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# The Development of a Comprehensive ADHD Program for Elementary School Educators

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The University of Southern Mississippi  
THE DEVELOPMENT OF A COMPREHENSIVE ADHD PROGRAM FOR  
ELEMENTARY SCHOOL EDUCATORS

by

Angie Lee Echoles

Abstract of a Capstone Project  
Submitted to the Graduate School  
of The University of Southern Mississippi  
in Partial Fulfillment of the Requirements  
for the Degree of Doctor of Nursing Practice

December 2013

## ABSTRACT

### THE DEVELOPMENT OF A COMPREHENSIVE ADHD PROGRAM FOR ELEMENTARY SCHOOL EDUCATORS

by Angie Lee Echoles

December 2013

On average, teachers will teach at least one student with Attention Deficit Hyperactivity Disorder (ADHD) in any given school year without receiving any instructions at all on ADHD. ADHD affects 3% to 7% of school-age students and one in every twenty children (Centers for Disease Control and Prevention (CDC), 2010). It is classified as one of the most common mental health disorders affecting school-age students. The American Psychiatric Association (APA, 2013) defines ADHD as a hereditary, non-curable, common childhood disorder. A triad of symptoms is associated with this disorder: inattention, hyperactivity, and impulsivity, which all have a major impact on the child's behavior in the classroom setting. Appropriate ADHD interventions can promote healthy development and success in the classroom for students diagnosed with ADHD. Research shows that school personnel do not effectively understand ADHD and the behaviors associated with this disorder resulting in multiple school suspensions, expulsion, office referrals, and excessive hospital readmissions.

The purpose of this project was to work with principals and provide consultation on development and implementation an elementary school wide ADHD program. This project had two components. The first component was a consultant component, and the second component was a program development component. The first component was delivered through the utilization of a consultant process geared toward school principals.

The second component provided school principals guidance on the development of a school wide ADHD program. The program was evaluated utilizing a survey of satisfaction. All participants unanimously agreed that ADHD programs are needed and that the training was beneficial.

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Our deepest fear is not that we are inadequate. Our deepest fear is that we are powerful beyond measure. It is our light, not our darkness that most frightens us. We ask ourselves, who am I to be brilliant, gorgeous, talented, and fabulous? Actually, who are you not to be? You are a child of God. Your playing small does not serve the world. There is nothing enlightened about shrinking so that others won't feel insecure around you. We are all meant to shine. It is not just in some of us: it is in all of us. Therefore, as we travel the roads of success and allow our own light to shine, our presence will automatically illuminate others. Marianne Williamson

The author would like to extend deepest appreciation to my committee Dr. Anita Boykins and Dr. Patsy Anderson. Special thanks to Dr. Patsy Anderson who took me under her wing and provided continued support throughout this doctoral journey. Dr. Anderson THANK YOU for being a confidence builder. You believed in me when I did not believe in myself. The road was difficult, as you would say, keeping me on track, particularly during the most difficult time when writing this dissertation. Your guidance, leadership, expertise, and most of all your patience has altered forever my life's path by enabling me to become Dr. Echoles. For that I will always be indebted to you!

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## TABLE OF CONTENTS

ABSTRACT .....	ii
ACKNOWLEDGMENTS .....	iv
LIST OF ABBREVIATIONS .....	viii
CHAPTER	
I. INTRODUCTION .....	1
Problem Statement	
Background	
Manifestation of the Subtypes	
Significance	
Need Assessment	
Objectives of the DNP Consultant Project	
II. REVIEW OF LITERATURE.....	8
Identified Gap in Literature	
Inadequate Training on ADHD	
Impact of ADHD in the School System	
Educator Training and Knowledge on ADHD	
Manifestation of ADHD in the Classroom	
Professional Development	
Components of High-Quality Professional Development Program	
Consultation	
Synthesis of the Literature	
Framework	
III. METHODOLOGY.....	18
Consultant Design	
ADHD Training Program Blueprint	
Training Manuals	
Lectures	
Evaluation Tools for ADHD Blueprint Component	
Pilot Phase III for Teachers	
Evaluation of Consultant Lectures for Teachers	
IV. RESULTS.....	32
Data Analysis	

Assumptions	
Budget and Resources (ADHD Program)	
V. DISCUSSION.....	34
Limitations of the Study	
Summary and Conclusions	
Plans to Disseminate and Future Implication	
APPENDIXES .....	37
REFERENCES .....	85

## LIST OF ABBREVIATIONS

<i>ACAAP</i>	American Academy of Child & Adolescent Psychiatry
<i>ADA</i>	Americans with Disabilities Act of 1990
<i>ADHD</i>	Attention Deficit Hyperactivity Disorder
<i>ANA</i>	American Nurses Association
<i>APA</i>	American Psychiatric Association
<i>CDC</i>	Centers for Disease Control and Prevention
<i>DNP</i>	Doctorate of Nursing Practice
<i>DSM-V</i>	Diagnostic and Statistical Manual of Mental Disorders
<i>ELL</i>	English Language Learners
<i>ESEA</i>	Elementary and Secondary Education Act
<i>IDEA</i>	The Individuals with Disabilities Education Act
<i>IEP</i>	Individualized Education Program
<i>KADDS</i>	Knowledge of Attention Deficit Disorder Scale
<i>LD</i>	Learning Disorder
<i>NCLB</i>	No Child Left Behind
<i>NIMH</i>	National Institute of Mental Health
<i>OECD</i>	Organization for Economic Cooperation and Development
<i>PD</i>	Professional Development

## CHAPTER I

### INTRODUCTION

#### Problem Statement

Although several laws are enacted to ensure that the two-million students diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) receive an appropriate public education, there are neither policies nor guidelines regulating schools to provide ADHD professional development training to educators. Convergence across studies corroborate that educators are not properly trained to manage students with ADHD in the classroom setting (Glass, 2000; Koller, 2004; Rones & Hoagwood, 2000). Attributable to educators' insufficient training and poor understanding regarding ADHD, this population of students are often overlooked and under-served in the school system (Breslau, 2008; Glass, 2000; Koller, 2004; Rones & Hoagwood, 2000).

While it is recognized that other factors contribute to the failure to thrive component connected with this population, this project will address teachers' limited knowledge by means of providing appropriate educational instructions to students with a diagnosis of ADHD in the classroom. Despite the fact that this lack of knowledge is well documented (Barkley, 2003), the educational system has been slow to respond to this problem with a solution. It is reasonable to enhance educators' knowledge about ADHD; as follows, educators will be more willing and able to provide classroom accommodations to cultivate improved educational outcomes for students with ADHD. One vessel for disseminating new knowledge is to coordinate school-wide ADHD programs to provide the required and desperately desired ADHD professional development training for teachers.

Students with ADHD often experience a wide range of problems such as a) high suspension and expulsion rates, b) poor academic achievement, c) grade retention, and d) higher school drop-out rates Barkley (as cited by U.S. Department of Education, 2009). With appropriate accommodations and effective teacher training (Glass, 2000; Koller, 2004; Rones & Hoagwood, 2000), the student with ADHD can thrive in the classroom setting.

Therefore, as part of the doctoral capstone project, the ADHD expert Doctor of Nursing Practice (DNP) student consulted with a local Gulf Coast elementary school principal to develop a consulting program. The consultant program was conducted over a period of five working days. The purpose of this project was to develop a school-wide ADHD program for elementary educators. The goal of the program was to provide training to increase educators' knowledge and skills to effectively manage behaviors exhibited by students with ADHD.

On average educators will teach at least one student with ADHD in any given school year without receiving any training at all on classroom management strategies for providing effective instruction to students diagnosed with ADHD (Glass, 2000). As a result of insufficient teacher knowledge and training, it is critical to heighten the awareness and seek support of school principals in order to meet mental health needs of students with ADHD. Principals can legalize this movement by supporting and promoting policies and procedures mandating district school-wide ADHD programs. In addition, principals should encourage teachers' participation in ADHD professional development training; simultaneously promoting vital organization change within the school system.

## Background

The diagnosis of ADHD is growing and is contributing to academic complications for many students and teachers. Research proclaims that 3% to 5% of elementary school-age students have an ADHD diagnosis American Psychiatric Association (APA). ADHD is a hereditary, non-curable, common childhood disorder characterized by a triad of symptoms to include hyperactivity, inattentive, and impulsive behaviors. However, impulsivity is often considered to be the most detrimental of the three symptoms (APA, 2013).

There are three subtypes of ADHD (Appendix A) which are defined according to which symptoms are the most prominent. The subtypes are: 1) predominantly hyperactive-impulsive subtype, 2) inattention subtype and 3) the combined subtype as described in the Diagnostic and Statistical Manual of Mental Disorders (APA, 2013). However, the following conditions must be evident for an accurate ADHD diagnosis.

Several of the inattentive or hyperactive-impulsive symptoms are present before age 6. Several symptoms are present in two or more setting, (e.g., at home, school). There is clear evidence that the symptoms interfere with, or reduce the quality of, social and school functioning. The symptoms are not better explained by another mental disorder (e.g. mood disorder). Teachers must be able to correctly differentiate which of the three subtypes depict the student's behaviors in the classroom and report observations to the appropriate personnel (e.g. principal, IEP team, health care providers) utilizing an ADHD rating scale of preference (Appendix B).

Centers for Disease Control and Prevention (CDC) in 2010 stated that approximately, 5% of students diagnosed with ADHD exhibit hyperactivity and

impulsivity symptoms but have no problem with inattention. Six or more of the nine symptoms are in the hyperactivity-impulsivity categories. Fewer than six of the nine symptoms of inattention are present, although inattention may still be present to some degree (CDC, 2010).

Roughly, 15% to 20% of students diagnosed with ADHD have the inattention subtype. Within this subtype, the majority of symptoms (six or more of the nine) are in the inattention category. Fewer than six symptoms of hyperactive-impulsivity are present, although hyperactivity-impulsivity may still be present to some degree. The combined subtype includes hyperactive-impulsive and inattentive symptoms. In this subtype six or more of the nine symptoms of inattention and six or more symptoms of hyperactivity-impulsivity are present. The combined type affects 75% of students with ADHD (CDC, 2010).

#### Manifestation of the Subtypes

Inattention subtype is evident when a student does not follow directions or finish tasks, and does not appear to be listening when someone is speaking, does not pay attention, and makes careless mistakes. A student displaying symptoms of the hyperactive subtype often fidgets, or bounces when sitting, does not stay seated as expected and is always talking. The impulsive subtype is evident when a student has difficulty waiting his or her turn, blurts out answers before the question is asked, and interrupts others. Though students with ADHD may initially illustrate as incorrigible, having an understanding of how to support them can coin a blueprint of happiness and success for both the teacher and the student.

## Significance

### *Mandates*

The Americans with Disabilities Act of 1990 (ADA), The Individuals with Disability Education Act (IDEA), and Section 504 of the Rehabilitation Act of 1973 are federal laws. These laws guarantee that a student with a diagnosis of ADHD receives an appropriate public education. In 1991, the Department of Education issued a policy regarding students diagnosed with ADHD stating that public schools must provide appropriate educational service to those identified as having ADHD (Chicago Office for Civil Rights, 2001). A preponderance of students with ADHD are now inclusive in the general education setting due in part to federal regulations, which specify that students are to be educated in the least restrictive environment. Consequently, this policy increases students with ADHD possibility of exposure to a teacher with inadequate or no ADHD knowledge and training (Rones & Hoagwood, 2000). Therefore, general education teachers must now be primed for non-academic issues such as managing behaviors of students with a diagnosis of ADHD, as well academic issues (Gable & Van Acker, 2000). Traditionally, it was perceived that only special education teachers required training on ADHD.

Florence County School District No. 4 versus Carter is the landmark educational malpractice lawsuit associated with the importance of properly educating students diagnosed with ADHD. In 1993, the Supreme Court ruled unanimously for the parents of a child diagnosed with ADHD to be compensated for private school expenses due to the school's failure to provide an appropriate education (Florence County School District No. 4 versus Carter, 1993).



### *Economic Impact*

In 2006, there were an estimated seven million ambulatory care visits for students diagnosed with ADHD. In 2005, the cost of care for this population of students came close to \$52 billion, roughly \$15,000 annually per individual (CDC, 2010). Additional cost is acquired by special education programs providing services, accommodations, and modification to students with ADHD (Pariseau, 2012). Therefore, by educating both general and special education teachers about ADHD; it can be instrumental in decreasing ambulatory visits, inpatient hospitalizations, school suspensions, and expulsions rates; subsequently improving the quality of life for this population.

### Needs Assessment

Specifically, 9.9% of Mississippi students ages 4-17 have a diagnosis of ADHD. This is equivalent to roughly two million students. Mississippi ranks 13<sup>th</sup> nationally in the summation of students diagnosed with ADHD (National Institute Mental Health, 2012). At least one student with ADHD will be taught by a teacher during any given school year that will not have received any ADHD training (Glass, 2000). Based on the need to supplement teacher knowledge about ADHD, the DNP student consulted with the principal at a local elementary school where teachers lack knowledge and skills on the symptoms of ADHD management. The DNP student learned about the school milieu by visiting the school weekly over a period of several months directly observing both teachers and students interacting in the classroom setting, attended extracurricular activities and parent activities. An open-ended discussion led to written identification of strengths and weaknesses in the school's current ADHD action plans.

After conducting a detailed and thorough need assessment, utilizing direct onsite observation the following were identified. Upon entering several classrooms, students with ADHD were isolated from the others and their desk was positioned in the back of the class. It appeared as though teachers perceived these students as a distraction. Several students were incorrectly labeled as being *bad*. Lastly, several of the classrooms were not conducive to learning for the student with ADHD.

After communicating with faculty, most stated they were not taught about how to recognize ADHD, or how to teach and support students with ADHD. Many acknowledged receiving a general overview of the symptoms of ADHD, but were not given extensive education about the many issues involved in supporting and teaching this population. Many articulated concerns regarding insight with what work best for managing ADHD in the classroom, especially if the student was not taking ADHD medication. The principal also expressed that teachers need training, guidance, and resource materials on ADHD and viewed the collaborative effort as a noteworthy opportunity for enhancing his and teachers' knowledge and understanding on ADHD.

#### Objectives of the DNP Consultant Project

To make the best possible difference in the life of a student with ADHD, educators must be knowledgeable of the best strategies of detection, treatment, and teaching to help students with ADHD succeed and become productive members of society. The objectives of this capstone project was to a) develop an ADHD program for elementary educators that will provide principals and teachers with knowledge and skills to deal more effectively with issues facing students with ADHD in the school system and b) increase teachers' satisfaction with educating students with ADHD.

## CHAPTER II

### REVIEW OF LITERATURE

After consulting nursing, medical, educational, and psychological databases such as Med-Pub, ERIC, CINAHL, PsycINFO, Google Scholar, and Medline; peer reviewed research on ADHD was compiled for review. A total of fifty articles were reviewed and twelve were chosen for inclusion in the literature review. In order to obtain the data that appear in this literature review, the following terms were used in the search: *ADHD and Classroom Management, Attention Deficit Hyperactivity Disorder, Kotter and Cohen Model of Change, Consultation, and Professional Development*. Additionally, journal articles published from 1999 to 2013 relating to ADHD were reviewed. One book, eight studies, and thirty-five peer-review journal articles were selected for analysis. Moreover, the author has incorporated all pertinent anecdotal and qualitative literature. A systematic review of the literature was conducted and assessed using a rating system which determined hierarchy of evidence (Appendix E).

#### Identified Gap in Literature

There are limited published studies of ADHD programs designed to educate teachers about ADHD. Most studies examine the efficacy of ADHD training programs (Barbarese & Olsen, 1998). This is startling considering teachers' frequent involvement in the assessment and treatment of students with ADHD (Bussing, Gary, & Leon, 2002). Since 1994, seventeen studies worldwide have attempted to assess teachers' knowledge of ADHD. It should be noted that six of the studies involved U.S. teachers and five studies involved only elementary teachers. Will professional development training increase teachers knowledge on ADHD?

### Inadequate Training on ADHD

Statistically speaking, 47% of school-age students have a mental health diagnosis requiring substantive mental health support in the classroom (CDC, 2010). Both regular and special education teachers testify feeling incapable and unqualified to recognize and/or intervene in mental health problems affecting today's students, although there is a desire (Koller, 2004). Additionally, Glass (2000); and Morris (2000) reports that elementary education teachers possess a compelling aspiration for more information on ADHD, although this information is not normally offered in the school system. Therefore, it seems unethical and immoral not to educate school personnel on this disorder.

### Impact of ADHD in the School System

Adelman and Taylor (2000) argue that schools are not traditionally viewed as being mental health providers. Yet, research indicates that students are not suitable for learning academic scholarship if their psychological needs are not met (Gable & Van Acker, 2000). According to Maslow's theory, the most basic needs must be met before an individual can desire a healthier lifestyle. The consequences of basic needs unmet are witness daily in the life-struggles of students faced with ADHD. As a result, students with ADHD who experience unresolved conflict in areas of personal, social, emotional, and academic issues are at risk for problems when focusing their attention on learning tasks in the classroom.

Although, the school's primary concern is education, positive mental health is the key to successful education, emotional health, and developmental outcomes, which impacts the student's overall health and welfare (American Federation of Teachers,

1995). Therefore, teachers should be proficient in utilizing fundamental mental health principles to foster students' social and emotional growth (Koller, 2004). According to the National Board for Professional Teaching Standards (2003) a teacher's mission extends beyond developing the cognitive capacity of their students; implying that teachers are also concerned with student development in other areas including the development of positive mental health and character. Thus, making it essential that schools to participate in meeting the mental health needs of their students who are troubled with a lack of social skills and an overload of mental health needs.

#### Educator Training and Knowledge on ADHD

One of the six studies in the United States conducted by Jerome and Hustler (1994) showed 85% of teachers stated they worked with one or more student with ADHD in the classroom at any given time and yet, 89% reported they had no instruction at all on ADHD. Surprisingly, 98% indicated they wanted additional training. A second study conducted by Barbaresi and Olsen (1998) determined teachers' knowledge of ADHD improved after professional development training. Results indicated teacher knowledge did improve with an increase in overall scores from 77% to 85%. Sciutto, Terjesen, and Bender (2000) conducted a third study. The purpose was to address the possibility of skewed results of Barbaresi and Olsen, 1998. The results were consistent with previous studies indicating teachers have an insufficient knowledge base of ADHD at 47%. A fourth study, Snider, Busch, and Arrowood (2003) assessed teachers' knowledge regarding treatment of ADHD, specifically concerning the use of stimulants. Overall, the teacher knowledge level was rated at 46%. The fifth study was conducted by Vereb and Diperna (2004) which showed overall knowledge of ADHD at 67%, which represented

an increase when compared to past studies. Finally, in the last study from the United States, Weyandt, Fulton, Schepman, Verdi, and Wilson (2009) conducted a study to investigate teachers' and psychologists' knowledge of ADHD. The results supported previous studies that teachers appear to have limited knowledge of ADHD.

Results from two Midwestern University Programs dispelled the myth that only special education teachers require training in the area of ADHD. The results of these studies confirm a lack of or limited knowledge of ADHD on both special and general education teachers. This validates a critical call for all teachers to receive training to amplify their knowledge and understanding about ADHD. Glass (2000) and Koller (2004) found that most teachers do not effectively understand ADHD and its associated behaviors. Shockingly, teachers perceive ADHD as a behavioral disorder instead of an educational problem. This lack of understanding confirms their limited ability to effectively teach students with ADHD. According to a report entitled New Freedom Commission on Mental Health (2003) schools are obligated to address and attend to the needs of all students in the education system.

#### Manifestation of ADHD in the Classroom

The core characteristics of ADHD can lead to a multitude of complications for students with ADHD in the school setting. These core characteristics impact academic, behavioral, and social functioning. Academically, students with ADHD underachieve compared to their peers (Anastopoulos, 1996; Barkley, 1998; Weiss & Hechtman, 1986). Behaviorally, they are described as students that generally act before they think and are in constant motion (Barkley, 2003; Schaub, 1998; & Teeter, 1998). They have difficulty paying attention, concentrating, following simple directives and completing assignments

(DuPaul & Stoner, 2002). Often, they are disruptive in the class, always talking without permission. Socially, they become frustrated easily with peers. Unquestionably, students with ADHD command more support from their teacher than their cohort. Consequently, the traditional teaching and discipline approaches often are disastrous for these students (Barkley, 1998; DuPaul & Stoner, 2002).

Although, ADHD greatly affects students' behaviors within the classroom, according to the National Civil Right Law, it is unlawful to suspend a student more than ten times per school year for exhibiting behaviors consistent with their diagnosis of ADHD (Chicago Office for Civil Rights, 2001). For this reason, a student facing a ten day or more suspension is entitled to have a review to clarify whether the misconduct was a manifestation of the disability. Even if the misconduct is found not to be a manifestation of the disability and the suspension is enforced, the student must continue to be provided a free, appropriate public education, even if educational instruction is provided in an alternate setting.

### Professional Development

In a qualitative study, authors interviewed sixteen teachers at different career stages to determine their attitudes and willingness to engage in professional development. The findings suggested that intent, value, and topic differed by career stages; however, regardless of their career stage, teachers were adamant that anything learned from professional development needed an application component and the content had to be relevant to their teaching contexts. Teachers' attitudes were also influenced by constraints that included time, money, and accountability issues (Schirduan & Case, 2001).

Professional development training provides teachers with knowledge and expertise necessary to manage challenging classroom behavior and improve academic, social, and emotional outcomes of students with ADHD. To assess the efficacy of three inservice programs, Javorsky and Zentall (2007) focused on knowledge, understanding, and functional-assessment interventions; forty-nine educators of students with ADHD and 196 of their students were identified. Three months after implementing all programs, improvement in teachers' attitudes and confidence regarding teaching students with ADHD was noted.

Ekrem and Taner (2012) conducted a study investigating teachers' views on professional development opportunities sponsored by the school where they work. The study involved ten teachers who worked in an upper level school in Turkey. Results of the study indicated that there are limited professional development opportunities offered by the school to teachers. The aim of the study conducted by Syed and Hussein (2010) was the development and evaluation of an ADHD training program for forty-nine teachers. An ADHD training program for teachers was designed and piloted in three different schools in Pakistan. End results showed the workshop improved knowledge of school teachers regarding ADHD, and it remained significant even after 6 months of training.

Professional development, commonly referred to as staff development, in-service training, or in-service education, is defined by the American Federation of Teachers (1995), as “a continuous process of individual and collective examination and improvement of practice” (p. 5). According to the No Child Left Behind Act (2001) professional development is a key strategy for improving teachers' knowledge and skills.



The National Staff Development Council (2012) defines professional development as a comprehensive, sustained and intensive approach to improving teachers' and administrators' effectiveness in raising student achievement. Professional development promotes joint accountability to improve student performance and embrace professional learning. Effective teacher professional development is critical for improving student achievement. Organization for Economic Cooperation and Development (OECD) defines professional development as activities that expand an individual's skills, knowledge, expertise, and other characteristics as a teacher (Organization for Economic Cooperation and Development, 2012).

#### Components of High Quality Professional Development Program

Research shows professional development training as an effective tool utilized to increase teachers' knowledge and understanding on ADHD (Barbaresi & Olsen, 1998). Common components of high-quality professional development emphasize content knowledge, an extended duration, and compatibility with other learning activities. According to the Elementary and Secondary Education Act (ESEA), to be considered *high quality*, the professional development activities must meet the following requirements: a) be sustained and classroom-focused, provided over time, and should not take the form of one-day; b) improve the teaching of academic subjects by contributing to an increase in teachers' knowledge to enable children to meet standards; c) provide training in the use of effective, scientifically based instructional strategies for a diverse range of students, thus helping to close the achievement gap; d) support the district and school needs assessment and district and school plans, including program/activity plans and Title I unified plans, if applicable; e) draw on resources available under other

programs such as No Child Left Behind Title (NCLB) IIA; and f) include strategies for developing curricula and teaching methods that integrate academic and vocational instruction (New Freedom Commission on Mental Health, 2003).

Madigan (2006) suggest that teachers' professional development training should include seven essential components: 1) activities should be directed to the students' learning; 2) the schools should use data for making decisions regarding the content and type of activities that will produce PD; 3) activities should be based on a valid practical research; 4) teachers' mastery of the content; 5) a long-term, effective, and focused program; 6) activities should be compatible with content that is learned in teacher education and undergo evaluation processes; and 7) PD should be adapted to the evaluation standards and the school's curriculum.

#### Consultation

Nursing consultation occurs when a nurse works with an individual, group, organization, or community with the specific purpose of assisting them to solve actual or potential problems related to the health status of patients or to the healthcare organization (Norwood, 2003, p. 3). It is recognized as a core competency (Barron & White, 2009), and an essential role component of advanced practice nurses (American Nurses Association, 2010), as well as nurses assuming advanced roles as educators and administrators (Forsyth, Rhudy, & Johnson, 2002).

American Nurses Association (2010) describes nursing consultation as an indirect nursing intervention: a nursing activity that is executed in absence of the patient but on his or her behalf or on the behalf of a population of patients. Barron and White (2009) maintain that consultation may enhance healthcare delivery systems, extend the

knowledge available to solve clinical problems, and foster the ongoing professional development of the consultant.

### Synthesis of the Literature

Although, teachers lack knowledge and understanding on ADHD (Sciutto et al., 2000), they have voiced a desire for training (Glass, 2000; Morris, 2002). To meet the needs of students with ADHD, it is imperative for teachers to have a clear understanding and recognition of ADHD symptoms and management of behaviors. The nurse with a Doctoral of Nursing Practice degree is prepared to bridge the gap (Appendix F) by developing and implementing successful organizational changes through advance practice roles such as ADHD expert consultants (American Association of Colleges of Nursing, 2013).

### Framework

The Practice Parameters for the Psychiatric to Schools Consultation Guideline served as evidence guiding the design for the development of the consulting program. The Practice Parameter for the Psychiatric Consultation to schools was developed by two medical doctors, Heather J. Walter and Irving H. Berkovith. The parameter was reviewed at the member forum at the 2003 annual meeting of the American Academy of Child and Adolescent Psychiatry (AACAP). It took 3 months for the parameter to be finalized. The practice parameter was approved by the AACAP Council September, 2005 (AACAP, 2005). The Kotter and Cohen's Change Model (Appendix C) will be used as the theoretical foundation to provide a framework for planning, developing, and implementing, the ADHD project. Both components will follow guidelines of the Logic model (Appendix D) for evaluation. Kotter and Cohen's Model of Change was created

through input received during interviews, that were conducted with nearly 400 people from 130 organizations; it was devised utilizing interviews and opinions (Kotter & Cohen, 2002).

CHAPTER III  
METHODOLOGY  
Consultant Design

In an attempt to address the educational needs of students with ADHD via providing guidance and education to administrators, faculty, staff and parents, the doctoral prepared student with practice expertise in child and adolescent psychiatry served as a consultant to the school principal. The DNP student provided guidance on the development of an educator comprehensive ADHD program that included training, policies, and resource materials on ADHD for teachers in an elementary school setting. The program was derived from concerns of the both, principal and teachers.

The principal suggested that teachers were not well prepared to meet the needs of students with ADHD and required additional training. Likewise, teachers voiced interest on receiving additional training on ADHD. The population for the proposed project was educators at a local elementary school. Similarly, once implemented, the scope of practice will be all educators, including kindergarten through high school.

ADHD Training Program Blueprint

Five main goals of the ADHD training program were delineated for the participants. 1) educators will be able to identify characteristics of ADHD, 2) educators will know their role in assessment of ADHD and intervention procedure, 3) educators will be familiar with treatment options for managing ADHD, 4) educators will be able to select and develop interventions for the classroom based on core symptoms displayed by the student, and 5) educators will be aware of available ADHD resources for students, family, and other educators.

## Training Manuals

The program comprised of nine manuals (Appendix G) intermingling the school, the educator, and the family. The Teaching Children with ADHD: Instructional Strategies and Practices handbook was design for stakeholders responsible for the implementation of the program. This manual provided an overall strategy for successful instruction on content to be included in a successful ADHD program. The Practical Guide for Schools manual was design to provide insight into ADHD and how it can be managed within the school context. Additionally, this manual provided an understanding of ADHD from the view of a child living with ADHD. The Strategies for School Counselors Working with ADHD in the School Setting manual described the key roles of counselor in identifying and referral of students with ADHD. Furthermore, it provided guidance to counselors regarding consulting with teachers, parents, and other school personnel as well a list of mnemonics that have proven to be effective when working with students in the school setting. The Placement Continuum manual provided a multitude of tools that assist with identifying special needs and appropriate school placement of students with ADHD. The Handbook for Teachers manual provided interventions and strategies that utilized in the classroom when providing educational instruction to students with ADHD. The two Parent resource manuals provided parents with a wealth of detailed information on ADHD. The Students and Psychotropic Medication: The School's Role manual provided guidance on developing policies and procedures regarding administering medications in school settings. This manual also provided medication administration tools to be utilized by the school nurse. The Resource Guide for School and Home manual provided helpful

hints in identifying and treating ADHD in the school setting and home setting. Plus, other supplementary ADHD booklets were provided resources for later reference.

### Lectures

#### *Unit 1: The Importance of Comprehensive School-wide ADHD Programs*

Schools are often consulted when a child is being tested for ADHD; therefore, knowledge of the symptoms is valuable particularly to a teacher. Teachers' abilities to assess and recognize potential ADHD allow for students to be afforded suitable placement and appropriate educational accommodations. The assessment of ADHD entail facts from the teacher or other school professional regarding core symptoms of ADHD, length of symptoms, and the extent of functional impairment. On occasion, many students show characteristics of ADHD, however, some of these actions maybe archetypal in lieu of their age. These behaviors must be exhibited to an atypical extent to confirm a diagnosis of ADHD. For many students with ADHD, a phone call from the teacher will be the first time their parents will start considering the prospect of ADHD. A massive amount of cases are brought to the attention of parents as a result of teacher's capability to recognize ADHD manifestation.

#### *Unit 2: Legislation that Establishes and Protects the Educational Rights of Students with ADHD*

- Section 504
- The Individuals with Disabilities Education Act-IDEA
- The Americans with Disabilities Act

There are two main laws protecting students with disabilities including those with ADHD: 1) The Individuals with Disabilities Education Act of 1997 (IDEA) and 2)

Section 504 of the Rehabilitation Act of 1973 (U.S. Department of Justice Civil Rights

Division, 2013). IDEA is special education law. Section 504 is a civil rights statute. Both laws guarantee to students a free and appropriate public education (FAPE) and instruction in the least restrictive environment (LRE), which promotes placement within classroom settings of peers without ADHD. Due to the fact, there are different criterion for eligibility, it is imperative that parents and teachers are well-informed of both IDEA and Section 504 and be fully knowledgeable about each.

Sometimes students with ADHD qualify for special education and other related services under the disability categories of specific learning disability (SLD) or emotional disturbance (ED). For example, a child who has ADHD who also has learning disabilities may be eligible under the SLD category. Students with ADHD most often are entitled special education and related services under the IDEA category of other health impaired (OHI). Eligibility criteria for this category entail that the student has a health problem such as ADHD causing an educational deficiency that has a major effect on the student's performance to the extent that special education is considered indispensable.

The Americans with Disabilities Act (ADA) is a constitutional right by law that prohibits discrimination against students with ADHD (U.S. Department of Justice Civil Rights Division, 2013). ADA does not merit special services for the student, however; it does allow reasonable accommodations to be made in the classroom setting. For example, students are allotted additional time to complete a quiz or weekly test.

*Unit 3: Importance of Informing Parents about Special Education and Related Services and Placement for the student with ADHD-Parental Involvement*

Schools must do their part to promote parental involvement. Parental involvement is considered crucial to improve behaviors of students with ADHD.



Parental education and support are notable components of treatment. Efficient parenting programs facilitate constructive parent-child relationships. Parents have the right to attend all meetings and appeal any decisions made regarding special education accommodation concerning their child.

*Unit 4: Providing Appropriate Accommodations and Treatment Modalities*

Psychosocial interventions teach students with ADHD to deal effectively with life stressors as a result of the three core symptoms of ADHD. The treatment is individualized and directed at areas which are challenging for that student. Focusing on these issues is extremely significant for the success of that student in and out the classroom for example; helping them to get along with others and forming therapeutic peer relationships. Psychosocial intervention combined with medication therapy is most effective. However, alternative treatment such as behavior management, classroom accommodations and social skills training are also advantageous.

*Behavioral Modification.* Behavioral interventions place emphasis on encouraging appropriate behavior with praise or reward and giving consequences for inappropriate behavior. The same response is identical each time a student displays an inappropriate behavior and is followed through with consistent rewards and consequences. A student with ADHD does not have the skills to modify his or her behavior without receiving help. A student experiencing ADHD needs to be managed in a specific way. They cannot be managed in a typical manner. The desire is to gradually decrease the undesirable behaviors and to reinforce the desirable behaviors. Behavior modification is effective when the intensity, frequency, and duration of the undesirable behaviors decreases and each increases with the desirable behaviors. Students with

ADHD function more efficiently under the proper consequences. *Reinforcers* are consequences that strengthen behavior. *Punishments* are consequences that weaken behavior. To manage behavior through consequences requires a multi-step process:

1. The problem must be defined, usually by count or description.
2. Plan a way to modify the behavior.
3. Identify a successful reinforcer.
4. Utilize the reinforcer consistently to shape or change behavior.

*Classroom Accommodations.* Keep in mind that all adjustments should be made in a way as to not draw negative attention on the student with ADHD. It is important not to publicly identify nor embarrass the student. It is no secret that a typical classroom is an overwhelming environment for a student with ADHD. It is overloaded with stimulation and distraction, challenges, and competitive peers. Students with ADHD can benefit from a variety of accommodations for example:

1. Seat the student near the teacher and away from doors and windows. This helps the child stay focused on the teacher.
2. Allow a student to tape-record assignments. Students with ADHD tend to have trouble remembering spoken instructions.
3. Provide the child with a note-taking partner. ADHD-related handwriting problems can make it hard to keep up when taking notes.
4. Give a lighter homework load. This is appropriate for children with ADD who struggle to get their homework done. The questions are just as hard, there are just fewer of them.

5. Grant extra time for test-taking. The idea is not to make the exam easier for the child but to level the playing field, by providing sufficient time for the child to show what he knows.
6. Let the student run occasional errands for the teacher. This can help hyperactive kids burn off some energy.

Additional accommodations include:

- Provide opportunities for movement and tactile input. Some students with ADHD benefit from sitting on a therapy ball instead of a standard chair.
- Provide a safe environment with encouragement and compliments for positive behavior while ignoring minor inappropriate behavior.
- Reformat documents to minimize clutter and providing documents in alternative formats.
- Provide clear and specific instructions.
- Break long assignments into smaller parts.
- Extend time to complete assignments and alternative testing arrangements.

*Social Skills Training.* Students with ADHD have difficulties with social interactions. Social skill training benefits children with ADHD in their social interactions. Having positive peer relationships and friendships is important for all children. Unfortunately, many kids with ADHD have a hard time making and keeping friends and being accepted within the larger peer group. Students with ADHD often experience social difficulties, social rejection, and interpersonal relationship failures. Educating teachers about ADHD and the ways in which it affects social skills and interpersonal behaviors can help alleviate much of the conflict blame. Social rejection causes emotional pain in

the lives of many students who have ADHD and can create havoc and lower self esteem throughout the life span.

#### *Unit 5: Pharmacological Treatment*

Stimulant drugs are the most commonly used treatment for ADHD and are an effective way of managing ADHD symptoms. When appropriate they are often helpful in reducing the negative behaviors that peers find off-putting. In order for medication to provide the optimal benefit that it can in helping to manage the core ADHD symptoms, there is often an ongoing need to monitor, and make adjustments along the way. Usually this information is obtained from the teacher. The clinician will also make clinical judgments about the effectiveness of the medication. These drugs improve ADHD symptoms in about 70% to 80% of children. They tend to reduce interruptive behavior, fidgeting, and other hyperactive symptoms, as well as help a person finish tasks and improve his or her relationships. Stimulants are not considered to be habit-forming in the doses used to treat ADHD in children, and there is no evidence that their use leads to drug abuse.

*Common Stimulants for ADHD.* There are many stimulants available to treat ADHD: short acting (immediate-release), intermediate-acting, and long-acting forms.

Common stimulants include:

- Adderall (intermediate-acting)
- Adderall XR (long-acting)
- Concerta (long-acting)
- Dexedrine (short-acting)
- Dexedrine capsule (intermediate-acting)

- Daytrana (a patch that delivers the drug on a long- or shorter-acting basis)
- Metadate CD (long-acting)
- Metadate ER (intermediate-acting)
- Methylin ER (intermediate-acting)
- Ritalin (short-acting)
- Ritalin LA (long-acting)
- Ritalin SR (intermediate-acting)
- Vyvanse
- Quillivant XR (long-acting)

The short-acting forms of the drug are usually taken two or three times a day and the long-acting ones just once a day. Newer forms of some stimulant drugs may reduce side effects and relieve symptoms for a longer period of time. They include Concerta (10-12 hour duration), Daytrana patch (7-10) hours, depending on how long it is worn), Ritalin LA (6-8 hours), Metadate CD (6-8 hours), and Adderall XR (10-12 hours).

*How Do Stimulants Work for ADHD?* For someone with ADHD, stimulants regulate impulsive behavior and improve attention span and focus by increasing the levels of certain chemicals in the brain, such as dopamine and norepinephrine, which help transmit signals between nerves.

*What Are the Side Effects of Stimulants?* Common side effects of stimulants which normally resolve after a few weeks of treatment as the body adjusts to the new medication are as follows:

- Headache
- Upset stomach

- Increased blood pressure

Additional, each participant received an ADHD toolkit. This toolkit included the following: 1) an inservice education program blueprint (Appendix V) for parents and educators; 2) staff development continuing education program blueprint (Appendix W) which consisted of five modules on ADHD; both programs follows information included in the nine training manuals which were provided to each participant during the consultation phase, 3) demographic questionnaire (Appendix J) and 4) in addition, for evaluation purposes a measure of satisfaction form (Appendix K); KADDS survey (Appendix M); teacher intervention survey (Appendix N) and a logic model evaluation worksheet (Appendix X).

There are several reasons why these topics were chosen. Most importantly, teachers have many misperceptions about children with ADHD (e.g. *The child is BAD*) that are likely to influence their approach to the student and wiliness to provide appropriate accommodations. Furthermore, evidence based treatment literature on stimulates was important because teachers play two major roles with respect to pharmacological treatment. First, they often are asked to provide information to assist the provider in deciding whether to place a student on medication and; secondly, more often than not are asked to provide feedback on the effectiveness of a prescribed medication. Next, exposure and explanations about educational laws of students with ADHD provide teachers with guidance for appropriate placement and highlights the specification of special education and related services that allow students to enter and advance in the general education classroom setting. Finally, the importance of parental

involvement, school programs that include parent training reduce problem behaviors significantly (Dishion & Kavanagh, 2003).

#### Evaluation Tools for ADHD Blueprint Component

A measure of satisfaction form will be completed subsequent to the ADHD inservice training to evaluate how beneficial teachers found the presentation, how applicable they believed it was to them, how effectively the material was presented, and whether they would recommend this training session to other teachers and schools. Teachers will rate these questions based on a 5-point Likert item scale ranging from strongly agree to strongly disagree.

Knowledge of Attention Deficit Disorders Scale (KADDS) survey (Appendix L) is a 36 item rating scale that uses a true (T), false (F) or don't know (DK) format. This format allows for differentiation of what teachers do not know from what they believe incorrectly (i.e., misconceptions). This instrument will be utilized to assess the knowledge acquired by educators and parents who completed the ADHD inservice education program. This measure will be utilized as an evaluation tool pre/post implementation of ADHD intervention. The KADDS was designed (Appendix M) to measure knowledge and misconceptions of ADHD in three specific areas: symptoms/diagnosis of ADHD, the treatment of ADHD, and associated features (i.e., general information about the nature, causes and prognosis of ADHD).

The teacher intervention survey (Appendix N). This tool will be utilized to assess whether teachers are actually employing techniques taught in the ADHD professional development programs post implementation. There have been many different interventions suggested for students with ADHD in the classroom, several of which are

listed on this tool. Participants are asked to answer each question by placing a check in the appropriate box. Teachers will rate these question based on a scale from 1 to 5 with 1 indicating very low and 5 indicating very high.

### Pilot Phase III for Teachers

#### *Participants*

The goal for the intervention was to provide faculty and staff with skills and techniques to deal more effectively with behaviors exhibited by ADHD students. Participants were a convenience sample of seven educators from a local elementary school from the Gulfport School District (one male-principal and six females-teachers) two African Americans, one Hispanic, and four Caucasians. Participants (Appendix J) varied according to gender, age, years of teaching and over 85% of the participants were female elementary educators, 25% were in the 31-40 age bracket, 28.6% indicating receiving training while obtaining their licensure, compared to 57.14% indicating that they have not received any additional training on ADHD. Yet, 85.71% reported having taught six or more students with ADHD (Appendix I).

The Gulfport school district includes 12 schools that serve 5,678 students in grades Kindergarten through 12. Published statistics for the district indicates that 5,480 students are enrolled in the Gulfport school district. The gender makeup of the district is 50% female and 50% male. The racial makeup of the district is 52.45% African American, 42.90% Caucasian, 3.14% Hispanic, 1.30% Asian, and 0.22% Native American. The Gulfport School District has fifteen students for every full-time equivalent teacher. Roughly, 12% of students have an Individualized Education Program (IEP). An IEP is a written plan for students, for example with ADHD and eligible for special needs



services. The Gulfport school district serves 1% English Language Learners (ELL). ELL students are in the process of acquiring and learning English Language skills (Gulfport School District, 2013).

### *Setting*

The setting was a local Elementary school located in Gulfport, MS. This school is one of eight elementary schools within the Gulfport School District. About 341 students are in attendance, there are eighteen students for every full-time equivalent teacher. The Mississippi average is fifteen students per full-time equivalent teacher.

### *Consultant Procedure*

The principal (Appendix P) and teachers (Appendix Q) signed written consents that the primary investigator collected. The ADHD consultant project was approved by The University of Southern Mississippi's Institutional Review Board (IRB). All IRB (Appendix R) requirements were met. The first component was a consultant process designed for the principal. The second component was a program development component that provided guidance and resource manuals to educators on the development of a school-wide ADHD program.

The consultant presentation was presented utilizing ADHD resource handouts and booklets. Both were distributed to administrators and teachers to supplement the material presented and to suffice as ADHD references. In addition to the week-long consultant project, the primary investigator also conducted several unstructured interviews with teachers to educate and provide additional resource materials on ADHD that could be beneficial when providing class room instruction to students with ADHD.

### Evaluation of Consultant Lectures for Teachers

Stakeholder satisfaction is a key consideration when deploying an empirically supported intervention. Therefore, collection of satisfaction data was important. Surveys of acceptability and expected effectiveness are relevant considerations during this stage of program development. The purpose of the demographic survey (Appendix J) was to identify statistical diversity amongst each participant. Questions on the demographic survey solicited information regarding gender, age, and ethnicity. Participants were asked to fill in the blank or circle correct response. The satisfaction survey (Appendix K) solicited satisfaction with provided resource manuals and satisfaction with the consultant project. Participants were asked if the training was useful, was the content organized and easy to read, if the participants would be able to apply the knowledge learned, and if they would recommend the training to others. Results indicated that participants were satisfied with all aspects of the project, as no item rated below agree by any participants. Each item had a possible rating of strongly agree, agree, neutral, disagree, and strongly disagree.

## CHAPTER IV

### RESULTS

#### Data Analysis

Data obtained through open-ended questions and focus group responses provided the consultant with insight on teachers' perception of the impact of the resources provided. Satisfaction ratings demonstrated the resource booklets provided by the principal investigator were perceived as a valuable resource for future use.

Additionally, data revealed the principal perceived that the ADHD consultant program was very beneficial and that teacher ADHD training is one of the greatest professional development need for teachers. Valuable information for professional development leaders and school administrators was provided by this study. For example, it was clear that the principal in this study perceived a need for a school-wide ADHD program and believes that it will be beneficial to both student and teacher.

#### Assumptions

There are assumptions associated with this proposal. The assumptions are:

1. The principals will continue to support implementation of the program.
2. The program will be developed and ready for implementation prior to December 2013.
3. All schools in the Gulfport school district will adopt the program.

#### Budget and Resources (ADHD Program)

The principle will ensure that resources are sufficient for the implementation and evaluation of the ADHD program. The budget for the ADHD program will be minimal.

The author will establish fiscal resources that are sufficient for the implementation and evaluation of the in program. Fiscal resources will include the following:

1. Meeting space is sufficient for the development team to assemble. The meeting space should be well lit, comfortable, and quiet. Tables and chairs should be available.
2. Equipment will be necessary and should include computers, printers, copiers, internet access, PowerPoint, and a display screen.
3. Supplies should be adequate to allow for the development and implementation of the project. Paper, writing utensils, and external memory devices will be necessary.
4. Resource booklets and additional handouts were provided to all participants. However, once the ADHD program is implemented, additional booklets are required for additional educators.
5. The need for additional resources is not realized at this time.

## CHAPTER V

### DISCUSSION

#### Limitations to the Study

The sample size was small which included seven participants. Furthermore, the study was designed to provide guidance and resources on the development of an ADHD school-wide program for elementary school teachers who provide educational instructions to students with a diagnosis of ADHD. It excluded the teachers in the school districts that were not elementary school teachers. The study did not include alternative schools or private schools. The project was limited to only one public elementary school and one school district.

The study results were limited to teachers' and the principal perceptions of the professional development experiences; therefore, the impact of professional development on the teachers' practice and student achievement was not determined. The impact of professional development in ADHD school-wide programs practices and student achievement may be perceived differently by teachers working in other school districts. Other limitations of the study include the possibility that the respondents may have given socially acceptable answers to the questions and issues related to the analysis of data.

#### Summary and Conclusion

Positive satisfaction amongst all educators regarding the ADHD resources and consultation was unanimous. Findings indicated that all participants agree the consultation was beneficial. Participants rated overall satisfaction as excellent. A direct content analysis reveals that while collaboration between the mental health system and school system is desirable and beneficial, time constraints present as major barriers for

teachers to receive consistent and effective training. Secondly, given the limited resources and training opportunities for educators on ADHD, it would benefit principals to promote school-wide ADHD programs.

#### Plans to Disseminate and Future Implication

The results of this study will be used to identify professional development opportunities and institutional support that may best assist faculty members in creating a positive educational experience for students with ADHD. The findings may also be used to create policy change advocating for school-wide ADHD programs and have such training for inclusion in the district wide staff development curriculums and afford to all faculty in the school district rather than presented to elementary educators only as such in this study.

The project validates that ADHD training is necessary to prepare teachers to help students with ADHD to levitate above those non-academic barriers that impede scholarship in the classroom. This training also safeguards school systems compliance with their federal responsibilities by ensuring that teachers are better prepared to deal with behaviors exhibited by students with ADHD in the classroom setting. Therefore, it is vitally important that principals support mandatory ADHD training for all educators.

Koller (2004), states that all teachers should know and be able to demonstrate the following concepts upon completion of their preservice requirements: a) understand the specific role that all teachers have in the prevention of mental health problems (e.g., creating positive classroom environments, promoting healthy peer relationships, and enhancing students' self-concept) from a knowledge of current evidence-based practices; b) know how to identify students who may have or who may be headed toward a mental

health problem (working with the depressed or child with ADHD); and c) know how to create a positive, strengths-based learning environment where learning academic content can occur, while the development of a positive self-image in the learner flourishes.

## APPENDIX A

### SUBSETS OF ADHD

**People with ADHD show a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development:**

1. **Inattention: Six or more symptoms of inattention for children up to age 16, or five or more for adolescents 17 and older and adults; symptoms of inattention have been present for at least 6 months, and they are inappropriate for developmental level:**
  - Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or with other activities.
  - Often has trouble holding attention on tasks or play activities.
  - Often does not seem to listen when spoken to directly.
  - Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., loses focus, side-tracked).
  - Often has trouble organizing tasks and activities.
  - Often avoids, dislikes, or is reluctant to do tasks that require mental effort over a long period of time (such as schoolwork or homework).
  - Often loses things necessary for tasks and activities (e.g. school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones).
  - Is often easily distracted
  - Is often forgetful in daily activities.
  
2. **Hyperactivity and Impulsivity: Six or more symptoms of hyperactivity-impulsivity for children up to age 16, or five or more for adolescents 17 and older and adults; symptoms of hyperactivity-impulsivity have been present for at least 6 months to an extent that is disruptive and inappropriate for the person's developmental level:**
  - Often fidgets with or taps hands or feet, or squirms in seat.
  - Often leaves seat in situations when remaining seated is expected.
  - Often runs about or climbs in situations where it is not appropriate (adolescents or adults may be limited to feeling restless).
  - Often unable to play or take part in leisure activities quietly.
  - Is often "on the go" acting as if "driven by a motor".
  - Often talks excessively.
  - Often blurts out an answer before a question has been completed.
  - Often has trouble waiting his/her turn.
  - Often interrupts or intrudes on others (e.g., butts into conversations or games)

**In addition, the following conditions must be met:** Several inattentive or hyperactive-impulsive symptoms were present before age 12 years.

- Several symptoms are present in two or more setting, (e.g., at home, school or work; with friends or relatives; in other activities).
- There is clear evidence that the symptoms interfere with, or reduce the quality of, social, school, or work functioning.
- The symptoms do not happen only during the course of schizophrenia or another psychotic disorder. The symptoms are not better explained by another mental disorder (e.g. Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

**Based on the types of symptoms, three kinds (presentations) of ADHD can occur:**

*Combined Presentation:* if enough symptoms of both criteria inattention and hyperactivity-impulsivity were present for the past 6 months. *Predominantly Inattentive Presentation:* if enough symptoms of inattention, but not hyperactivity-impulsivity, were present for the past six months. *Predominantly Hyperactive-Impulsive Presentation:* if enough symptoms of hyperactivity-impulsivity but not inattention were present for the past six months. Because symptoms can change over time, the presentation may change over time as well.

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000.



## APPENDIX B

## ADHD RATING SCALE

Child Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

	BEHAVIOR	ALWAYS OR VERY OFTEN	OFTEN	SOMEWHAT	RARELY OR NEVER
Inattention	Fails to give close attention to details or makes careless mistakes in schoolwork\homework.				
	Has difficulty keeping attention on tasks or play activities.				
	Does not seem to listen when spoken to directly.				
	Does not follow through on instructions and fails to finish schoolwork or chores.				
	Has difficulty organizing tasks and activities.				
	Avoids or strongly dislikes task that require sustained mental effort (e.g., homework).				
	Loses things necessary for task or activities (e.g., pencils, and books, etc).				
	Is easily distracted by outside stimuli.				
	Is forgetful in daily activities.				
	<b>TOTALS FOR INATTENTION</b>				
Hyperactivity and Impulsivity	Fidgets with hands or feet or squirms in desk.				
	Leaves seat in situations in which remaining seated is expected (e.g., dinner table).				
	Runs about or climbs in situations where it is inappropriate.				
	Has difficulty playing quietly.				
	Is, on the go or acts driven by a motor.				
	Talks excessively.				
	Blurts out answers to questions before the questions have been completed.				
	Has difficulty waiting turn.				
	Interrupts other or intrudes on others (e.g., butts into games).				
	<b>TOTALS FOR HYPERACTIVITY AND IMPULSIVITY</b>				

Completed By \_\_\_\_\_ Parent \_\_\_ Teacher \_\_\_\_\_ Other \_\_\_\_\_

American Washington DC; American Psychiatric Association: 2013

For each line below, put an x in the box that best describes the child's behavior over the last six months

## APPENDIX C

## KOTTER AND COHEN MODEL OF CHANGE



## APPENDIX D

## EVALUATION MATRIX

Evaluation Question(s) What do you want to know?	Indicators-Evidence How will you know it?	Timing When will you collect data?	Data Collection		
			Sources Who will have this information?	Methods How will you gather the information?	Sample Who will we question?
1. Are teachers satisfied with the provided resources?	1. a. Teachers voice satisfaction	Pre-implementation	Teachers	Survey	Teachers
2. Are principals satisfied with consulted program?	2. a. Principals voiced satisfaction b. Implementation of an ADHD program c. Push for policy change initiatives for school wide ADHD training\programs	Pre-implementation Post - implementation	Principal	Interview	Principal
3. Has teachers' behaviors and attitude toward teaching students with ADHD improved as a result of ADHD resources\ program?	3. a. Students with ADHD: decrease referrals to office b. Decrease disruptive behaviors in classroom	During\Post implementation of the program	Teachers Principal	Interview	Teachers Principal
4. Are teachers using new skills to manage ADHD behaviors in the classroom?	4. a. Improved compliance of student behaviors in classroom b. Less classroom distraction per student with ADHD c. Increase student\teacher productivity	During\Post implementation of the program	Teachers	Survey Interview	Teachers Principal
5. Did program implementation lead to overall school performance?	5. a. Decrease school suspension\expulsion rates b. Improved state scores\ Improved academia for students with ADHD d. Decrease in student grade retention rate	Post implementation of the program	Principal	Interview principal	Principal

<b>How will the data be analyzed?</b>	<b>How will the data be interpreted?</b>	<b>How will the results be communicated - reported?</b>			
		<b>To Whom</b>		<b>When? Where? How?</b>	
<p>All survey analyses will be analyzed using SPSS.</p> <p>Descriptive Analysis will be used to analyze demographic variables and teacher's individual responses.</p> <p>Mixed methodology analysis will be completed by the principal investigator and statistician</p> <p>Identification numbers will be added to surveys. Use software to analyze the data.</p>	<p>Will identify the mean, mode, standard deviation of demographic data</p>	<p>USM faculty, staff, and students</p>		<p>Dec. 2013, USM capstone defense Written and oral report</p>	

## APPENDIX E

## REVIEW OF LITERATURE EVIDENCE TABLE

Authors Date	Study Type	Retrieved	Data Collection	Key findings	Title of Article	Level of Evidence
Barbarese, W.J., & Olsen, R.D. (1998)	Empirical Study	PsycINFO	Journal of Developmental and Behavioral Pediatrics,19, 94-100	44 schoolteachers (mean age 42 yrs) staffing a 750- student school completed a Pre intervention and post intervention questionnaires assessed teachers' training and knowledge concerning <b>ADHD</b> .  <b>Results:</b> Teachers knowledge increased after the intervention. Results: Teachers knowledge improved after the intervention.	An ADHD Educational Intervention for Elementary School Teachers	VI
Bussing, R., (2002)	Quantitative Study	Education Source	Journal of Behavioral Disorders, 27(4), 327- 339.	This study examined 365 randomly selected general education teachers' information and perception of ADHD.  <b>Results:</b> Teacher have limited ADHD knowledge. 94% of the teachers expressed wanting more ADHD training.	General Classroom Teachers' Information and Perceptions of ADHD.	II
Ekrem,C. & Taner A. (2012)	Qualitative approach and "case study	Academic Journal	International Online Journal of Educational Sciences, 4(3), 672-690	In this study it is aimed to investigate teachers' views on <b>professional development</b> opportunities provided by the school they work in. The study was carried out with ten	Upper Primary School Teachers' Views About Professional Development Opportunities	VI

				<p>subject specialist-teachers who work in upper level of a primary school in city of Erzurum, Turkey.</p> <p><b>Results:</b> Showed that school <b>development</b> and <b>professional development</b> opportunities were limited by school to teachers.</p>		
Glass, C.S., & Weagar, K. (2000)	Empirical	Academic Search Premier	Education, 121(2), 412-421.	<p>This study examines 225 <b>teachers'</b> perceptions of the incidence of <b>ADHD</b> among their students,</p> <p><b>Results:</b> Many <b>teachers</b> who did not believe the disorder to be of biological origin. Teachers lack knowledge on ADHD. Desire additional training.</p>	Teacher Perceptions of the Incidence and Management of ADHD	VI
Javorsky, J. & Zentall, S. (2007)	Quantitative Study	Academic Search Premier	Behavioral Disorders, 32(2), 78-93.	<p>To assess the effectiveness of 3 inservice programs that focused on knowledge, understanding, and/or functional-assessment interventions, we identified 49 educators of students with attention deficit-hyperactivity disorder (ADHD) and 196 of their students.</p> <p><b>Results:</b> Three months after implementing all programs we found improved <b>teachers'</b> attitudes about and confidence in teaching students with ADHD and improved self-</p>	Professional Development for Teachers of Students with ADHD and Characteristics of ADHD	III

				reported ability to provide accommodations.		
Jerome, L & Hustler, P (1994)	Comparative Study	Medline	Canadian Journal of Psychiatry, 39, 563-566.	The purpose of this study was to compare and contrast 439 American and 850 Canadian <b>teachers'</b> knowledge and attitudes regarding <b>ADHD</b>  <b>Results:</b> indicate that both samples had little in-service training regarding <b>ADHD and an ADHD knowledge gap.</b> 98% desired additional training.	A Comparison of American and Canadian Teachers' Knowledge and Attitudes Toward ADHD	VI
Koller, J., Osterlind, S., Paris, K., & Weston, K (2004)	Quantitative Study	PsycINFO	International Journal of Mental Health Promotion, 6(2), 40-46.	Teachers lack ADHD knowledge	Differences between Novice and Expert Teacher' Undergraduate Preparation and Ratings of Importance in the area of Children Mental Health	VI
Sciutto, Mark J., Terjesen, Mark D., Bender Frank (2000)	Quantitative Study	Education Source	Psychology in Schools, 37(2), 115-122	The present study examined 149 elementary school <b>teachers'</b> knowledge and misperceptions of <b>ADHD. Teachers</b> completed the Knowledge of Attention Deficit Disorders Scale (KADDS), a new instrument designed to measure specific areas of knowledge about <b>ADHD.</b>  <b>Results: Teachers knowledge of ADHD was insufficient</b>	Teachers' Knowledge and Misperception of ADHD	VI
Snider, V., Busch, T., & Arrowood, L. (2003)	Quantitative Study	Academic Search Premier	Remedial and special Education, 24(1), 47-57.	A random sample of 200 general educators and 200 special educators from Wisconsin were surveyed.  <b>Results:</b> Revealed	Teacher Knowledge of Stimulant Medication and ADHD	III

				that teachers have limited knowledge about ADHD and the use of stimulant medication.		
Syed, E. U & Hussein, S. A. (2010)	Empirical Study; Quantitative Study	PsycINFO	Journal of Attention Disorders, 13(4), 420-423	<p>A <b>teachers'</b> training program for <b>ADHD</b> was designed and a pilot run in 3 schools of Karachi, Pakistan. 49 <b>Teachers'</b> knowledge regarding signs and symptoms of <b>ADHD</b> was tested before and after the workshop and then again after 6 months using an <b>ADHD</b> knowledge questionnaire.</p> <p><b>Results:</b> The authors conclude that the workshop improved the knowledge of the school teachers regarding <b>ADHD</b> symptomatology, and it remained significant even after 6 months of training.</p>	Increase teachers' knowledge about ADHD after a week – long training program.	VI
Vereb, Rebecca L., DiPerna, James. C., (2004)	Quantitative Study	Academic Search Premier	School Psychology Review, 33(3), 421-428.	<p>Forty-seven elementary <b>teachers</b> participated in the study). The sample was primarily female (94%) Grades K-6. Participating <b>teachers</b> had a mean of 13 years of teaching experience (SD = 8.76), and 85%, 4.3%, and 10.6 % were certified in general education, special education, or both domains, respectively.</p> <p><b>Results:</b> Teachers showed increased knowledge after intervention</p>	Teachers, Knowledge of ADHD	VI
Weyandt, L., Fulton, K., Schepman, S., Verdi, G., & Wilson. K	Quantitative Study	Academic Search Premier	Psychology in the Schools, 46, 951-961	The purpose of this study was to investigate <b>teacher</b> and school <b>psychologists'</b> knowledge of Attention-	Assessment of Teacher and School Psychologist Knowledge of ADHD	VI



(2009)				<p>Deficit/Hyperactivity Disorder (ADHD). One hundred thirty-two kindergarten through 12th-grade general education <b>teachers</b>, special education <b>teachers</b>, and school <b>psychologists</b> responded to a 24-item questionnaire concerning treatment and possible causes of ADHD.</p> <p><b>Results:</b> Teachers require additional ADHD training</p>		
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## APPENDIX F

## MEETING THE DOCTOR OF NURSING PRACTICE (DNP) ESSENTIALS

Essential I – Scientific Underpinnings for practice	Implementation of an exceptional capstone project- (ADHD school-wide program) utilizing the Kotter and Cohen Model of Change.
Essential II – Organizational and System Leadership for Quality Improvement and Systems Thinking	Improving patient outcomes by educating staff about ADHD and the impact it has on students to promote more positive life styles and healthier developmental outcomes students.
Essential III – Clinical Scholarship and Analytical Methods for Evidence-Based Practice	Compiling and Disseminating ADHD evidence-base resource booklets for school administrators, teachers, staff and parents.
Essential IV – Information Systems/Technology and Patient Care Technology for the improvement and Transformation Health Care	Utilizing PowerPoint to delivery presentations modules for Consultant\ADHD program.
Essential V – Health Care Policy for Advocacy in Health Care	Advocating for better outcomes for students with ADHD by providing evidence based strategies and classroom management accommodation to faculty and staff.
Essential VI – Interprofessional Collaboration for Improving Patient and Population Health Outcomes	Collaborative efforts between DNP student and school system. DNP student will work closely with school principals and faculty to improve teachers’ satisfaction and productivity and improve attention to instruction, and decrease disruptive behavior of students.
Essential VII – Clinical Prevention and Population Health for Improving the Nation’s Health	Addressing educational and health care disparities for students diagnosed with ADHD to promote fostering positive outcomes for his/her mental, physical, developmental, emotional, and spiritual needs.
Essential VIII – Advanced Nursing Practice	Acting as an ADHD expert by providing guidance on the development and implementation of an ADHD program for Pass Road Elementary School.

## APPENDIX G

## PHASE 2: PROJECT TRAINING MANUALS

<i>The ADHD handbook Teaching Children with ADHD: Instructional Strategies and Practices</i>	This manual provides instruction to SCHOOLS on how to implement a successful ADHD program.
<i>The Practical Guide</i>	This manual provides SCHOOLS insight into ADHD and how it can be managed within the school context.
<i>The Strategies for School Counselors Working with ADHD in the School Setting</i>	This manual supplies EDUCATORS with key roles of in identifying and referral of students.
<i>The Placement Continuum</i>	This manual provides EDUCATORS a multitude of tools that assist with identifying special needs and appropriate school placement of students with ADHD.
<i>The Students and Psychotropic Medication: The School's Role</i>	This manual provides guidance to setting SCHOOLS policies and procedures regarding administering medication.
<i>A Resource Guide for both School and Home</i>	This manual provides helpful hints to assist in identifying and treating ADHD in the SCHOOL setting and HOME setting.
<i>The Handbook for Teachers</i>	This manual provides TEACHERS with intervention and strategies to be utilized in the classroom when providing educational instruction to students with ADHD.
<i>The Resource Guide for Parents</i>	This manual provides PARENTS with a wealth of detailed information on ADHD.

APPENDIX H  
INSTRUMENTS

The Demographic Questionnaire	This tool solicited information regarding gender, age, ethnicity, highest degree completed and number of years teaching.
Satisfaction Survey	On this measure, the author solicited satisfaction with provided resource manuals and satisfaction with the consultant project.
Knowledge of Attention Deficit disorders Scale (KADDS) survey- Annual Performance Competency Evaluation tool	This 36 question tool assesses teacher's knowledge of ADHD.
Teacher Intervention Survey- (KADDS) Annual Continuous Performance Improvement Tool	This tool assesses teacher usage of specific intervention taught in ADHD program.

APPENDIX I  
DEMOGRAPHIC SPREADSHEET

Category	Responses	N	% of Sample
Gender	Male	1	14.28
	Female	6	85.72
Age	21-30	1	14.28
	31-40	4	25
	41-50	1	14.28
	51+	1	14.28
Current grade	Kindergarten	1	14.28
	1	1	14.28
	2	1	14.28
	3	1	14.28
	4	1	14.28
	5	1	14.28
	Across grade levels	0	0
Job Role	Regular Education Teacher	6	100%
	Special Education Teacher	0	0
	(Principal)		
Learned about ADHD in an educator program	NO	5	71.4%
	Yes	2	28.6%
How many previous hours of ADHD training have you had	0	4	57.14
	1-3	3	42.86
	4-8	0	0
	9+	0	0
Number of students taught with suspected \diagnosed ADHD	0	0	0
	1-2	0	0
	3-5	1	14.29
	6+	6	85.71

## APPENDIX J

## PART I – DEMOGRAPHICS SURVEY

Please answer the following questions by either writing your answer on the blank or circling your response.

## A. Identifying Data

1. Gender \_\_\_\_\_
2. Your age 18-20    21-30    31-40    41-50    51+
3. Grade level(s) you currently teach? \_\_\_\_\_
4. Classes you currently teach? a. General Ed b. Special Ed
5. Ethnicity \_\_\_\_\_
6. Did you learn about ADHD during your teacher training?
  - a. No
  - b. Yes
7. How many hours of training have you received on ADHD
  - a. None
  - b. 1-3 (i.e., was taught in part of class)
  - c. Yes, 4-8 (i.e., had an entire semester course on ADHD)
  - d. Yes, 9+
8. How many students with documented ADHD have you taught?
  - a. 0
  - b. 1 or 2
  - c. 3-5
  - d. 6 or more

## APPENDIX K

## ADHD EVALUATION SATISFACTION SURVEY

Please indicate your impressions of the items listed below.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1. The trainer provided useful information.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. I will be able to apply the knowledge learned from the training material.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. The resource booklets met my objectives.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. The content was organized and easy to follow.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. The materials distributed were pertinent and useful.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. The trainer was able to provide materials to meet my needs.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. I was satisfied with the resource booklets provided by the trainer.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. The resource booklets were clear and understandable.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. I would recommend this trainer to others to receive training and resources on ADHD.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10. How do you rate the resource booklets overall?

Excellent	Good	Average	Poor	Very poor
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Other comments?

**THANK YOU FOR YOUR PARTICIPATION!**

## APPENDIX L

## KNOWLEDGE OF ATTENTION DEFICIT DISORDERS SCALE (KADDS)

## PERFORMANCE IMPROVEMENT ANNUAL EVALUATION TOOL

**If you are unsure of an answer, respond Don't Know (DK), DO NOT GUESS.**

**Please DO NOT leave any items BLANK.**

True (T), False (F), or Don't Know (DK) (circle one):

1. Most estimates suggest that ADHD occurs in approximately 15% of school age children **T F DK**
2. Current research suggests that ADHD is largely the result of ineffective parenting skills. **T F DK**
3. Children with ADHD are frequently distracted by extraneous stimuli. **T F DK**
4. Children with ADHD are typically more compliant with their fathers than with their mothers. **T F DK**
5. In order to be diagnosed with ADHD, the child's symptoms must have been present before age seven. **T F DK**
6. ADHD is more common in the 1st degree biological relatives (i.e. mother, father) of children with ADHD than in the general population. **T F DK**
7. One symptom of children with ADHD is that they have been physically cruel to other people. **T F DK**
8. Antidepressant drugs have been effective in reducing symptoms for many children with ADHD. **T F DK**
9. Children with ADHD often fidget or squirm in their seats. **T F DK**
10. Parent and teacher training in managing a child with ADHD are generally effective when combined with medication treatment. **T F DK**
11. It is common for children with ADHD to have an inflated sense of self-esteem or grandiosity. **T F DK**
12. When treatment of a child with ADHD is terminated, it is rare for the child's symptoms to return. **T F DK**
13. It is possible for an adult to be diagnosed with ADHD. **T F DK**
14. Children with ADHD often have a history of stealing or destroying other people's things. **T F DK**
15. Side effects of stimulant drugs used for treatment of ADHD may include mild insomnia and appetite reduction. **T F DK**
16. Current wisdom about ADHD suggests two clusters of symptoms: One of inattention and another consisting of hyperactivity/impulsivity. **T F DK**
17. Symptoms of depression are found more frequently in children with ADHD than in children without ADHD. **T F DK**
18. Individual psychotherapy is usually sufficient for the treatment of most children with ADHD. **T F DK**



19. Most children with ADHD "outgrow" their symptoms by the onset of puberty and subsequently function normally in adulthood. **T F DK**
20. In severe cases of ADHD, medication is often used before other behavior modification techniques are attempted. **T F DK**
21. In order to be diagnosed as ADHD, a child must exhibit relevant symptoms in two or more settings (e.g., home, school). **T F DK**
22. If a child with ADHD is able to demonstrate sustained attention to video games or TV for over an hour, that child is also able to sustain attention for at least an hour of class or homework. **T F DK**
23. Reducing dietary intake of sugar or food additives is generally effective in reducing the symptoms of ADHD. **T F DK**
24. A diagnosis of ADHD by itself makes a child eligible for placement in special education. **T F DK**
25. Stimulant drugs are the most common type of drug used to treat children with ADHD. **T F DK**
26. Children with ADHD often have difficulties organizing tasks and activities. **T F DK**
27. Children with ADHD generally experience more problems in novel situations than in familiar situations. **T F DK**
28. There are specific physical features which can be identified by medical doctors (e.g., pediatrician) in making a definitive diagnosis of ADHD. **T F DK**
29. In school age children, the prevalence of ADHD in males and females is equivalent. **T F DK**
30. In very young children (less than 4 years old), the problem behaviors of ADHD children (e.g. hyperactivity, inattention) are distinctly different from age appropriate behaviors of children without ADHD. **T F DK**
31. Children with ADHD are more distinguishable from children without ADHD in a classroom setting than in a free play situation. **T F DK**
32. The majority of children with ADHD evidence some degree of poor school performance in the elementary school years. **T F DK**
33. Symptoms of ADHD are often seen in children without ADHD who come from inadequate and chaotic home environments. **T F DK**
34. Behavioral/Psychological interventions for children with ADHD focus primarily on the child's problems with inattention. **T F DK**
35. Electroconvulsive Therapy (i.e. shock treatment) has been found to be an effective treatment for severe cases of ADHD. **T F DK**
36. Treatments for ADHD which focus primarily on punishment have been found to be the most effective in reducing the symptoms of ADHD. **T F DK**

## APPENDIX M

## KADDS SCORING PROCEDURE

**KADDS Scoring Procedure:**

- Initially, responses are entered into SPSS as follows: True=1, False=2, Don't Know=3. Tabulation of misconceptions must be conducted before recoding as correct/incorrect (described below). A misconception is defined as an incorrect response (i.e., answering FALSE to a question for which TRUE is the correct answer). DON'T KNOW responses are not considered misconceptions.
- In order to obtain subscale and total scale scores, all correct answers need to be recoded so that correct answers get a score of 1 and incorrect and don't know answers get a score of 0. The recode statements are as follows:

**Recodes:**Correct answer is *false*:

(1 = 0) (2=1) (3=0) Items: 1, 2, 7, 11, 12, 14, 18, 19, 22, 23, 24, 27, 28, 29, 30, 34, 35, 36, 37, 38, 39

Correct answer is *true*:

(1=1) (2=0) (3=0) Items: 3, 4, 5, 6, 8, 9, 10, 13, 15, 16, 17, 20, 21, 25, 26, 31, 32, 33

**KADDS Subscales:**

Associated Features (i.e., General): 1, 4, 6, 13, 17, 19, 22, 24, 27, 28, 29, 30, 31, 32, 33

Symptoms/Diagnosis: 3, 5, 7, 9, 11, 14, 16, 21, 26

Treatment: 2, 8, 10, 12, 15, 18, 20, 23, 25, 34, 35, 36

Note. Items 37, 38, 39 are new items (not in the original KADDS). We have not classified them into one of the subscales. They are included primarily for test development purposes at this time

## APPENDIX N

## TEACHER INTERVENTION SURVEY

There have been many different interventions suggested for students with ADHD, several of which are listed below. Please answer each question by placing a check in the appropriate box with **1 indicating very low and 5 indicating very high. Please only check one box. If you are undecided, please check the box you feel is most appropriate.**

**A. TEACHER ATTENTION:** give student positive and negative verbal feedback, as well as nonverbal feedback such as nods, frowns, smiles, and pats of approval. **Very Low 1 Low 2 Moderate 3 High 4 Very High 5**

**B. TOKEN ECONOMY:** awarding tokens or points which are dependent upon specified appropriate behaviors. **Very Low 1 Low 2 Moderate 3 High 4 Very High 5**

**C. RESPONSE COST:** taking away privileges, tokens, or points, for inappropriate behavior. **Very Low 1 Low 2 Moderate 3 High 4 Very High 5**

**D. TIME-OUT FROM POSITIVE REINFORCEMENT:** restricting the child's access to positive reinforcement such as placing the child in the corner of the room on a chair **Very Low 1 Low 2 Moderate 3 High 4 Very High 5**

6. How likely would you be to implement this intervention if you had a student in your class who had documented ADHD and who exhibited inattention, hyperactivity, and/or impulsivity (even if he or she was taking medication for these symptoms)? **Very Low 1 Low 2 Moderate 3 High 4 Very High 5**

**E. STRUCTURE:** providing organization in the classroom such as posting rules, providing students with daily schedule **Very Low 1 Low 2 Moderate 3 High 4 Very High 5**

**F. PHYSICAL ARRANGEMENT:** arranging seats in classroom, such as having student with ADHD in close proximity to teacher **Very Low 1 Low 2 Moderate 3 High 4 Very High 5**

**G. USE OF CUES, PROMPTS AND ATTENTION CHECKS:** using short verbal cues, such as "All eyes on me" or "Listen," subtle nonverbal prompts, a timer, when giving directions, someone repeats them back to the class. **Very Low 1 Low 2 Moderate 3 High 4 Very High 5**

**H. BRIEF ACADEMIC TASKS INTERSPERSED WITH PASSIVE TASKS:** presenting tasks briefly, providing instructions in a stepwise fashion rather than all at once, mixing active tasks (doing a project on something) with passive tasks (completing a worksheet independently) **Very Low 1 Low 2 Moderate 3 High 4 Very High 5**

**I. PEER TUTORING:** have student help or be helped by another student **Very Low 1 Low 2 Moderate 3 High 4 Very High 5**

APPENDIX O  
LETTER OF COPYRIGHT

Hi Angie,

Thank you for your interest in the KADDS. I would be glad to send you a copy of the KADDS (along with a brief manual) and grant permission for use in your research. I only ask that you send me a very brief overview of your proposed project for my records and that you agree to send me a copy of the results when available. If you send me an e-mail agreeing to this, I will forward an electronic copy of the manual, which includes the scale.

Mark

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Mark J. Sciutto, Ph.D.  
Department of Psychology  
Muhlenberg College  
Allentown, PA 18104  
(484) 664-3649  
[sciutto@muhlenberg.edu](mailto:sciutto@muhlenberg.edu)

>>> Angie Echoles 08/08/12 4:39 AM >>>

Dr. Sciutto, Hello my name is Angie Echoles, MSN, RN, I am currently enrolled in the Doctorate Nursing Practice(DNP) Program , I have completed my first year, I will soon be embarking upon my capstone project which is still fuzzy at the moment. I need to acquire copyright to adopt your KADDS SURVEY, as my methodology to collect my data in which I will be assessing teachers' level of knowledge regarding ADHD. Could you give a direct link to the whereabouts of your KADDS Survey? Thanks for your cooperation with this matter.

Angie Echoles

## APPENDIX P

## LETTER TO PRINCIPAL

Pass Road Elementary  
37 Pass Road north  
Gulfport, Ms 39507

Dear Mr. Hudson:

I am a graduate student in the Doctor of Nursing Practice Program at the University of Southern Mississippi. I would like to request your cooperation and allow me to come into your school and provide consultation on Attention Deficit/Hyperactivity Disorder (ADHD). This project is important because research indicates that there is at least one student in every classroom with ADHD. If we can identify what teachers know about the disorder as well as what kinds of interventions they are likely to use and the reasons why some interventions are acceptable, we can help teachers implement effective interventions for students with ADHD.

All information obtained in connection with the project will be kept confidential. I realize that you and your teachers are very busy. Your decision to participate in this project is completely voluntary. You are free to participate or withdraw at any time. If you choose not to participate, or if you withdraw; there will be no penalty or loss of benefits that you are entitled to receive.

Additionally, your teaching or job status will in no way be affected by your decision to participate or not participate. If you have any questions about this research study, please contact the principal investigator at 228-383-0706 or [Godloveu@att.net](mailto:Godloveu@att.net). If you have questions about your rights as a person who is taking part in a research study, you may contact a member of the Division of Research Compliance of the University of South Mississippi at 601-266-6820. This research project/study and informed consent form were reviewed and approved by the University of Southern Mississippi Institutional Review Board for the protection of human subjects. Approval Consent Form Expiration Date: 6/16/2014

Thank you very much for your cooperation! I certify that participants have been provided with an informed consent form that has been approved by the University of Southern Mississippi's Institutional Review Board that contains the nature, demands, risks and benefits involved in participating in this study. I further certify that a phone number has been provided in the event of additional questions.

Sincerely,

Angie Echoles, MSN, RN  
[godloveu@att.net](mailto:godloveu@att.net)

Doctor of Nursing Practice Graduate Student  
University of Southern Mississippi

I, \_\_\_\_\_ agree to participate in a capstone project conducted by Angie Echoles. Name & Position \_\_\_\_\_ Principal's Signature Date \_\_\_\_\_

## APPENDIX Q

### CONSENT

Dear Faculty:

I am interested in providing guidance on developing an Attention-Deficit/Hyperactivity Disorder (ADHD) program at your facility. I am extremely grateful to you for taking time out of your busy schedule to assist me in my project. The following pages contain a demographic survey. It should take you about 5minutes to complete the demographic and needs assessment survey. You will not be paid for your participation in this study. By taking part in this study, you will be helping to provide information to determine if teachers need more training on the subject of ADHD and to help school psychologists recommend interventions that teachers find useful. There are no risks to participating in this study.

Your privacy and research records will be kept confidential to the extent of the law. Authorized research personnel, and the USM Institutional Review Board may inspect the records from this research project. The results of this capstone may be published. However, the data obtained from you will be combined with data from other people in the publication. The published results will not include your name or any other information that would in any way personally identify you. Surveys will not contain any code names or numbers. The researcher will be the only ones to have access to the data. If you would like a copy of the results, please feel free to contact me (information provided below).

Your decision to participate in this project is completely voluntary. You are free to participate or withdraw at any time. If you choose not to participate, or if you withdraw; there will be no penalty or loss of benefits that you are entitled to receive.

Additionally, your teaching or job status will in no way be affected by your decision to participate or not participate. If you have any questions about this research study, please contact the principal investigator at 228-383-0706 or [Godloveu@att.net](mailto:Godloveu@att.net). If you have questions about your rights as a person who is taking part in a research study, you may contact a member of the Division of Research Compliance of the University of South Mississippi at 601-266-6820. This research project/study and informed consent form were reviewed and approved by the University of Southern Mississippi Institutional Review Board for the protection of human subjects. This approval is valid until the date provided below. Approval Consent Form Expiration Date: 6/16/2014. Thank you very much for your cooperation! I certify that participants have been provided with an informed consent form that has been approved by the University of Southern Mississippi's Institutional Review Board that contains the nature, demands, risks and benefits involved in participating in this study. I further certify that a phone number has been provided in the event of additional questions.

Sincerely,

Angie Echoles, MSN, RN  
godloveu@att.net  
Doctor of Nursing Practice Graduate Student  
University of Southern Mississippi

## APPENDIX R

## IRB APPROVAL LETTER

**INSTITUTIONAL REVIEW BOARD**

118 College Drive #5147 | Hattiesburg, MS 39406-0001

Phone: 601.266.6820 | Fax: 601.266.4377 |

[www.usm.edu/irb](http://www.usm.edu/irb)

**NOTICE OF COMMITTEE ACTION**

The project has been reviewed by The University of Southern Mississippi Institutional Review Board in accordance with Federal Drug Administration regulations (21 CFR 26, 111), Department of Health and Human Services (45 CFR Part 46), and university guidelines to ensure adherence to the following criteria:

- The risks to subjects are minimized.
- The risks to subjects are reasonable in relation to the anticipated benefits.
- The selection of subjects is equitable.
- Informed consent is adequate and appropriately documented.
- Where appropriate, the research plan makes adequate provisions for monitoring the data collected to ensure the safety of the subjects.
- Where appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of all data.
- Appropriate additional safeguards have been included to protect vulnerable subjects.
- Any unanticipated, serious, or continuing problems encountered regarding risks to subjects must be reported immediately, but not later than 10 days following the event. This should be reported to the IRB Office via the "Adverse Effect Report Form".
- If approved, the maximum period of approval is limited to twelve months.

Projects that exceed this period must submit an application for renewal or continuation.

PROTOCOL NUMBER: **13080201**

PROJECT TITLE: **The Development of a Comprehensive ADHD Program for Elementary School Educators**

PROJECT TYPE: **Dissertation**

RESEARCHER(S): **Angie Lee Echoles**

COLLEGE/DIVISION: **College of Nursing**

DEPARTMENT: **Advanced Practice Nursing**

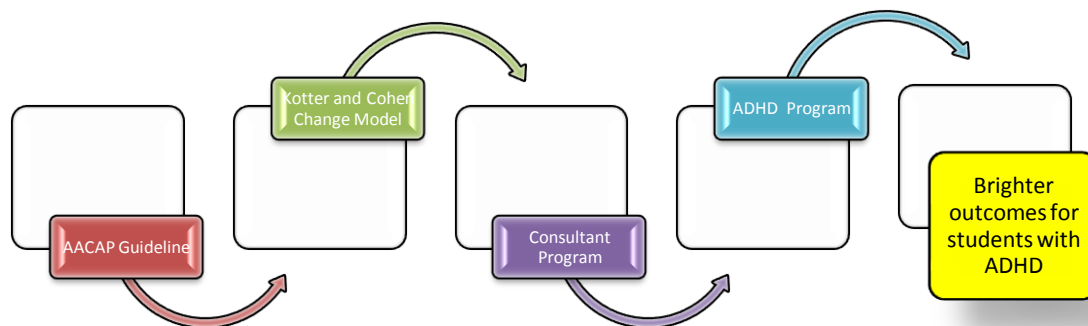
FUNDING AGENCY/SPONSOR: **N/A**

IRB COMMITTEE ACTION: **Exempt Approval**

PERIOD OF APPROVAL: **08/16/2013 to 08/15/2014**

**Lawrence A. Hosman, Ph.D.**  
**Institutional Review Board**

APPENDIX S  
PROJECT FRAMEWORK MODEL





## APPENDIX T

## CONSULTANT PROJECT OUTLINE

PHASE 1-On-Site Consultation for Principal (Appendix U)

PHASE 2-Inservice Training Booklets for Educators and Parents (Appendix G)

PHASE 3-Inservice Training Program for Parents and Educators (Appendix V)

PHASE 4-Staff Development Continuing Education Program on Attention Deficit Hyperactivity Disorder “TEACHERS” Modules (Appendix W)

PHASE 5-Advanced Knowledge Dissemination & Follow-Up Consultation (Evaluation after implementation of ADHD program)

Follow-Up Assessment

Additional On-Site Consultation

Additional Training on ADHD

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## APPENDIX U

## PHASE 1-ON-SITE CONSULTANT PROGRAM

Unit	Description
<i>Unit 1: The Importance of Assessing and Identifying Students with ADHD</i>	Core symptoms of ADHD Duration of symptoms Degree of functional impairment and associated conditions.
<i>Unit 2: Legislation that Establishes and Protects the Educational Rights of Students with ADHD</i>	Section 504 The Individuals with Disabilities Education Act-IDEA The Americans with Disabilities Act
<i>Unit 3: Parental Involvement : Importance of Informing Parents about Special Education and Related Services and Placement for the ADHD Student</i>	Parental Involvement Parental Rights
<i>Unit 4: Providing Appropriate Accommodations and Treatment Modalities</i>	Behavioral Modification Classroom Accommodations Social Skills Training
<i>Unit 5: Pharmacological Treatment</i>	Stimulant Drugs Common Stimulants for ADHD Side Effects of Stimulants?

## APPENDIX V

PHASE 3-AN INSERVICE EDUCATION PROGRAM FOR PARENTS AND  
EDUCATORS

The ADHD Handbook Teaching Children with ADHD: Instructional Strategies and Practices (Facilitator's Guide) to be used by the school-based team members responsible for implementation of the inservice education program.

- Provides information regarding components of a successful program for students with ADHD in the school setting.

The Practical Guide for Schools and the Resource Guide for Parents (General Knowledge Base Manual): A wealth of information regarding the nature and needs of students with ADHD.

- Diagnostic Criterion for ADHD
- Characteristics
- Prevalence
- Causes
- Myths and misperceptions
- Code of Practice-Shared roles for teachers and parents

Legal Issues Manual: Provides an overview of federal educational laws that apply to students with ADHD.

- Identifies ways to advocate for children with ADHD
- Provides models for Section 504 programs

Placement Continuum -Assessment Manual: Identifies problematic issues in school-based assessment.

- Reviews commonly used flowcharts
- Delineates types of assessment approaches
- Provides school-based assessment approach and protocol

School and Home-Intervention Manual: Provides essential information regarding medical and school/home interventions for students with ADHD.

- Common medical interventions
- School-based monitoring of medication effects
- Overview of school- and home-based interventions
- Practical academic, behavioral, cognitive-behavioral, social skills, self esteem building and attribution training activities
- Intervention model and accommodation plan

Adapted from Project Facilitate: An inservice education program for educators and parents,” by L.A. Worthington, J.F. Wortham, C.R. Smith, and D. Patterson 1997, Teacher Education and Special Education, 20(2) p123-32.

## APPENDIX W

## PHASE 4-STAFF DEVELOPMENT

## Continuing Education Program on Attention Deficit Hyperactivity Disorder Modules

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 Module I Characteristics and Identification

- Historical background on ADHD
- Clinical description
- Diagnosis
- Comorbidity
- Assessment
- Multicultural considerations

## Module II Pharmacological Intervention

- Stimulants
- Most common use
- Side effects

## Module III Effective Classroom Interventions

- Behavioral and academic interventions for the classroom setting

## Module IV Parent involvement in group and individual meetings to extend the behavior modification program to the home setting

- Home setting
- School setting

## Module V Social skills training

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Adapted from the Irvine Paraprofessional Program Model: promising practice for serving students with ADHD. By: Kotkin R, Journal Of Learning Disabilities, 0022-2194, 1998 Nov-Dec, Vol. 31, Issue 6

## APPENDIX X

ANNUAL PERFORMANCE IMPROVEMENT PLANNING EVALUATION:  
WORKSHEET

When will you collect data for each method you've chosen?

Method	Before program	During program	Immediately after	Later

Will a sample be used?

No

Yes

If yes, describe the procedure you will use.

---

 Pilot testing: when, where, how?
 

---

**Analyze and Interpret**

How will the data be analyzed?

Data analysis  
methods:

Who responsible:

---



---

**How will the information be interpreted—by whom?**

---



---

**What did you learn? What are the limitations?**

---



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## Use the Information

**How will the evaluation be communicated and shared?**

To whom	When/where/how to present

Next steps?

---



## Manage the evaluation

<input type="checkbox"/>	Human subject's protection
<input type="checkbox"/>	Management chart
<input type="checkbox"/>	Timeline
<input type="checkbox"/>	Responsibilities
<input type="checkbox"/>	Budget



## Standards

<input type="checkbox"/>	Utility
<input type="checkbox"/>	Feasibility
<input type="checkbox"/>	Propriety
<input type="checkbox"/>	Accuracy

## APPENDIX Y

## TIMELINE

Date	Objective
<b>September 2012-Jan 2013</b>	Review literature to determine relevancy of ADHD Consultant program, which will be implemented by using the Kotter and Cohen Change Model.
<b>Jan 2013-Feb 2013</b>	Develop proposal for ADHD Consultant program.
<b>Feb 2013</b>	Present proposal for approval to develop ADHD Consultant program.
<b>March 2013</b>	Meet with principals to review proposed plan and select other team members.
<b>March 2013-April 2013</b>	Observe ADHD students and teachers interaction in the classroom setting. Spend time interacting with the principal of the school and assessing and discussing current ADHD action plans already in place.
<b>April 2013-June 2013</b>	Develop guidelines for consultant project. Include others and stakeholders in the process when appropriate.
<b>July 2013</b>	Develop consultation implementation timeframe.
<b>Aug 2013-Sept 2013</b>	Implementation of consultant project.

## APPENDIX Z

## RESULTS

## DESCRIPTIVE STATISTICS-DEMOGRAPHIC SURVEY

	N	Mean	Std. Deviation
Gender	7	1.86	.378
Age	7	2.29	.951
Current grade	6	3.50	1.871
Job/role	6	1.00	.000
ADHD educator program	7	1.29	.488
Previous hours ADHD training	7	1.43	.535
Students with ADHD	7	2.86	.378
Valid N (list wise)	6		

## STATISTICS-DEMOGRAPHIC SURVEY

	Gender	Age	Current grade	Job/ Role	ADHD educator program	Previous hours ADHD training	Students with ADHD
Valid	7	7	6	6	7	7	7
N	0	0	1	1	0	0	0



## Frequency Table

		Gender			
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	male	1	14.3	14.3	14.3
	female	6	85.7	85.7	100.0
	Total	7	100.0	100.0	

		Age			
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	18-20	1	14.3	14.3	14.3
	21-30	4	57.1	57.1	71.4
	31-40	1	14.3	14.3	85.7
	41-50	1	14.3	14.3	100.0
	Total	7	100.0	100.0	

		Current grade			
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	kindergarten	1	14.3	16.7	16.7
	1st grade	1	14.3	16.7	33.3
	2nd grade	1	14.3	16.7	50.0
	3rd grade	1	14.3	16.7	66.7
	4th grade	1	14.3	16.7	83.3
	5th grade	1	14.3	16.7	100.0
Missing	Total	6	85.7	100.0	
	System	1	14.3		
Total		7	100.0		

		Job/role			
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	regular education teacher	6	85.7	100.0	100.0
Missing	System	1	14.3		

Total		7	100.0
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#### ADHD educator program

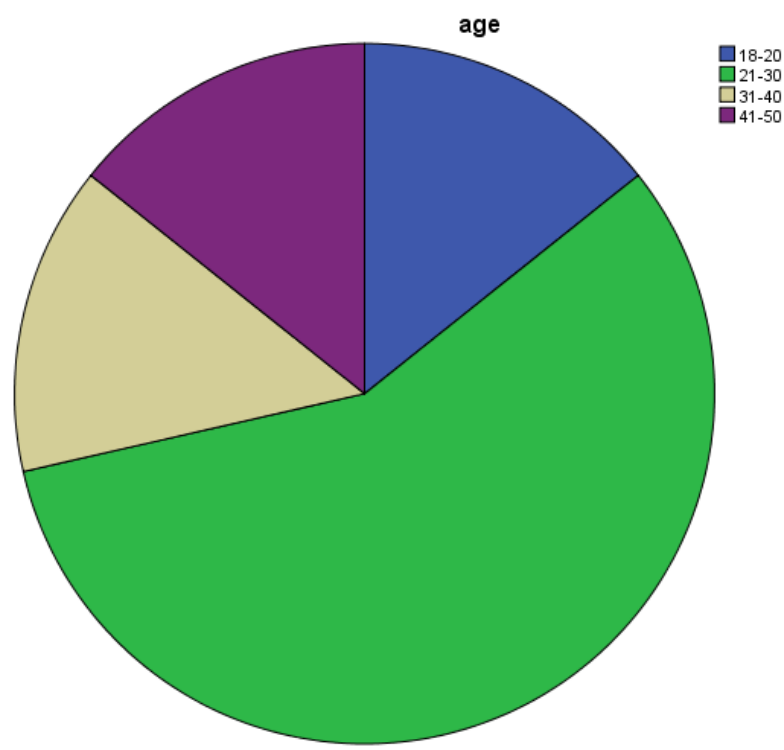
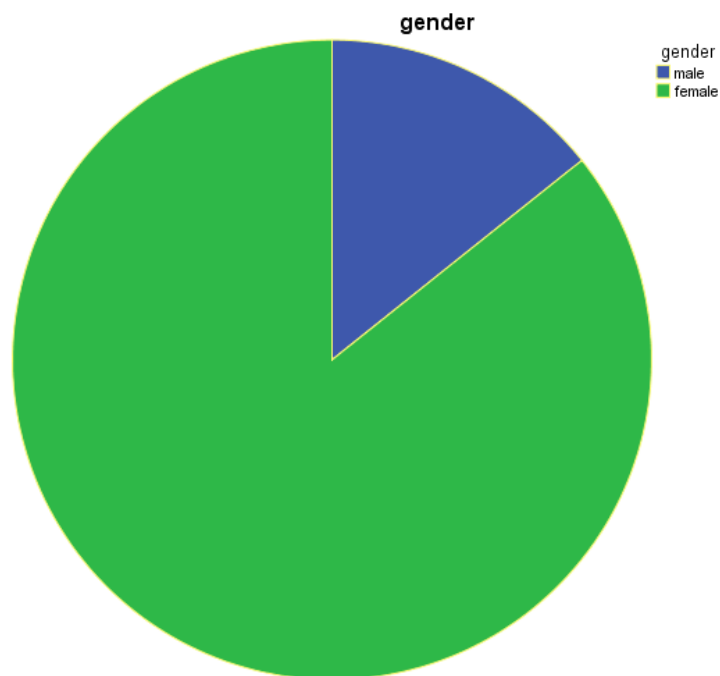
	Frequency	Percent	Valid Percent	Cumulative Percent
Valid no	5	71.4	71.4	71.4
Valid yes	2	28.6	28.6	100.0
Total	7	100.0	100.0	

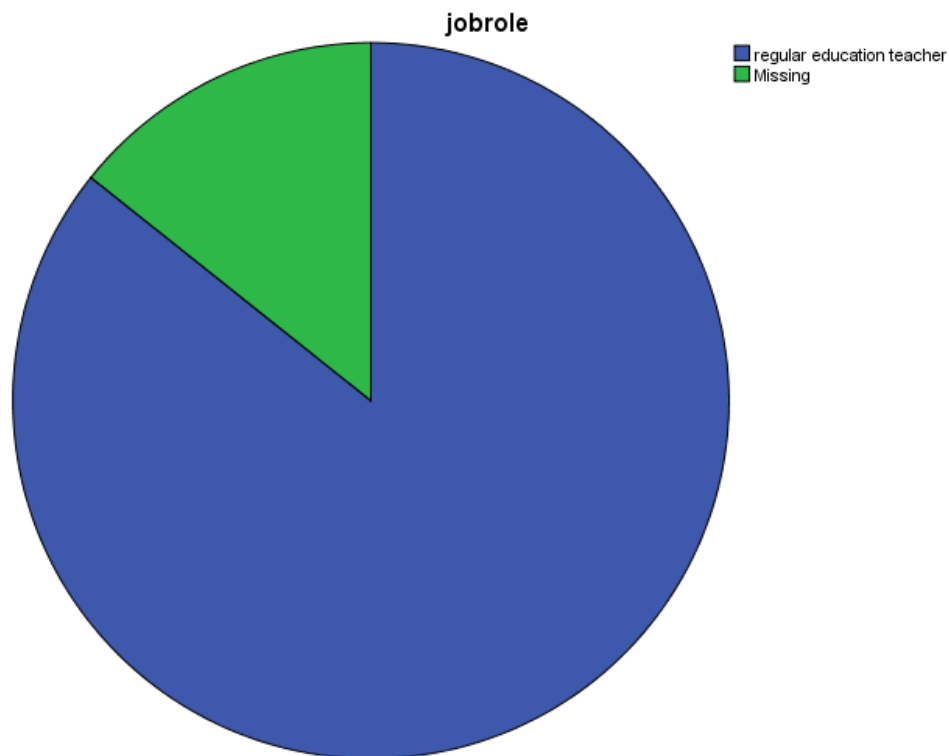
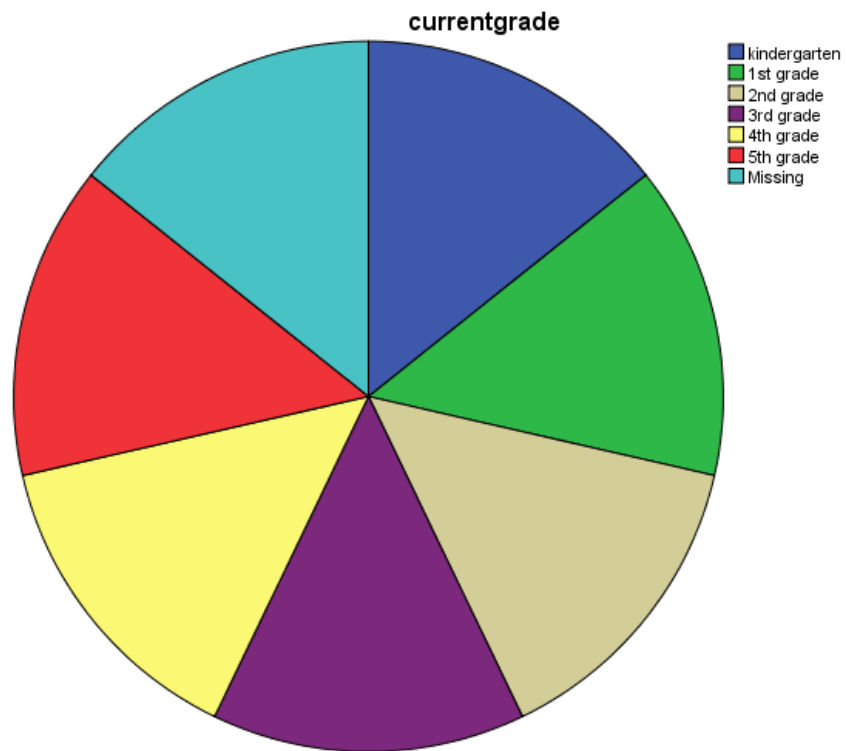
#### Previous hours ADHD training

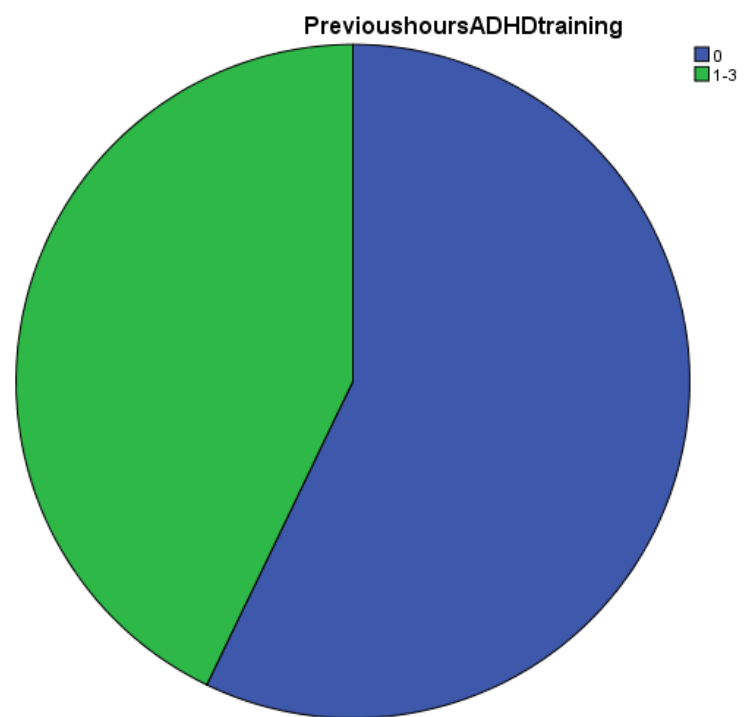
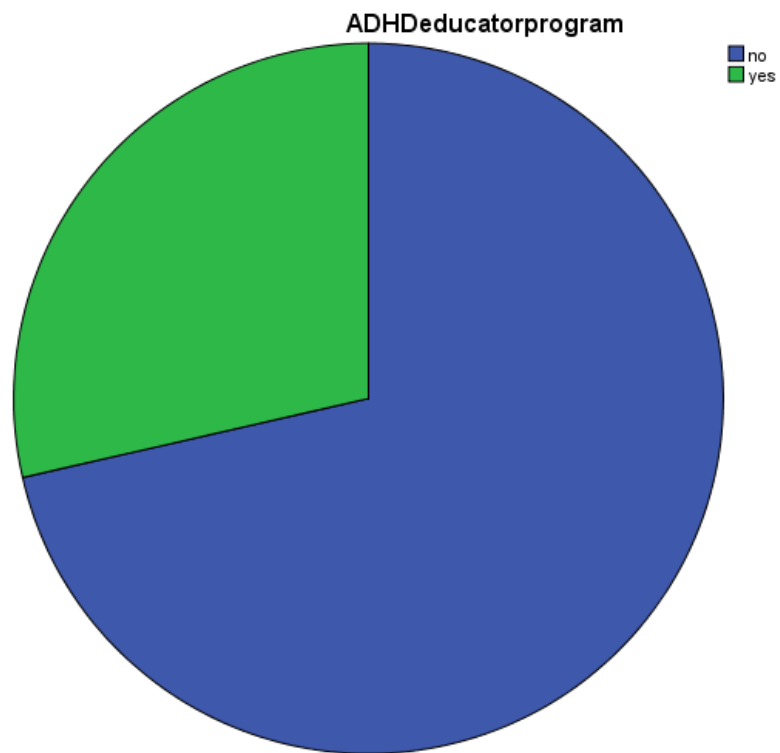
	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 0	4	57.1	57.1	57.1
Valid 1-3	3	42.9	42.9	100.0
Total	7	100.0	100.0	

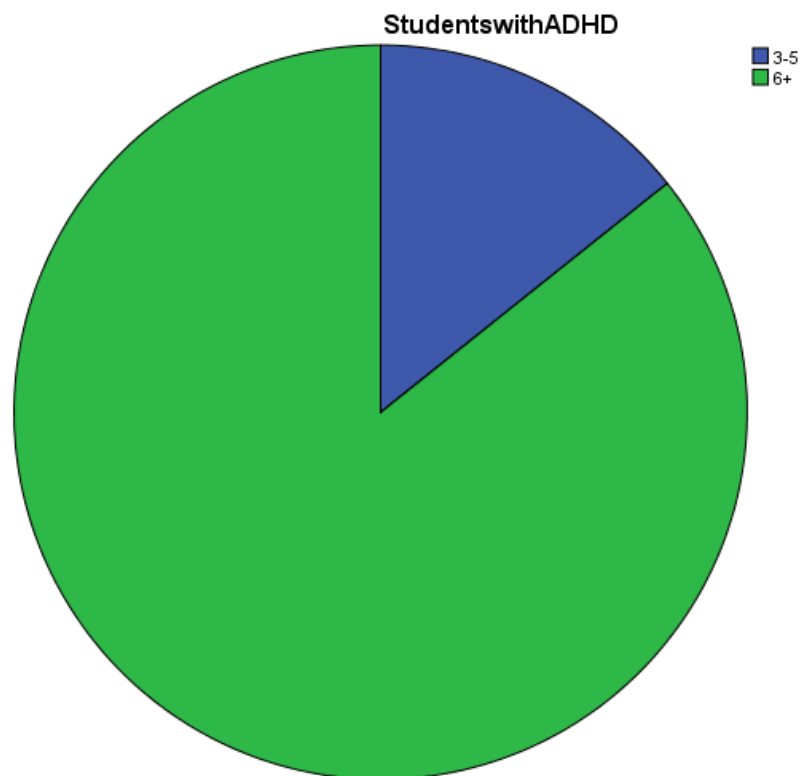
#### Students with ADHD

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 3-5	1	14.3	14.3	14.3
Valid 6+	6	85.7	85.7	100.0
Total	7	100.0	100.0	









**Frequency Table****q1**

	Frequency	Percent	Valid Percent	Cumulative Percent
agree	3	42.9	42.9	42.9
Valid strongly agree	4	57.1	57.1	100.0
Total	7	100.0	100.0	

**q2**

	Frequency	Percent	Valid Percent	Cumulative Percent
agree	2	28.6	28.6	28.6
Valid strongly agree	5	71.4	71.4	100.0
Total	7	100.0	100.0	

**q3**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid strongly agree	7	100.0	100.0	100.0

**q4**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid strongly agree	7	100.0	100.0	100.0

**q5**

	Frequency	Percent	Valid Percent	Cumulative Percent
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	agree	1	14.3	14.3	14.3
Valid	strongly agree	6	85.7	85.7	100.0
	Total	7	100.0	100.0	

**q6**

		Frequency	Percent	Valid Percent	Cumulative Percent
	neutral	1	14.3	14.3	14.3
Valid	agree	3	42.9	42.9	57.1
	strongly agree	3	42.9	42.9	100.0
	Total	7	100.0	100.0	

**q7**

		Frequency	Percent	Valid Percent	Cumulative Percent
	agree	1	14.3	14.3	14.3
Valid	strongly agree	6	85.7	85.7	100.0
	Total	7	100.0	100.0	

**q8**

		Frequency	Percent	Valid Percent	Cumulative Percent
	agree	3	42.9	42.9	42.9
Valid	strongly agree	4	57.1	57.1	100.0
	Total	7	100.0	100.0	



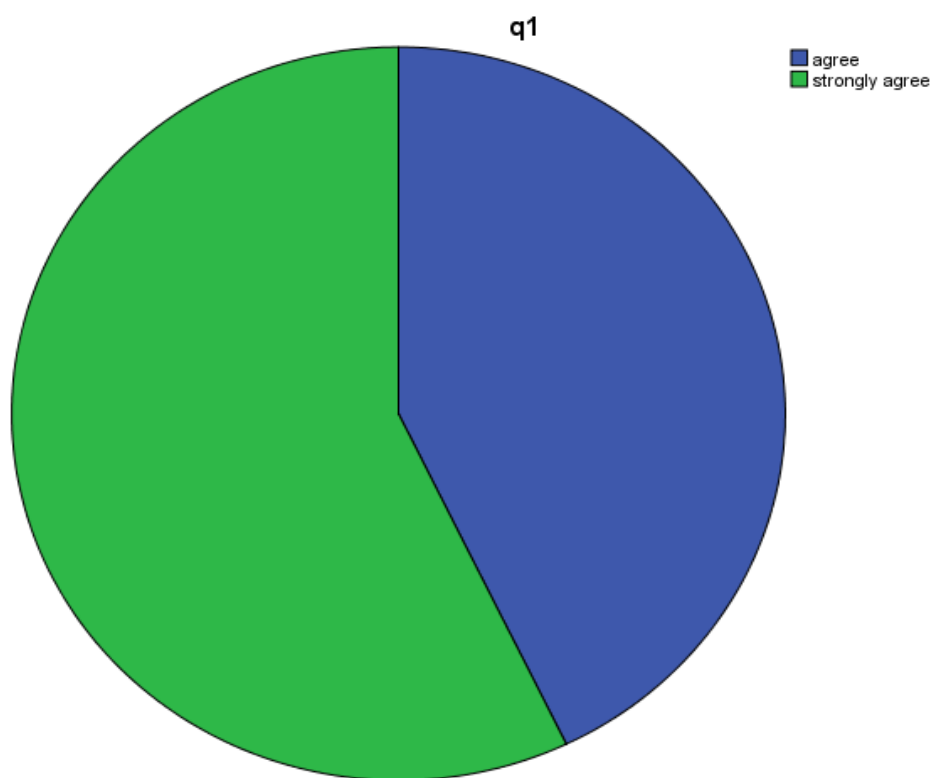
**q9**

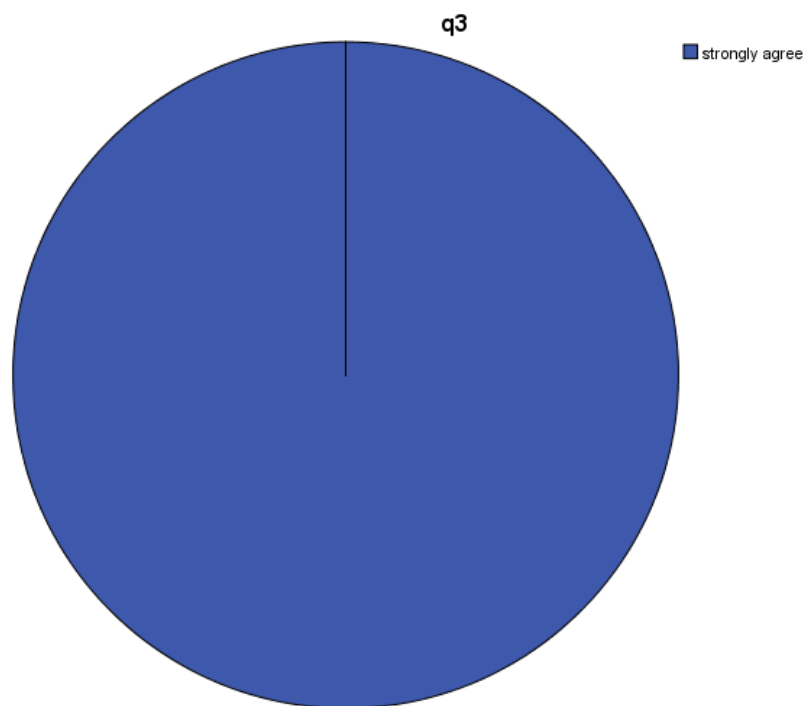
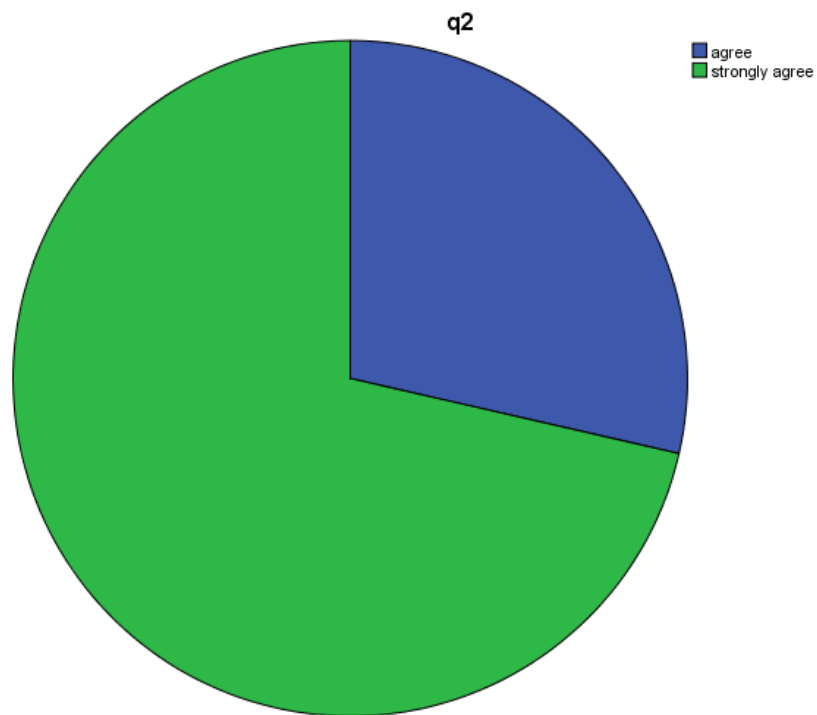
	Frequency	Percent	Valid Percent	Cumulative Percent
agree	3	42.9	42.9	42.9
Valid strongly agree	4	57.1	57.1	100.0
Total	7	100.0	100.0	

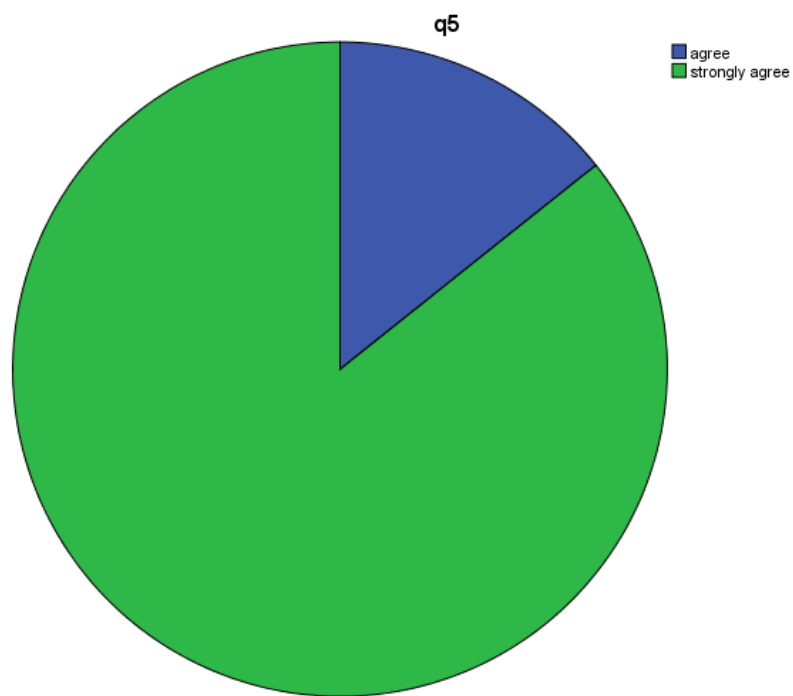
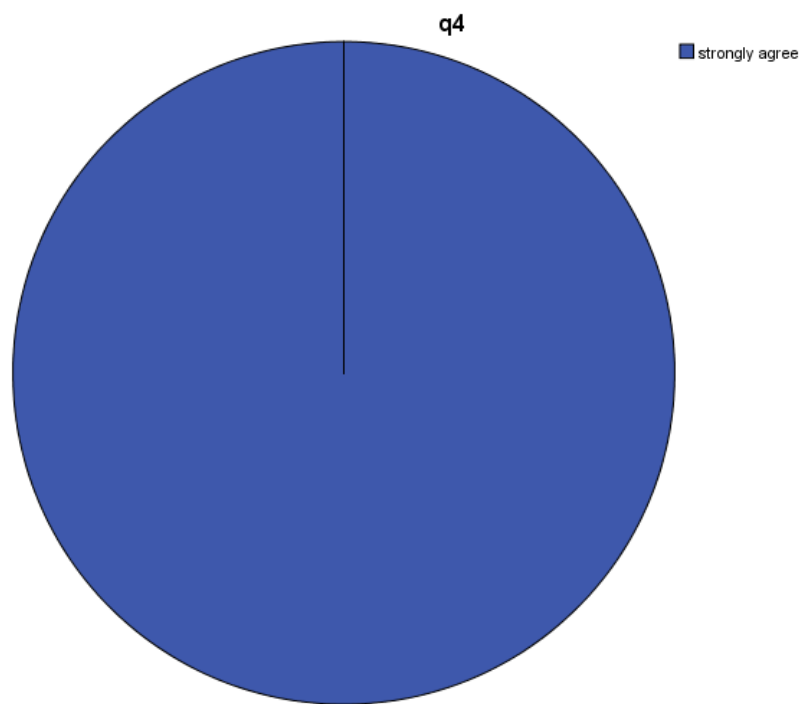
**q10**

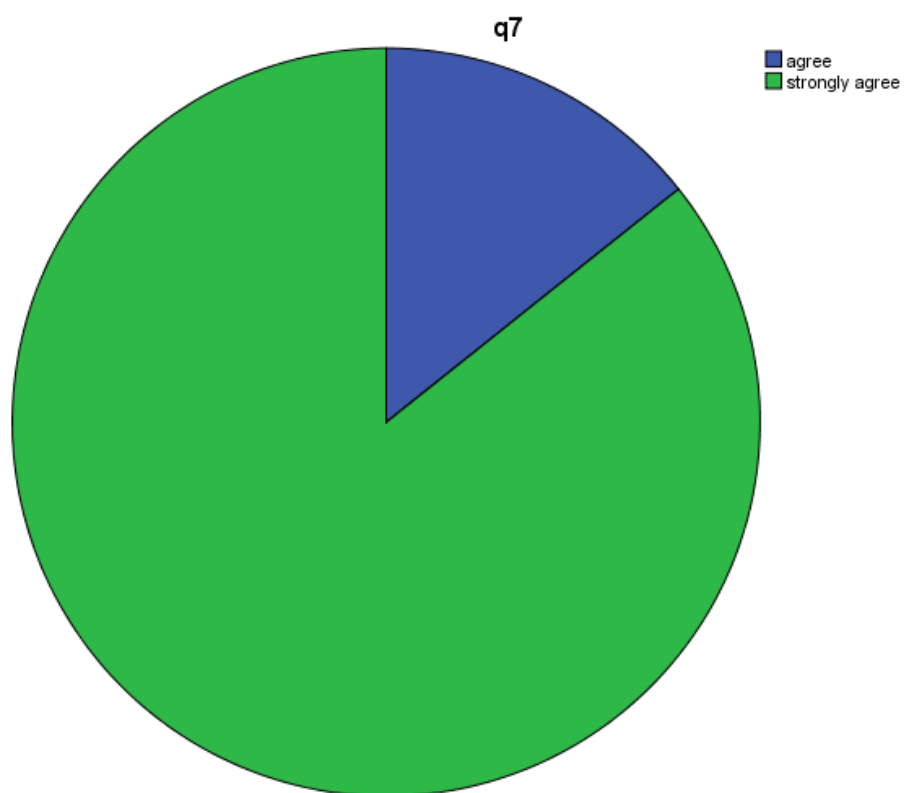
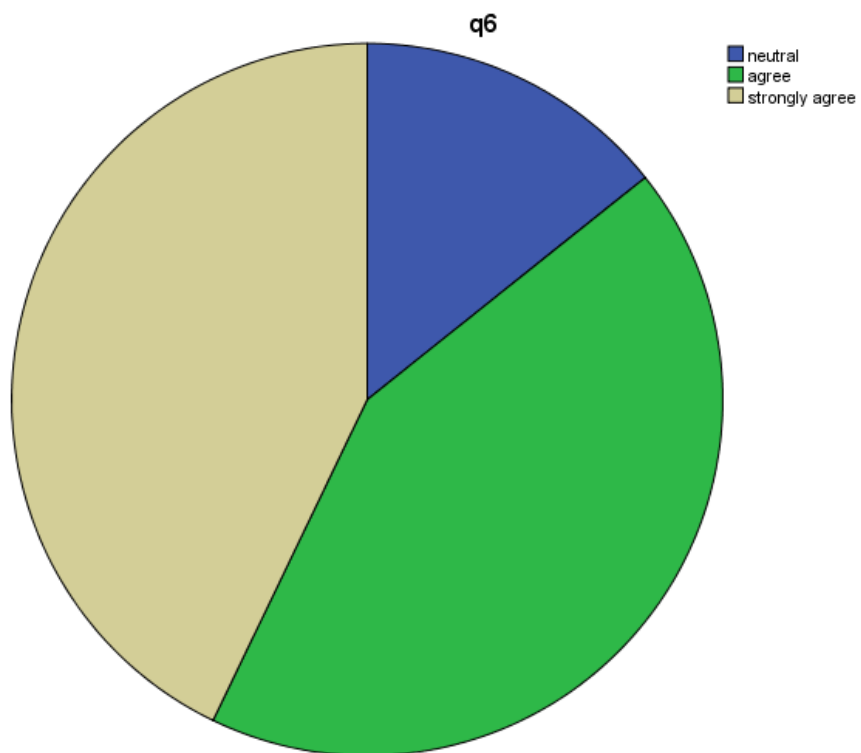
	Frequency	Percent	Valid Percent	Cumulative Percent
good	3	42.9	42.9	42.9
Valid excellent	4	57.1	57.1	100.0
Total	7	100.0	100.0	

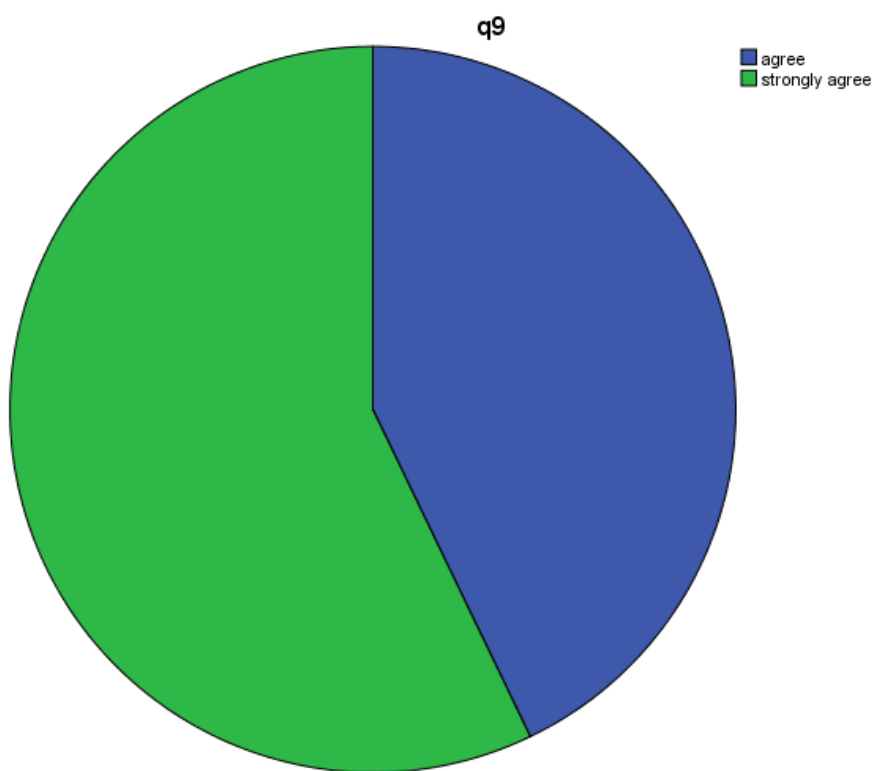
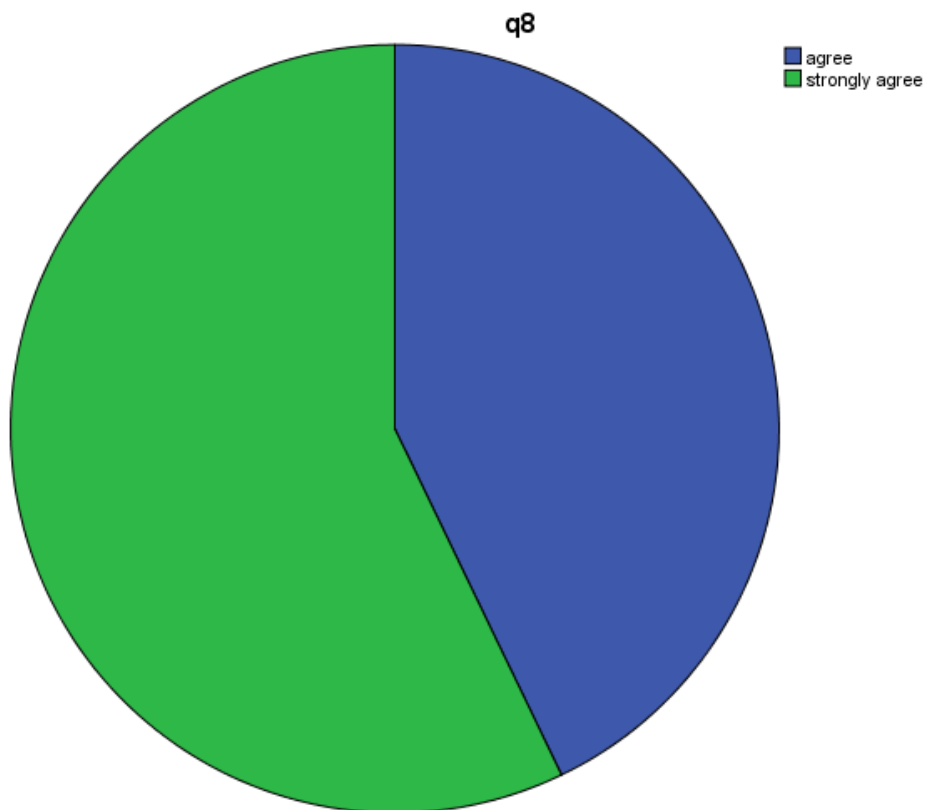
### Pie Chart

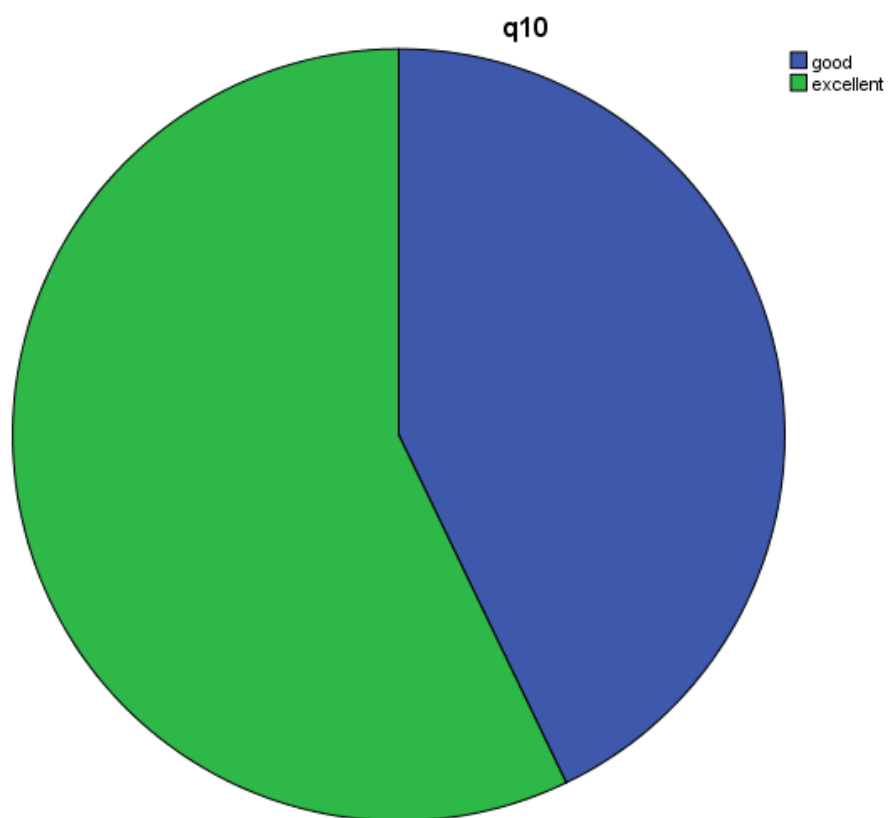












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