, W. & Harper, J. (1985). Variations in multidisciplinary team composition for identifying learning disabled children. *The Mental Retardation and Learning Disability Bulletin*, 13, 40-48.
- Gable, R. A., Manning, M. L., Hendrickson, J. M., & Rogan, J. P. (1997). A secondary student instructional support team (ASSIST): Teachers face the challenge of student diversity. *The High School Journal*, October/November, 22-27.
- Gartner, A., & Lipsky, D. K. (1992). Beyond special education: Toward a quality system for all students. In T. Hehir & T. Latus (Eds.), *Special Education at the century's end: Evolution of theory and practice since 1970* (pp. 123-157). Cambridge, MA: Harvard Educational Review.

- Gartner, A., Lipsky, D. K., & Turnbull, A. P. (1991). *Supporting families with a child with a disability: An international outlook*. Baltimore: Paul H Brookes.
- Gerber, M.M. (1984). The department of education's sixth annual report to congress on P.L. 94-142: is congress getting the full story? *Exceptional Children*, 51, 209-224.
- Goldstein S., Strickland, B. Turnbull, P. & Curry, L. (1980). An observational analysis of the IEP Conference. *Exceptional Children* 46, 278-286.
- Graden, J. L., Zins, J.E., & Curtis M. J. (Eds.). (1988). *Alternative educational delivery systems: Enhancing instructional options for all students*. Washington, D.C.: National Association of School Psychologists.
- Gresham, F.M., MacMillan, D.L., & Bocian, K.M. (1998). Agreement between school study team decisions and authoritative definitions in classification of students at-risk for mild disabilities. *School Psychology Quarterly*, 13, 181-191.
- Gresham, F.M. & Witt, J.C. (1997). Utility of intelligence tests for treatment planning, classification, and placement decisions: recent empirical findings and future directions. *School Psychology Quarterly*, 12, 249-267.
- Gilliam, J. E. (1979). Contributions and status rankings of educational planning committee participants. *Exceptional Children*, 45, 466-468.
- Gillung, T. B. & Rucker, C. N. (1977). Labels and teacher expectations. *Exceptional Children* 43, 464-465.

- Hart, V. (1977). The use of many disciplines with the severely and profoundly retarded. In E. Sontag (Ed.), *Educational programming the severely and profoundly handicapped*. Reston, VA: Council for Exceptional Children, Division on Mental Retardation.
- Henderson, A. T. (1989). *The evidence continues to grow: Parent involvement improves student achievement*. Columbia, MD: National Committee for Citizens in Education.
- Hibbs, E. D. & Jensen, P. S. (Eds.). (1996). *Psychosocial treatments for child and adolescent disorders: Empirically based strategies for clinical practice*. Washington, D.C.: American Psychological Association.
- Hoff, M. K., Fenton, K. S., Yoshida, R. K., & Kaufman, M. J. (1978). Notice and consent: The school's responsibility to inform parents. *Journal of School Psychology, 16*, 265-273.
- IDEA (1997). Retrieved August 10, 2002, from <http://www.ideapractices.org/law/regulations/regs/SubpartE.php>.
- Jacobs, L. (1991). Assessment concerns: A study of cultural differences, teacher concepts, and inappropriate labeling. *Teacher Education and Special Education, 14*, 43-48.
- Johnson, L. J. & Blankenship, C. S. (1984). A comparison of label-induced expectancy bias in two preservice teacher education programs. *Behavioral Disorders, 9*, 167-174.
- Kagan, S. L. (1984). *Parent involvement research: A field in search of itself* (Report No. 8). Boston, MA: Institute for Responsive Education.

- Kazdin, A. E. (1997). A model for developing effective treatments: Progression and interplay of theory, research, and practice. *Journal of Clinical Child Psychology*, 26, 114-129.
- La Greca, A. M. & Schuman, W. B. (1995). Adherence to Prescribed Medical Regimens, In M. C. Roberts (Ed.), *Handbook of Pediatric Psychology*. New York: The Guilford Press.
- Lamorey, S. & Ryan, S. (1998). From contention to implementation: A comparison of team practices and recommended practices across service delivery models. *Infant-Toddler Intervention*, 8, 309-331.
- Lynch, E. W. & Stein, R. (1982). Perspectives on parent participation in special education. *Exceptional Education Quarterly*, 3, 56-64.
- McKinney, J. D. & Hocutt, A. M. (1982). Public school involvement of parents of learning-disabled children and average achievers. *Exceptional Education Quarterly*, 3, 64-73.
- McNamara, K. M. & Hollinger, C. L. (1997). Intervention-based assessment: Rates of evaluation and eligibility for specific learning disability classification. *Psychological Reports*, 81, 620-622.
- McNamara, K., Telzrow, C., & DeLamatre, J. (1999). Parent reactions to implementation of intervention-based assessment. *Journal of Educational and Psychological Consultation*, 10, 343-362.
- McWilliam, P. J., Winton, P. J., & Crais, E. R. (1996). *Practical strategies for family-centered intervention*. San Diego, CA. Singular Publishing Group.

- MacMillan, D.L. & Forness, S.R. (1998). The role of IQ in special education placement decisions: primary and determinative or peripheral and inconsequential? Remedial & Special Education Special Issue: The history of special education: Essays honoring the bicentennial of the work of Jean Itard, 19, 239-253.
- MacMillan, D. L. & Reschly, D. J. (1999). Overrepresentation of minority students: The case for greater specificity or reconsideration of the variables examined. *Journal of Special Education, 32*, 15-24.
- Maheady, L., Algozzine, B., & Ysseldyke, J. E. (1984). Minority overrepresentation in special education: A functional assessment perspective. *Special Services in the Schools, 1*, 5-19.
- Mamlin, N. & Harris, K. R. (1998). Elementary teachers' referral to special education in light of inclusion and prereferral: "Every child is here to learn ... but some of these children are in real trouble." *Journal of Educational Psychology, 90*, 385-396.
- Mash, E. J. (1998). Treatment of child and family disturbance: A behavioral systems perspective. In E. J. Mash & R. A. Barkley (Eds.), *Treatment of childhood disorders* (pp. 3-54). New York: The Guilford Press.
- Mattison, R. E., Lynch, J. C., Kales, H., & Gamble, A. D. (1993). Checklist identification of elementary schoolboys for clinical referral or evaluation of eligibility for special education. *Behavioral Disorders, 18*, 218-227.
- Merriam-Webster, Inc. (1985). *Webster's ninth new collegiate dictionary*. Springfield, MA: Merriam-Webster.

- Muhlenhaupt, M. (2002). Family and school partnerships for IEP placement. *Journal of Visual Impairment & Blindness*, 96, 175-178.
- NJCLD Learning Disability Roundtable. (2002, August). Policy Recommendations for the Reauthorization of the IDEA. *NASP Communique*, 31, 1.
- Nealis, L. K. (2002). White House commission issues report on special education. *NASP Communique*, 31, 18-20.
- O'Reilly, C., Northcraft, G.B., & Sabers, D. (1989). The confirmation bias in special education eligibility decisions. *School Psychology Review*, 18, 126-135.
- O'Shea, D. J., O'Shea, L. J., Algozzine, R. & Hammitte, D. J. (2001). Families and teachers of individuals with disabilities. Boston: Allyn & Bacon.
- Orelove, F. P. & Sobsey, D. (1996). *Educating children with multiple disabilities: A transdisciplinary approach* (3rd ed.). Baltimore: Paul H. Brookes.
- Palmer, D. J. 1983. An attributional perspective on labeling. *Exceptional Children* 49, 423-429.
- Patton, J. M. (1998). The disproportionate representation of African Americans in special education: Looking behind the curtain for understanding and solutions. *Journal of Special Education*, 32, 25-31.
- Paul, J. L. (1981). *Understanding and working with parents of children with special needs*. New York: Holt, Rinehart & Winston.
- Polifka, J.C. (1981). Compliance with Public Law 94-142 and consumer satisfaction. *Exceptional Children*, 48, 250-254.

- Potter, M.L., Ysseldyke, J.E., Regan, R.R., & Algozzine, B. (1983). Eligibility and classification decisions in educational settings: Issuing “passports” in a state of confusion. *Contemporary Educational Psychology*, 8, 146-157.
- Rae, W. A., Worchel, F. F., & Brunnquell, D. (1995). Ethical and Legal Issues in Pediatric Psychology. In M.C. Roberts (Ed.), *Handbook of Pediatric Psychology*. New York: The Guilford Press.
- Rainforth, B. & York, J. (1987). Integrating related services in community instruction. *Journal of the Association for Persons with Severe Handicaps*, 12, 190-198.
- Rankin, P. T. (1967). *The relationship between parent behavior and achievement of inner-city elementary school children*. Paper presentation at the annual meeting of the American Educational Research Association, Washington, DC. (ERIC Document Reproduction Service No. ED 017 550)
- Reschly, D. J. (1981). Psychological testing in educational classification and placement. *American Psychologist*, 36, 1094-1102.
- Roberts, M. C. (Ed.), (1995). *Handbook of Pediatric Psychology*. New York: The Guilford Press.
- Rolison, M. A. & Medway, F. J. 1985. Teachers’ expectations and attributions for student achievement: effects of label, performance pattern, and special education intervention. *American Educational Research Journal* 22, 561-573.
- Santrock, J. W. (2001). *Adolescence*. Boston: McGraw Hill.
- Rosenfield, S. A. & Gravois, T. A. (1996). *Instructional Consultation Teams, Collaborating for Change*. New York: The Guilford Press.

- Salvia, J. & Ysseldyke, J. E. (Ed.). (1998). *Assessment*. Boston: Houghton Mifflin Company.
- Sattes, B. (1985). *Parent involvement: A review of the literature* (Report No. 21). Charleston, WV: Appalachia Educational Laboratory.
- Schlechty, P. C. (1990). *Schools for the 21st century: Leadership imperatives for educational reform*. San Francisco: Jossey-Bass.
- Sears, C. J. (1981). The transdisciplinary approach: A process for compliance with Public Law 94-142. *Journal of the Association for the Severely Handicapped*, 6, 22-29.
- Seely, D. S. (1985). *Education through partnership*. Washington, DC: American Enterprise Institute for Public Policy Research.
- Shaw, S. R. & Swerdik, M. E. (1995). Best practices in facilitating team functioning. In A. Thomas & J. Grimes (Ed.), *Best Practices in School Psychology III* (pp.153-160). Washington, DC: The National Association of School Psychologists.
- Shriver, M.D. & Kramer, J.J. (1993). Parent involvement in an early childhood special education program: a descriptive analysis of parent demographics and level of involvement. *Psychology in the Schools*, 30, 255-263.
- Simpson, R. L. (1982). Future training issues. *Exceptional Education Quarterly*, 3, 81-88.
- Stevens, J. P. (2002). *Applied multivariate statistics for social sciences* (p.10). Mahwah: Lawrence Erlbaum Associates, Publishers.

- Stone, F. H. (1988). Work with disturbed children and families: Reflections on the multi-disciplinary team approach. *Maladjustment and Therapeutic Education*, 6, 93-97.
- Talbert-Johnson, C. (1998). Why so many African-American students in special ed? *School Business Affairs*, 64, 30-35.
- Thompson, R. J., Jr., Gustafson, K. E., Hamlett, K. W., & Spock, A. (1992). Psychological adjustment of children with cystic fibrosis: The role of child cognitive processes and maternal adjustment. *Journal of Pediatric Psychology*, 17, 741-755.
- Thousand, J. S. & Villa, R. A. (1992). Collaborative Teams: A powerful tool in school restructuring. In R.A. Villa, J.S. Thousand, W. Stainback, & S. Stainback (Eds.), *Restructuring for caring and effective education* (pp.73-108). Baltimore: Paul H. Brooks.
- Turnbull, A. P. & Leonard, J. (1980). Parent involvement in special education: emerging advocacy roles. *School Psychology Review*, 10, 37-44.
- Vacc, N. A., Vallecorsa, A. L., Parker, A., Bonner, S., Lester, C., Richardson, S., & Yates, C. (1985). Parents' and educators' participation in IEP conferences. *Education & Treatment of Children*, 8, 153-162.
- Valdez, S. (2002). Informed consent for special education: What do parents need to know about outcomes? *NASP Communique*, 31, 10.
- Vaughn, S., Bos, C. S., Harrell, J. E., & Lasky, B. A. (1988). Parent participation in the initial placement/IEP conference ten year after mandated involvement. *Journal of Learning Disabilities*, 21, 82-89.

- Vosler-Hunter, R. W. (1989). Families and professionals working together: Issues and opportunities. *Focal Point*, 4, 1-4).
- Wehman, T. & Gilkerson, L. (1999). Parents of young children with special needs speak out: perceptions of early intervention services. *Infant-Toddler Intervention*, 9, 137-167).
- Wise, P.S. Best Practices in Communicating with Parents, In A. Thomas & J. Grimes (Eds.), *Best Practices in School Psychology III* (pp. 279-288). Washington, DC: The National Association of School Psychologists, 1995.
- Witt, J.C., Miller, C.D., McIntyre, R.M., & Smith, D. (1984). Effects of variables on parental perceptions of staffings. *Exceptional Children*, 51, 27-32.
- Yoshida, R. K. (1983). Are multidisciplinary teams worth the investment? *School Psychology Review*, 12, 137-143.
- Yoshida, R. K., Fenton, K. S., Maxwell, J. D., & Kaufman, M. J. (1978). Group decision making in the planning team: Myth or reality? *Journal of School Psychology*, 16, 237-244.
- Ysseldyke, J.E. & Algozzine, B. (1982). Bias among professionals who erroneously declare students eligible for special services. *Journal of Experimental Education*, 50, 223-228.

APPENDIX A

OSU School Psychology Program

434 Willard Hall
Stillwater, OK 74078
(405) 744-6040
(405) 744-6756 (fax)

January 2003

To Whom It May Concern:

I am a doctoral student in the School Psychology program at Oklahoma State University. As part of a research project I have developed a plan to help parents be more effective members on multidisciplinary teams and make more informed decisions regarding their child's potential special education classification and Individual Education Program (IEP). I would like permission to contact you by phone and/or mail to give you more information about this project. If you would prefer to be contacted by e-mail, please provide your e-mail address as well.

Please sign this letter if you would like to be contacted. Please do not hesitate to call at 405-269-7559 or e-mail, crawfsa@okstate.edu if you have any questions.

Sincerely,

Stephanie Hirsch, M.S.
OSU School Psychology Doctoral Candidate

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____, authorize: _____

(name of parent)

(name & address of agency releasing information)

to release to: **Stephanie Hirsch**
Oklahoma State University
434 Willard Hall
Stillwater, OK 74078

the following information: phone number, mailing address and e-mail address
for the following purpose: to contact regarding child's referral

I understand that the confidentiality of my records is protected by law and that they cannot be released without my written consent unless otherwise provided by law. I also understand that I may revoke this consent at any time.

(Date)

(Signature of Parent or Guardian)

APPENDIX B

OSU School Psychology Program

434 Willard Hall
Stillwater, OK 74078
(405) 744-6040
(405) 744-6756 (fax)

Parent Name
Address
City, State, Zip Code

Dear Parent Name:

I am a doctoral student in the School Psychology program at Oklahoma State University. As part of a research project I have developed a plan to help parents be more effective members on multidisciplinary teams and make more informed decisions regarding their child's potential special education classification and Individualized Education Program (IEP).

This research project is designed to provide parents information about specific learning disabilities and the classification and IEP process. This project is for parents who have children and adolescents who have been referred for a special education evaluation. The goal is to find ways to help you become an active and informed member on the multidisciplinary team that could make decisions about your child's educational program. I would like to invite you to participate in our free program.

If you would be willing to participate in this project please sign the consent form and mail it back using the self-addressed, pre-stamped envelope. You have been provided with two consent forms so that you may keep one for your records. If you still have questions please call (405) 269-7559, and ask to speak with Stephanie Hirsch or e-mail me at crawfsa@oksate.edu.

Again, please feel free to call if you have any questions. I look forward to hearing from you.

Sincerely,

Stephanie Hirsch, M.S.
OSU School Psychology Doctoral Candidate

APPENDIX C

INFORMED CONSENT FORM

OKLAHOMA STATE UNIVERSITY

School Psychology Program
Spring 2003 Study: Classification & IEP

I, _____, hereby authorize or direct Stephanie A. Hirsch or other approved research assistants under the supervision of Dr. Terry A. Stinnett to perform the procedures listed here.

This is an experimental research outcome study (a type of research study). Experimental treatment outcome studies include only people who choose to take part in them. Please take your time to make your decision. Discuss this with your family and friends.

You are being asked to take part in this study because your child has been referred for a special education evaluation.

Why is this study being done?

This study is designed to investigate methods to inform parents about specific learning disabilities, the classification and IEP procedure.

How many people will take part in this study?

About 60 parents will take part in this study. About 60 of these parents will be recruited from Oklahoma and Texas Public Schools.

What is involved in the study?

You may be asked to complete a demographic information sheet, preview educational materials, and complete questionnaires pertaining to special education and your satisfaction with classification and IEP meetings you attended. The regular education teacher who attended the meetings will also be asked to complete a questionnaire. The meetings will also be audio taped. The evaluation report, referral for testing form, and IEP goals and objectives will be copied and obtained. After you have participated the purpose of the study will be discussed with you and any questions you may have will be answered.

How long will I be in the study?

It is estimated that your participation will require a total of an hour to two hours, including the time you spend in the meetings. Prior to attending the classification and IEP meetings you will be asked to complete two questionnaires (this should take approximately 15 minutes). During the

meetings you may be asked to complete a checklist (meetings generally last 30 minutes to an hour). After the meetings you will be asked to complete a satisfaction questionnaire (this should take approximately 15 minutes). Your participation is entirely voluntary; you can withdraw your consent at any time and discontinue participation without penalty.

What about confidentiality and privacy?

All information about you and your child and any information you provide will be kept strictly confidential and in locked files. You and your child will not be identifiable by name or description in any reports or publications about this study. All the questionnaires will be identified only by numerical codes. After the meeting the identifiable information on the tape will be erased and identified only by a numerical code. At the parent's request they may also have a copy of the tape. The copies of the evaluation report, referral for testing form, and the IEP goals and objectives will also have the identifiable information removed and identified by numerical codes only. Information containing your name (i.e., contact form and informed consent form) will be kept separate from numbered materials and in a secure place. Therefore, all information provided will be anonymous.

What are the risks of the study?

The risks in this study are minimal and do not exceed those ordinarily encountered in daily life. If at any point you experience discomfort or have questions or concerns, research assistants will be available to discuss these with you.

What are the benefits to taking part in the study?

Your participation in this research study may enhance your participation in the special education process and gain information about learning disabilities. In addition, you will gain helpful information during the debriefing portion of this study and receive an informational handout.

What other options are there?

Instead of being in this study, you have these options:

- You may choose not to participate
- You may choose to seek information from another source.

What are the costs?

All services provided by the project are free to participants.

What are my rights as a participant?

Taking part in this study is voluntary. You may choose not to take part or may leave the study at any time. If you decide to take part and then decide against it, you can withdraw for any reason.

Whom do I call if I have questions or problems?

If you have questions about the study, contact the Principal Investigator Stephanie Hirsch at (713) 460-7825 Monday through Friday, 8 a.m. to 4 p.m. You may also leave a message after hours or on weekends at (281) 894-0138 and your phone call will be returned.

I have been fully informed about the procedures listed here. I am aware of what I will be asked to do and of the risks and benefits in this study. I also understand the following statements:

I understand that participation is voluntary and that I will not be penalized if I choose not to participate. I also understand that I am free to withdraw my consent and end my participation in this project at any time without penalty after I notify the project director.

I may contact Dr. Stinnett at 744-9456. I may also contact Sharon Bacher, IRB Executive

Secretary, Oklahoma State University, 203 Whitehurst, Stillwater, OK 74078.

Phone: 405-744-5700.

I have read and fully understand the consent form. I sign it freely and voluntarily. A copy has been given to me.

Signature of Parent: _____ Date: _____ Time: _____

Child's Name (printed): _____

Principal Investigator: _____ Date: _____

Signature of person authorized to sign for subject, if required

Witness(es) if required: _____

RECRUITER STATEMENT

I certify that I have personally explained all elements of this form to the subject or his/her representative before requesting the subject or his/her representative to sign it.

Signed: _____ Date: _____
Project director or authorized representative

APPENDIX D

Demographic Information

Directions: Please answer each question to the best of your ability. Please circle your responses except where otherwise specified.

1. Your child's current age: _____ years
2. Your child's sex: Male or Female
3. Your relationship to the child:
(Please also circle whether you are the biological, step, or adoptive, parent.)
 - a. mother (biological, step, adoptive)
 - b. father (biological, step, adoptive)
 - c. legal guardian: _____
4. Number of children in the family:
 - a. 1
 - b. 2-3
 - c. 4-5
 - d. 6-7
 - e. 8 or more
5. Age of child's mother:
 - a. younger than 18 years
 - b. 18-25 years
 - c. 26-35 years
 - d. 36-45 years
 - e. 46 or older
6. Age of child's father:
 - a. younger than 18 years
 - b. 18-25 years
 - c. 26-35 years
 - d. 36-45 years
 - e. 46 or older
7. Yearly income range in home where child lives:
 - a. below \$5,000
 - b. \$5-10, 000
 - c. \$11-20,000
 - d. \$21-40,000
 - e. \$40,000 and above

8. Highest educational level of child's mother:
- a. grade school/some high school
 - b. high school graduate
 - c. partial college/technical training
 - d. college graduate
 - e. Graduate training or degree
9. Highest educational level of child's father:
- a. grade school/some high school
 - b. high school graduate
 - c. partial college/technical training
 - d. college graduate
 - e. Graduate training or degree
10. Ethnic background of child's mother:
- a. African American/Black
 - b. Asian/Pacific Islander
 - c. Caucasian/White
 - d. Hispanic/Latino
 - e. American Indian/Alaska Native
 - f. Other: _____
11. Ethnic background of child's father:
- a. African American/Black
 - b. Asian/Pacific Islander
 - c. Caucasian (White)
 - d. Hispanic/Latino
 - e. American Indian/Alaska Native
 - f. Other: _____
12. Marital status of child's parent(s):
- a. single (never married)
 - b. married
 - c. separated
 - d. divorced
 - e. widowed
13. If divorcing or divorced, status of divorce:
- a. in progress
 - b. recent
 - c. long time

14. If divorced who does child spend the majority of the time? (Mother, Father, equal split, etc.) Please explain.

15. Do you have any other children placed in special education? (Yes or No) If so, who, what age, and what is the special education classification?

16. Do you have any previous experience with special education? (Yes or No) If so, please explain.

APPENDIX E

Parent Questionnaire (PKQ)

1) Please answer yes or no about each of the following items you believe to be a parental right during the classification and IEP process. (Circle yes or no)

- | | | |
|-----|----|---|
| Yes | No | Consenting to an initial evaluation is part of the parents' rights. |
| Yes | No | Parents have the right to be provided written notice of classification meeting. |
| Yes | No | Parents have the right to be provided written notice of the IEP meetings. |
| Yes | No | Parents have the right to attend classification meetings. |
| Yes | No | Parents have the right to attend IEP meetings. |
| Yes | No | Parents have the right to be active participants during classification meetings |
| Yes | No | Parents have the right to be active participants during IEP meetings. |
| Yes | No | Parents have the right to receive a copy of the evaluation report. |
| Yes | No | Parents have the right to accept or reject the initial evaluation results and recommended eligibility and placement decision. |
| Yes | No | Parents have the right to have an independent evaluation conducted by a private psychologist. |
| Yes | No | Inspecting and reviewing all educational records is a parent right. |
| Yes | No | Parents have the right to request a due process hearing. |

2) Please answer yes or no about each of the following items you believe describe specific learning disabilities. (Circle yes or no)

- | | | |
|-----|----|---|
| Yes | No | Specific Learning disabilities are neurological disorders that interfere with a person's ability to store, process, or produce information, and create a "gap" between one's ability and performance. |
| Yes | No | A characteristic of children with a Specific Learning Disability is that they do not achieve commensurate with their same age peers. |
| Yes | No | A characteristic of children with a Specific Learning Disability is that they show a significant discrepancy between intellectual ability and achievement. |
| Yes | No | Individuals with Specific Learning Disabilities are generally of average or above average intelligence. |
| Yes | No | Learning disabilities often run in families. |
| Yes | No | Specific Learning Disabilities could include: oral expression, listening comprehension, written expression, basic reading, reading comprehension, mathematics calculation, and mathematics reasoning. |

Yes	No	Individuals with Specific Learning Disabilities can have severe difficulties in some areas while excelling in others.
-----	----	---

3) Please answer yes or no (circle yes or no) about each of the following items that would make a child ineligible for a Specific Learning Disability. If their difficulty is a result of:

Yes	No	Visual, hearing, or motor impairment
Yes	No	Mental retardation
Yes	No	Emotional disturbance
Yes	No	Environmental, cultural, or economic disadvantages

4) Please answer yes or no about each of the following individuals that you believe would be an appropriate member of the multidisciplinary team (circle yes or no)

Yes	No	Regular education teachers
Yes	No	Special education teachers
Yes	No	School psychologists
Yes	No	School counselors
Yes	No	Principals
Yes	No	Parents

5) Please answer yes or no about each of the following items that you believe describe parental roles in the classification and IEP process (circle yes or no):

Yes	No	The parents' role during classification and IEP meetings is one of listening to the school personnel present evaluation results.
Yes	No	The parents' role during classification and IEP meetings is one of active participation.
Yes	No	The parents' role during classification and IEP meetings is making a collaborative decision with the school personnel.
Yes	No	Parents may appeal the school's decision if they disagree with the findings of the multidisciplinary team.

6) Please answer yes or no about each of the following items that you believe describe a main function of the IEP (circle yes or no):

Yes	No	Communication.
Yes	No	Resolution.
Yes	No	Commitment.
Yes	No	Management
Yes	No	Compliance
Yes	No	Evaluation

7) Please answer yes or no about each of the following items that you believe describe the school's role in the classification and IEP process (circle yes or no):

- | | | |
|-----|----|--|
| Yes | No | The school personnel are responsible for delivering information to the parent about the evaluation results. |
| Yes | No | The school personnel's role during classification and IEP meetings is one of active participation. |
| Yes | No | The school personnel make the decision regarding a student's eligibility for a Specific Learning Disability. |

APPENDIX F

“Being a Member of a Multidisciplinary Team”

Multidisciplinary teams (MDTs) are made up of qualified professionals and the parents of the child of concern. Qualified professionals may include but are not limited to the regular education teacher, the special education teacher, a school psychologist, a school administrator, etc. Together team members decide whether the child is eligible for special education services and if so develop an Individualized Education Program (IEP). The shared goal of the team is to have the best possible outcome for the child. The following tips for team members may help effective team functioning to occur.

- Remember the key term “collaboration” = cooperation & teamwork:
 - A collaborative relationship is equal and trusting
 - Establish positive, friendly relationships with other team members
 - Be a team member that is considerate, respectful, and genuine
- Know the rules: Develop an understanding of the classification and IEP process.
- Come prepared: know the specific outcomes you want for your child.
- Be clear, calm and direct when speaking. Avoid becoming defensive and/or reactive.
- Listen carefully and responsively; take time to think about applicable information.
- If there is confusion, you might ask: "do I understand correctly that ...?"
- If you do not understand, say so: "I do not understand that, would you explain it a little more; or do you mean X or Y?"

- Translate complaints



your criticisms and
into requests.

- If you are going to criticize or complain, always assume that you have misunderstood the situation and ask questions first to check the facts. This is a simple courtesy, which may save you from embarrassment. While assertiveness and persistence are crucial, anger and aggressiveness can work against you and can damage important relationships.
- Thank other team members and express appreciation.

(adapted from suggestion by the National Association of School Psychologists:
<http://www.nasponline.org/publications/cq283disabilities.htm> & Developing & Implementing IDEA-IEPs, Burns, 2001)

Parent Rights Specified by Law

Although Public Law 105-17 (IDEA-97-Individuals with Disabilities Education Act) guarantees that children with a disability will receive a “free, appropriate public education” in the public schools, a child’s parents are responsible for protecting these rights. **INFORMED AND INVOLVED PARENTS ARE A CHILD’S FIRST AND BEST ADVOCATES.** (Oklahoma Parents Center, <http://www.okparents.org/rights.htm>)

WRITTEN NOTIFICATION: You have the right:

- to be informed in writing, and in enough time to respond, of the school’s plans for your child: to evaluate, to place in special education, to hold an IEP meeting, to change the IEP, or to stop special education services
- to be informed in your native language, unless it is clearly not feasible

EVALUATION: You have the right:

- to a full, free and individual testing of your child’s educational needs for purposes of evaluation and placement
- to refuse permission for evaluation of your child to determine whether s/he is eligible for special education services
- to obtain an outside, independent evaluation if you are unhappy with the school’s evaluation
- to have your child re-evaluated at least every three years if necessary

THE IEP PROCESS: You have the right:

- to participate in the planning of your child’s IEP (the complete statement of all her/his special instruction and related services)
- to state your opinions and make recommendations for special education services
- to review your child’s IEP and their progress toward goals at least once a year
- to request changes in your child’s IEP
- to request an IEP meeting at any time

DUE PROCESS: You have the right:

- to ask the school to discuss any disagreement about your child’s identification, evaluation, IEP, or placement
- to request an impartial hearing if you disagree with the school about your child’s identification, evaluation, IEP, or placement

RECORDS: You have the right:

- to see your child’s school records at any time and to have copies made
- to know what kinds of records exist and where they are located
- to request that a record be explained, changed, or destroyed

SPECIAL EDUCATION: You have the right:

- to a free and appropriate public education (FAPE) for your child
- to know about all special education services
- to question or appeal the placement of your child in a special education class or service
- to other educational settings at public expense if a local school is not appropriate

Special Education Terms and Definitions

(adapted from IDEA-97 & Making Decisions About Diverse Learners, Aefsky, 2000 & Dictionary of Special Education Terms: <http://www.feat.org/legal/speddict.htm>)

Specific Learning Disability (SLD) – neurological disorders that interfere with a person’s ability to store, process, or produce information, and create a “gap” between one’s ability and performance. Children with a SLD do not achieve commensurate/equal with their same age peers. They show a significant discrepancy/difference between intellectual ability and achievement. Individuals with SLDs are generally of average or above intelligence. Learning disabilities often run in the family. SLDs could include: oral expression, listening comprehension, written expression, basic reading, reading comprehension, mathematics calculation, and mathematics reasoning. Individuals with SLDs can have severe difficulties in some areas while excelling in others. **Note** this disorder does not include learning problems due to visual, hearing, or motor disabilities, mental retardation, emotional disturbance, or environmental, cultural, or economic disadvantage.

Referral – the request to identify and assess a child’s special education needs; a referral may be made by a parent, teacher, medical personnel, or anyone with specific knowledge of the child.

Assessment - a collecting and bringing together of information about a child’s needs, which may include social, psychological, and educational evaluations used to determine services; a process using observation, testing, and test analysis to determine an individual’s strengths and weaknesses in order to plan his or her educational services.

Individualized Education Program (IEP) - a written education plan, mandated by law, for a school-aged child with disabilities developed by a team of professionals (teacher, therapists, parent, etc.) and the child’s parents that defines a child’s disability, states current levels of educational performance, describes the child’s learning and educational needs, what services the child will need, and specifies annual goals and short-term objectives. It is reviewed and updated yearly.

Placement – the classroom, program, service, and/or therapy that is selected for a student with special needs. Placement occurs after the IEP is written.

Related Services - transportation and developmental, corrective, and other support services that a child with disabilities requires in order to benefit from education; examples of related services include: speech pathology and audiology, psychological services, physical and occupational therapy, recreation, counseling services, interpreters for the hearing impaired, and medical services for diagnostic and evaluation purposes.

Resource Room - a classroom in which a student may receive resource specialist instruction.

Least Restrictive Environment (LRE) - a term referring to a federal mandate that students with special education needs are offered programs to promote maximum interaction with regular education students as close to home as possible. The LRE is an educational setting or program that provides a student with disabilities with the chance to work and learn to the best of his or her ability; it also provides the student as much contact as possible with children without disabilities, while meeting all of the child's learning needs and physical requirements.

Mainstreaming - a term referring to the time during which a special education student participates in chronologically age-appropriate regular education activities, either academic or non-academic (e.g. math and reading or lunch, recess, and art).

IDEA-97-Individuals with Disabilities Education Act- The Individuals with Disabilities Education Act Amendments of 1997 were signed into law on June 4, 1997. This Act strengthens academic expectations and accountability for the nation's 5.8 million children with disabilities and bridges the gap that has too often existed between what children with disabilities learn and what is required in regular curriculum.

Free Appropriate Public Education (often referred to as FAPE) - one of the key requirements of IDEA, which requires that an education program be provided for all school-aged children (regardless of disability) without cost to families; the exact requirements of "appropriate" are not defined, but other references within the law imply the most "normal" setting available.

Gifted and Talented Education (GATE) – a program designed to meet the educational needs of students with above average intelligence in specific learning areas; a student may be eligible for both special education and GATE.

Mediation - an informal meeting held when parents and school district personnel cannot agree on a child's educational program; this step comes before a due process hearing.

Due Process (procedure) - action that protects a person's rights; in special education, this applies to action taken to protect the educational rights of students with disabilities. Also, the legal procedures set up to resolve disagreements between parents and school districts over some part of a child's special education program.

Parent Training – a related service; parents receive specific training in skills required to implement their child's IEP as well as an understanding of special education law and parental rights and responsibilities under these laws.

Parent Training and Information Programs - programs that provide information to parents of children with special needs about acquiring services, working with schools and educators to ensure the most effective educational placement for their child, understanding the methods of testing and evaluating a child with special needs, and making informed decisions about their child's special needs.

1. What does intelligence or cognitive ability mean?

The process people use for remembering, reasoning, understanding, and using judgment; the potential ability to learn. In special education terms, a cognitive disability refers to difficulty in learning.

2. Are students with learning disabilities dumb?

No, individuals with learning disabilities are generally of average or above average intelligence. Individuals with learning disabilities can have marked difficulties on certain types of tasks while excelling at others.

3. Whose responsibility is it to help a student who is having difficulty in school?

Parents and professionals should both have a responsibility to address a child's learning difficulties. One of the key requirements of IDEA-97, is that an education program be provided for all school-aged children (regardless of disability) without cost to families; the exact requirements of "appropriate" are not defined, but other references within the law imply the most "normal" setting available.

4. How can you tell the difference between a student who is lazy versus one who is struggling?

A student who is struggling will not be able to improve their functioning regardless of rewards given to them in an effort to do better. A student who is struggling will not respond to steps the regular education teacher takes (interventions) to try to improve the student's functioning. These steps or interventions might include tutoring for example.

5. What pre-referral interventions were tried?

Pre-referral interventions are steps taken before a student is referred to an assessment to help the student do better. This could include tutoring, a behavior modification plan, and other accommodations.

6. Will my child progress out of special education and back into regular education?

Learning disabilities are not cured and do not go away, but individuals can learn to compensate for and even overcome areas of weakness. If the child is receiving special education services they should be placed in the least restricted environment. A student may be able to compensate for their difficulties and only need support from special education teachers, such as being able to visit the resource room.

7. What is the least restrictive environment for the instruction of my child?

There is a federal mandate that students with special education needs are offered programs to promote maximum interaction with regular education students as close to home as possible. The LRE is an educational setting or program that provides a student with disabilities with the chance to work and learn to the best of his or her ability; it also provides the student as much contact as possible with children without disabilities, while meeting all of the child's learning needs and physical requirements.

8. What is the prognosis for my child if he or she is not placed in special education?

School failure and illiteracy are responsible for a vicious, harmful downward cycle of frustration and despair.

Eligibility Check Sheet & Questions

(adapted from IDEA-97 & The National Center for LDs facts: <http://www.ncld.org/info/index.cfm>)

Use this Check Sheet during the classification meeting to help you follow along as an active team member. The following are criteria/reason used to determine/decide whether your child qualifies for special education services. The questions and answers on the back may help you as well, and/or may prompt you to ask questions that you may have in addition.

- ☐ Not achieving commensurate/equal with same age peers
- ☐ Impaired ability levels in one or more academic area (e.g. reading, math)
- ☐ Significant difficulty with one or more of the following academic areas:
 - ☐ Oral expression
 - ☐ Listening comprehension
 - ☐ Written expression
 - ☐ Basic reading skill
 - ☐ Reading comprehension
 - ☐ Mathematics computation
 - ☐ Mathematics reasoning
- ☐ Difficulty is not primarily due to a visual, hearing, or motor impairment
- ☐ Difficulty is not due to mental retardation
- ☐ Difficulty is not due to emotional disturbance
- ☐ Difficulty is not due to environmental, cultural, or economic disadvantage
- ☐ Provided with appropriate learning experiences
- ☐ School success is not feasible without a special education classification and services
- ☐ An evaluation was conducted that included many ways of obtaining information: tests, interviews, and observations
- ☐ Prior to the referral interventions or attempts to help the student were completed and the student was not receptive, helped
- ☐ The tests used were not biased against the student due to cultural differences
- ☐ The student was assessed in their native language or non-verbal tests were used

Individualized Education Program (IEP) Guide

(taken from IDEA-97 & Developing & Implementing IDEA-IEPs, Burns, 2001)

IDEA has specified 6 primary functions that an IEP should serve:

- 1) Communication – serves as a communication vehicle between parents and school, which enables parents, who are equal participants to jointly decide the child's needs, services to be provided, and anticipated outcomes.
- 2) Resolution – provides an opportunity for resolving any differences between the parents and the school in regard to their education needs.
- 3) Commitment – provides in writing a commitment of resources necessary to meet the educational and related service needs of the child.
- 4) Management – used to ensure that each child is provided a free and appropriate education.
- 5) Compliance – serves as a monitoring device, which may be used by authorized personnel to determine whether the child is receiving a free and appropriate education agreed upon by the parents and school.
- 6) Evaluation – serves as an evaluation tool to determine the child's progress toward meeting projected outcomes.

Examples of clearly written and measurable goals and objectives for an IEP:

- ❖ Goal: Improve reading readiness
 - Objective #1: Improve word attack skills
 - Objective #2: Improve vocabulary
 - Objective #3: Improve comprehension
 - Measurable Annual Goal: Increase sight-word recognition to 80% as measured by a flash-card assessment of 100 selected sight-words by June 20.
 - Benchmark #1: Increase sight-words to 30% by November 1.
 - Benchmark #2: Increase sight-words to 45% by January 30.
 - Benchmark #3: Increase sight-words to 60% by March 20.
 - Benchmark #4: Increase sight-words to 80% by June 20.
- ❖ Goal: Increase knowledge of mathematics facts with 85% accuracy as measured by a curriculum based assessment of 100 selected mathematic facts by June 15.
 - Objective #1: Knows facts with addends from 0-2 with 100% accuracy by December 15.
 - Objective #2: Knows facts with addends from 0-5 with 95% accuracy by February 15.
 - Objective #3: Knows facts with addends from 0-7 with 90% accuracy by March 31.
 - Objective #4: Knows facts with addends from 0-9 with 85% accuracy by June 15.

Questions to ask:

Does the IEP include?

- ☐ The student's general levels of educational performance/beginning benchmark
- ☐ How the disability affects general (regular education) curriculum involvement
- ☐ How the disability affects nonacademic performance (examples: transportation, recess, meals, clubs, athletics, and special interest groups)
- ☐ Measurable annual goals: a plan of expectations and how to determine progress
- ☐ Measurable goals for each of the student's identified needs
- ☐ Measurable goals that meet disability-related needs
- ☐ Measurable short-term objectives/benchmarks
- ☐ Special education services: focus on instruction, and result in educational growth, enhanced learning or improved educational performance
- ☐ Related services: transportation and such developmental, corrective, and other supportive services as required to assist a child with a disability to benefit from special education (example: occupational or speech therapy)
- ☐ Supplementary aids and services: aids, services, and other supports that are provided in regular education classes or other education related settings to enable children w/disabilities to be educated with non-disabled children to the maximum extent appropriate (examples: amplification devices, peer tutor, or recorded notes)
- ☐ Program modifications and supports (example: extra time for tests)
- ☐ Regular curriculum involvement
- ☐ Nonparticipation statement: an explanation of the extent, if any, to which the child will not participate with non-disabled children in the regular class and in special education
- ☐ Test accommodations (examples: individualized testing or oral responses)
- ☐ Alternate assessments (if necessary)
- ☐ The beginning date of services
- ☐ Location, duration, & frequency of services
- ☐ How goal progress will be measured
- ☐ How progress will be reported to parents

Burns, E. (2001). Developing and implementing IDEA-IEPs. Springfield, IL: Charles C Thomas, Publisher LTD.

APPENDIX G

PVCF

Code	Category Definition
PQ	Passive Question
AQ	Active Question
PR	Passive Response
AR	Active Response
PI	Passive Interjection
AI	Active Interjection
AK	Acknowledgement
ST	Special Education Teacher
RT	Regular Education Teacher
SP	School Psychologist
	Other:

30 – Second Interval Recording

Minute	1	2
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		

APPENDIX H

Parent Perception & Satisfaction (SPQ)

Here is a list of statements regarding the classification and IEP meeting. After each statement, is a rating scale from 1 to 5. Rate each statement according to your personal attitudes, beliefs, and feelings with the following:

	1	2	3	4	5
	strongly disagree	disagree	no opinion	agree	strongly agree
1. The school personnel did things to help my child and my family	1	2	3	4	5
2. The school personnel did things to help my child only	1	2	3	4	5
3. I was asked if I thought my child was eligible for a disability	1	2	3	4	5
4. I was asked if I was satisfied with the decision that was made today	1	2	3	4	5
5. I felt like an active participant in the classification meeting	1	2	3	4	5
6. I felt like an active participant in the IEP meeting	1	2	3	4	5
7. I am satisfied with the decision that was made today	1	2	3	4	5
8. The school personnel took the time (before any evaluations were done) to tell me what they were going to do and why?	1	2	3	4	5
9. The objectives of the classification meeting were clear to me	1	2	3	4	5
10. The objectives of the IEP meeting were clear to me	1	2	3	4	5
11. The evaluator assessed my child by observing him or her in the classroom	1	2	3	4	5
12. The evaluator assessed my child using formal tests	1	2	3	4	5
13. The evaluator assessed my child using informal curriculum based tests	1	2	3	4	5
14. The evaluator interviewed me as part of the assessment	1	2	3	4	5
15. The evaluator interviewed my child as part of the assessment	1	2	3	4	5
16. The evaluator interviewed the teachers as part of the assessment	1	2	3	4	5
17. I felt like I was part of the assessment process	1	2	3	4	5
18. I prepared myself for the meetings by obtaining information about learning disabilities	1	2	3	4	5
19. I was asked about my concerns during the meetings	1	2	3	4	5
20. I felt I was supposed to listen during the meetings but not express my thoughts and feelings	1	2	3	4	5
21. The size of the multidisciplinary team was too small	1	2	3	4	5
22. The size of the multidisciplinary team was too big	1	2	3	4	5
23. Differences of status/standing/importance existed among the team members	1	2	3	4	5
24. The school personnel gave me my turn to say things during the meetings	1	2	3	4	5
25. The school personnel encouraged me to say as much as they did in the meetings	1	2	3	4	5
26. The school personnel conducted the meeting as if they had decided the outcome before I even arrived	1	2	3	4	5
27. I felt the school blamed me for my child's problem	1	2	3	4	5
28. Many technical terms were used that I did not understand	1	2	3	4	5
29. The role of each team member was clear to me	1	2	3	4	5
30. I had a difficult time asking questions because there were so	1	2	3	4	5

many people present					
31. The meetings gave me a clearer understanding of my child	1	2	3	4	5
32. The school personnel gave me a chance to make suggestions and give input	1	2	3	4	5
33. The team members provided information in an organized manner	1	2	3	4	5
34. Each team member was equally involved in the meetings	1	2	3	4	5
35. I gave suggestions at the meetings	1	2	3	4	5
36. I felt like an equal in making classification decisions	1	2	3	4	5
37. I felt like an equal in making IEP decisions	1	2	3	4	5
38. I felt a responsibility for making the correct decision	1	2	3	4	5
39. I understand what services are available for my child	1	2	3	4	5
40. I was given alternative choices to special education placement and their consequences	1	2	3	4	5
41. Sufficient time was allowed for this meetings to take place	1	2	3	4	5
42. My time was well spent at the meetings	1	2	3	4	5
43. I felt prepared to take an active role during the classification meeting	1	2	3	4	5
44. I felt prepared to take an active role during the IEP meeting	1	2	3	4	5

45. List the 3 biggest barriers to being involved during the classification meeting

- 1)
- 2)
- 3)

46. List the 3 biggest barriers to being involved during the IEP meeting

- 1)
- 2)
- 3)

47. List the 3 most helpful and least helpful aspects of the classification meeting

- | | |
|----|----|
| 1) | 1) |
| 2) | 2) |
| 3) | 3) |

48. List the 3 most helpful and least helpful aspects of the IEP meeting

- | | |
|----|----|
| 1) | 1) |
| 2) | 2) |
| 3) | 3) |

49. If you had the power to improve one thing about the meetings what would it be?

50. Additional comments?

APPENDIX I

Teacher Perception & Satisfaction (TSPQ)

Here is a list of statements regarding the classification & IEP meeting. This is designed to be completed by the regular education teacher. After each statement, is a rating scale from 1 to 5. Rate each statement according to your personal attitudes, beliefs, and feelings with the following:

	1	2	3	4	5
	strongly disagree	disagree	no opinion	agree	strongly agree
51. The school personnel did things to help the child and family	1	2	3	4	5
52. The school personnel did things to help the child only	1	2	3	4	5
53. The parent was asked if they thought their child was eligible for a disability	1	2	3	4	5
54. The parent was asked if they were satisfied with the decision that was made today	1	2	3	4	5
55. I felt like an active participant in the classification meeting	1	2	3	4	5
56. I felt like an active participant in the IEP meeting	1	2	3	4	5
57. I am satisfied with the decision that was made today	1	2	3	4	5
58. The school personnel took the time before any evaluations were done to tell the parent what they were going to do and why	1	2	3	4	5
59. The objectives of the classification meeting were made clear to the parent	1	2	3	4	5
60. The objectives of the IEP meeting were made clear to the parent	1	2	3	4	5
61. The evaluator assessed the child by observing him or her in the classroom	1	2	3	4	5
62. The evaluator assessed the child using formal tests	1	2	3	4	5
63. The evaluator assessed the child using informal curriculum based tests	1	2	3	4	5
64. The evaluator interviewed me as part of the assessment	1	2	3	4	5
65. The evaluator interviewed the child as part of the assessment	1	2	3	4	5
66. The evaluator interviewed the parent as part of the assessment	1	2	3	4	5
67. The parent seemed prepared for the meeting	1	2	3	4	5
68. The parent was asked about his/her concerns during the meetings	1	2	3	4	5
69. The parent should listen during the meetings and not express thoughts and feelings	1	2	3	4	5
70. The size of the multidisciplinary team was too small	1	2	3	4	5
71. The size of the multidisciplinary team was too big	1	2	3	4	5
72. Differences of status/standing/importance existed among the team members	1	2	3	4	5
73. The school personnel gave parents a turn to say things during the meetings	1	2	3	4	5
74. The school personnel encouraged parents to say as much as they did in the meetings	1	2	3	4	5
75. The school personnel conducted the meetings as if they all had decided the outcome before the parent even arrived	1	2	3	4	5
76. I felt the school blamed the parent for the child's problem	1	2	3	4	5
77. Many technical terms were used during the meetings	1	2	3	4	5

78. The role of each team member was clear to the parent	1	2	3	4	5
79. The parent asked questions during the meetings	1	2	3	4	5
80. The meetings gave the parent a clearer understanding of his/her child	1	2	3	4	5
81. The school personnel gave the parent a chance to make suggestions and give input	1	2	3	4	5
82. The team members provided information in an organized manner	1	2	3	4	5
83. Each team member was equally involved in the meetings	1	2	3	4	5
84. The parent gave suggestions at the meetings	1	2	3	4	5
85. I felt like the parent was an equal in making classification decisions	1	2	3	4	5
86. I felt like the parent was an equal in making IEP decisions	1	2	3	4	5
87. The parent understands what services are available for the child	1	2	3	4	5
88. The parent was given alternative choices to special education placement and their consequences	1	2	3	4	5
89. Sufficient time was allowed for the meetings to take place	1	2	3	4	5
90. My time was well spent at the meetings	1	2	3	4	5
91. The parent took an active role during the classification meeting	1	2	3	4	5
92. The parent took an active role during the IEP meeting	1	2	3	4	5

93. List the 3 most helpful and least helpful aspects of the classification meeting

- | | |
|----|----|
| 1) | 1) |
| 2) | 2) |
| 3) | 3) |

94. List the 3 most helpful and least helpful aspects of the IEP meeting

- | | |
|----|----|
| 1) | 1) |
| 2) | 2) |
| 3) | 3) |

95. If you had the power to improve one thing about the meetings what would it be?

96. Additional comments?

APPENDIX J

Development Milestones for Middle Childhood (Ages 6-12 years)

(adapted from Prentice Hall Companion Website Development Across the Life Span, Author, Date:
http://wps.prenhall.com/hss_feldman_developmen_3/0,5466,260160-,00.html)

Physical Development

- on average children grow 2–3 inches a year
- on average children gain from 5-7 pounds a year
- children have advanced fine motor skills (e.g. writing, drawing, cutting with scissors)
- children have advanced gross motor skills (e.g. muscle coordination)

Intellectual Development

- children actively and appropriately use logic
- children can take multiple aspects of a situation into consideration
- children are still using concrete physical reality to problem solve, they have yet to master abstract reasoning
- children's memory improves (they begin to use strategies to improve memory)

Language Development

- children's vocabulary continues to increase
- children's mastery of grammar improves
- children's understanding of syntax (rules of language) grows
- children become more knowledgeable in use of pragmatics

Social Development

- children begin to use social comparison; they increasingly compare themselves to others
- children look to others who are similar to them when selecting friends
- children are developing their own internal standards
- children tend to follow rules based on rewards and punishments
- children's friends provide information about the world and other people
- children's friends provide social support

**Oklahoma State University
Institutional Review Board**

Protocol Expires: 5/4/2004

Date: Monday, May 05, 2003

IRB Application No ED03115

Proposal Title: THE RELATIONSHIP OF PARENT EDUCATION AND PARENTAL INVOLVEMENT
DURING SPECIAL EDUCATION CLASSIFICATION AND IEP MEETINGS FOR
SPECIFIC LEARNING DISABILITIES ON CHILD OUTCOMES

Principal
Investigator(s):

Stephanie Hirsch
434 Willard
Stillwater, OK 74078

Terry Stinnett
445 Willard
Stillwater, OK 74078

Reviewed and
Processed as: Expedited

Approval Status Recommended by Reviewer(s): Approved

Dear PI :

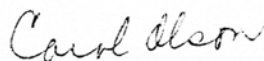
Your IRB application referenced above has been approved for one calendar year. Please make note of the expiration date indicated above. It is the judgment of the reviewers that the rights and welfare of individuals who may be asked to participate in this study will be respected, and that the research will be conducted in a manner consistent with the IRB requirements as outlined in section 45 CFR 46.

As Principal Investigator, it is your responsibility to do the following:

1. Conduct this study exactly as it has been approved. Any modifications to the research protocol must be submitted with the appropriate signatures for IRB approval.
2. Submit a request for continuation if the study extends beyond the approval period of one calendar year. This continuation must receive IRB review and approval before the research can continue.
3. Report any adverse events to the IRB Chair promptly. Adverse events are those which are unanticipated and impact the subjects during the course of this research; and
4. Notify the IRB office in writing when your research project is complete.

Please note that approved projects are subject to monitoring by the IRB. If you have questions about the IRB procedures or need any assistance from the Board, please contact Sharon Bacher, the Executive Secretary to the IRB, in 415 Whitehurst (phone: 405-744-5700, sbacher@okstate.edu).

Sincerely,



Carol Olson, Chair
Institutional Review Board

VITA

Stephanie Ann Hirsch

Candidate for the Degree of

Doctor of Philosophy

Thesis: THE IMPACT OF PARENT EDUCATION AND
MULTIDISCIPLINARY MEETINGS FOR
SPECIFIC LEARNING DISABILITIES

Major Field: Educational Psychology

Biographical:

Personal Data: Born in Panorama City, California, in July 1975; received Bachelor of Science degree in Psychology and Masters of Science in Applied Behavioral Studies from Oklahoma State University, Stillwater, Oklahoma in May 1999 and May 2001, respectively. Completed the requirements for the Doctor of Philosophy with a major in Educational Psychology at Oklahoma State University in December 2004.

Experience: Raised in Steamboat Springs, Colorado; employed by Oklahoma State University, School of Applied Health and Educational Psychology as a graduate teaching assistant, 1999 to 2003. Employed by OU Health Sciences Center, CCAN as a research assistant and Child Study Center as a psychology extern, 2002 to 2003.

Professional Membership: American Psychological Association,
National Association of School Psychology

Name: Stephanie Ann Hirsch

Date of Degree: December 2004

Institution: Oklahoma State University

Location: Stillwater, Oklahoma

Title of Study: THE IMPACT OF PARENT EDUCATION ON PARTICIPATION
AND SATISFACTION IN MULTIDISCIPLINARY MEETINGS
FOR SPECIFIC LEARNING DISABILITIES

Pages in Study: 135

Candidate for the Degree of Doctor of Philosophy

Major Field: School Psychology

Scope and Method of Study: Parents are increasingly being seen as partners in special education and initiatives to increase parent participation have been enacted under Public Law 94-142 and currently the Individuals with Disabilities Education Act. Parents are viewed as valuable members of the multidisciplinary team that makes eligibility and IEP planning decisions. The most common referral that leads to a formal evaluation and special education classification is that of students displaying academic difficulty. This study investigated parental factors that were present during a Specific Learning Disability classification meeting. The study examined whether increased training and knowledge resulted in enhanced outcomes for students; increased parent satisfaction with the classification process and interaction with other team members; and whether increased information provided to parents increased the amount and quality of their participation in the process. Participants included parents of children who were suspected of having a Specific Learning Disability (SLD). Participants were randomly assigned to three conditions. These conditions consisted of education, attention, and control. The *SLD informational packet* was compiled to educate parents. The *Knowledge Attainment & Satisfaction Questionnaire*, *Parent Verbalization Coding Form*, *Satisfaction and Perception Questionnaire*, and *School Personnel Questionnaire* were researcher-developed measures that were used.

Findings and Contributions: The results of this study indicated that parent training was an effective method for informing parents about learning disabilities and the special education process, and helping them become active multidisciplinary team members. Parent training increased the amount of quality participation during multidisciplinary meetings. This training also increased the amount of perceived quality parent participation by parents and regular education teachers. Parents also showed increased amounts of knowledge about learning disabilities and special education procedures. Parent satisfaction was not largely effected by participating in parent training.

Advisor's Approval: Dr. Terry Stinnett