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# Implementation of a behavioral parent training program in a behavioral health practice

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# IMPLEMENTATION OF A BEHAVIORAL PARENT TRAINING PROGRAM in A BEHAVIORAL HEALTH PRACTICE

by

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**A DNP PROJECT**

**Submitted in partial fulfillment of the requirements for the Degree of Doctor of Nursing Practice to The School of Graduate Studies of The University of Alabama in Huntsville**

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**2019**

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Staci Clark Morgan 6/25/2019

Student Signature Date

## DNP PROJECT APPROVAL FORM

Submitted by Tracie Clark Morgan in partial fulfillment of the requirements for the degree of Doctor of Nursing Practice and accepted on behalf of the Faculty of the School of Graduate Studies by the DNP project committee.

We, the undersigned members of the Graduate Faculty of The University of Alabama in Huntsville, certify that we have advised and/or supervised the candidate on the work described in this DNP project. We further certify that we have reviewed the DNP project manuscript and approve it in partial fulfillment of the requirements for the degree of Doctor of Nursing Practice.

Dr. Louise O'Keefe LO'Keefe Committee Chair 4/25/2019
(Date)

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DRB Graduate Dean

## DEDICATION

I would like to dedicate this project to my wonderful husband, Whitson Morgan. I am grateful for his unwavering love, encouragement and support along this journey. His enthusiasm and commitment to the pursuit of knowledge inspired me to persevere during difficult times. I would also like to dedicate this project to my three amazing children, Hampton, Haley, and Hannah. It is my hope that by completing this journey, I have shown them the value of hard work, education, and the importance of determination and perseverance in the face of difficulty.

## ABSTRACT

The School of Graduate Studies

The University of Alabama in Huntsville

Degree: Doctor of Nursing Practice College: Nursing

Name of Candidate: Tracie Clark Morgan, MSN, CRNP

**Title:** Implementation of a Behavioral Parent Training Program in a Behavioral Health Practice

**Background and Review of Literature**: Attention Deficit Hyperactivity Disorder (ADHD) is the most common chronic neurobehavioral disorder of childhood. Research suggests increased parent-child conflict exists in families with an ADHD child. The evidence indicates links between child behavior problems and parenting practices. Authoritarian and permissive parenting are associated with poorer outcomes than authoritative parenting in ADHD children. Behavioral Parent Training (BPT) is an evidence-based intervention recommended for treatment of ADHD. BPT is recommended as first line treatment in ADHD children under age six and as a combination treatment approach for children older than age six. BPT programs have demonstrated significant improvement in frequency of the problem behaviors of inattention, hyperactivity, and impulsivity associated with ADHD.

**Purpose:** The purpose of this DNP project was to evaluate the efficacy of a BPT program in a local behavioral health practice. Furthermore, the project examined the impact of a behavioral parent training program on increasing effective parenting strategies, which can improve outcomes for ADHD children.

**Methods:** A quasi-experimental, preintervention and postintervention design was used. The framework that guided this project was the "Quality-Caring Model". Pre- and Post-BPT Parenting Scales and Vanderbilt ADHD Diagnostic Rating Scales for Parents and Teachers were used to evaluate efficacy of the BPT program

**Results:** Percent change for each participant pre- and post-BPT was calculated. Excel software was utilized to obtain descriptive statistics. The Wilcoxon Rank Sum test was used to compare pre-intervention and post-intervention groups. The Parenting Scale overall score and overreactivity factor score showed significant improvement post-BPT ($p=0.05$).

**Implications/Conclusions:** Participation in a BPT program can affect parenting practices and improve outcomes for ADHD children. BPT programs are effective in reducing negative parenting practices and improving outcomes for this population. BPT programs should be utilized to improve the management of ADHD problem behaviors and decrease stress on the parent-child relationship.

## ACKNOWLEDGMENTS

I am sincerely grateful for the support and guidance of my chair, Dr. Louise O'Keefe, and The University of Alabama in Huntsville, College of Nursing, who helped make the completion of this project possible. I also would like to express my gratitude to Dr. Angelique Andrews, whose guidance, support, and clinical expertise was crucial to the success of this project. I would like to acknowledge Brandy Worthy, BCBA, for providing her clinical expertise and conducting the BPT training sessions. Finally, I would like to acknowledge the staff at HAPPI Behavioral Health. Their hard work, enthusiasm and commitment helped make this project successful.

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## Implementation of a Behavioral Parent Training Program Evaluation Proposal

### Identification of the Problem

Medication and behavioral interventions are well established Attention Deficit Hyperactivity Disorder (ADHD) treatments. Medication has proven to be effective in reducing core symptoms of inattention, impulsivity, and hyperactivity associated with ADHD. However, benefits in social functioning and academic achievement are limited because medication does not have the ability to alter maladaptive parenting. Research has demonstrated that behavioral parent training (BPT) programs are effective in improving children's behaviors, parenting practices, social skills, and academic achievement (Lessard et.al., 2016). BPT programs focus on educating parents about the cause and function of the problem behaviors of ADHD. BPT programs aim to improve parental effectiveness for preventing, managing, and correcting these problem behaviors. BPT also strives to improve the behavioral compliance of the child and improve the familial harmony (Heath et al., 2015). Numerous BPT protocols have been developed for parents of children with ADHD. These protocols have included group and individual sessions with durations ranging from 8-35 weeks. Despite the American Academy of Pediatrics recommendation to employ behavioral training as a first line therapy for the treatment of ADHD, a recent study revealed that only 44% of current ADHD patients and their parents received behavioral therapy within the last year (Danielson, Visser, Chronis-Tuscano, & DuPaul, 2018). Additionally, research reveals that 40-60% of families who enroll in behavioral parent training programs terminate therapy prematurely. The potential impact of BPT is often limited by parental drop out, inadequate resources, stigma related to receiving mental health treatment, and accessibility (Baumel, Pawar, Kane, & Correll, 2016). For private practices and communities to commit resources toward making behavioral parent training programs available, it must be evident these treatments are

feasible to implement on a large scale and produce significant improvements in outcomes for these children and their families (Loren et al., 2015).

**PICOT Question**

In parents of children ages 4-8 diagnosed with ADHD, does participation in a BPT program improve parenting practices and decrease ADHD problem behaviors over 2 months?

**Objectives**

There were several objectives of this BPT program. The first objective was to ensure improved access to BPT programs. Second, to improve the parent-child relationship. Thirdly, to decrease the frequency and severity of the problem behaviors associated with ADHD in both the home and academic setting. Finally, this BPT program aimed to improve the overall quality of life for ADHD children and their families.

**Purpose**

Modification of parenting behavior patterns can be challenging. Unproductive parenting behaviors can increase stress in families, and this increase is exaggerated in families with ADHD children. Established unproductive behavior patterns between parents and ADHD children must change to decrease stress within the family and foster better behavioral outcomes for the ADHD child (Munoz-Silva, Lago-Urbano, Sanchez-Garcia, & Carmona-Marquez, 2017). Evaluating a BPT program instituted to reduce the problem behaviors of ADHD and improve the parent-child relationship and overall patient and family quality of life in a community ADHD practice population is necessary to understand whether the program is effective, and to compare its efficacy to other potential programs which might be used to replace or augment the initial program. The purpose of this BPT program was to increase knowledge and understanding of ADHD, while providing effective parenting strategies to improve outcomes for ADHD children.

## Review of Evidence

### Search Strategy

A structured search of the literature using PRISMA was conducted to determine the current evidence regarding BPT efficacy in the treatment and management of ADHD. The databases used were PubMed/Medline, Cochrane and CINAHL. Keyword searches were used to review MeSH headings. The keywords included: ADHD, behavioral parent training, ADHD treatment and management, parenting stress in ADHD, ADHD BPT efficacy, and ADHD BPT outcomes. The search of the literature revealed ADHD treatment is complex and there are apparent gaps regarding the utilization of behavioral parent training interventions. Articles obtained from the search were reviewed, and subsequently, the ancestry method was used to expand the literature review. Limiters included research articles, systematic reviews, clinical practice guidelines, within the past five years, peer-reviewed, evidence-based practice, English language, and preschool, school age, and adolescent population.

### Behavioral Parent Training Programs

The behavior pattern involving hyperactivity, inattention, and lack of impulse control which frequently presents in children with ADHD can be a challenge for parents. These parents must engage as more active participants in the behavior management of their child (Heath et al., 2015). A renewed interest exists within the field of ADHD in exploring how child functioning is affected by the psychopathology of the parents. Studies have demonstrated that a key environmental component for the child is his or her family. Family can be linked to social difficulties, academic performance, and a variation in comorbidities for children who suffer from ADHD. Changes in marital or family functioning, familial relationships, and lowered parental confidence are associated in varying degrees with ADHD affected children (Margari et al.,

2013). Parents of ADHD children also experience more self-blame, depression, social isolation, and marital discord (Vierhile, Robb, & Ryan-Krause, 2009). Studies have demonstrated that parents of ADHD children exhibit higher rates of disapproving, dictating, and scorning behaviors toward their children. These parents use command repetition, reprimanding, verbal directives, and correction more than parents of non-ADHD children. Rewarding and responsive behaviors occur less frequently in parents of children with ADHD (Margari et al., 2013). These families have unique needs and demands. Balancing work and family demands, while trying to effectively manage the difficult behaviors associated with ADHD, remains a continual challenge for these families (Sellmaier, Leo, Brennan, Kendall, & Houck, 2016).

**Parenting Practices**

Researchers confirm that parent-child interactions are more conflictual in families with an ADHD child compared to those without (Cappe et al., 2017). This conflict creates increased stress levels and negatively affects this important relationship. Ineffective parenting styles have been identified as a major causative factor of behavior problems. Both permissive parenting and authoritarian parenting are associated with increased child behavior problems (Schilling et al., 2017). Due to the prevalence and devastating consequences of the problem behaviors associated with ADHD, research has focused on developing effective treatment regimens to prevent and manage these problem behaviors to improve outcomes for these patients and their families (Schilling et al., 2017).

**Effectiveness of Behavioral Parent Training Programs**

Behavioral parent training (BPT) is recommended as an efficacious first line treatment for ADHD children (Cappe et al., 2017). BPT promotes positive, reliable, dependable, and

nurturing parenting interventions which can reduce the frequency and severity of problem behaviors. Consequently, BPT can decrease parental stress and reduce negative outcomes.

ADHD children and their families face numerous challenges resulting in additional family problems such as increased levels of parent-child conflict, sibling rivalry, increased parenting stress, marital discord, and lack of family cohesion (Cheung & Theule, 2016). These problems affect the overall quality of life for ADHD children and their families. BPT programs provide parents with strategies to change behaviors and improve the parent-child relationship. BPT assists parents in developing clear, consistent expectations, directions, and limits. Parents learn proactive, not reactive methods of discipline. BPT programs offer interventions which can boost confidence and assist parents in improving social skills and working cooperatively with others (CHADD, 2018).

**Behavioral Parent Training Modalities**

Many different modalities can be utilized for behavioral parent training, including webinars, digital applications, and traditional behavior parent training provided with a licensed therapist. The Agency for Healthcare Research and Quality (AHRQ) published a report recommending programs provided by a licensed therapist proven to work in young children with ADHD. The Triple P (Positive Parenting Program), Incredible Years Parenting Program, Parent-Child Interaction Therapy, and New Forest Parenting Program are examples of recommended BPT programs (CDC, 2018).

Traditional BPT is primarily delivered in a clinical setting. The focus is on improving the parent-child relationship and strategies to help parents develop disciplinary skills to reduce problem behaviors. Recent research efforts have been focused on developing targeted approaches to improving engagement and reducing drop out from BPT programs. Traditional BPT typically

consists of 8-12 sessions which meet on a weekly or biweekly basis. BPT can be group or individual sessions. Technology based programs of BPT are also available. Technology based programs are guided by evidence based theoretical frameworks which provide guidance on adequate and inadequate parenting strategies (Baumel et al., 2016). Technology based programs have the potential to decrease barriers of accessibility, stigma, resources, and financial costs of traditional BPT programs. Recent research suggests that technology based BPT programs have similar efficacy when compared with traditional BPT (DuPaul et al., 2017). However, BPT programs are still more frequently offered in the traditional group or individual format by trained healthcare professionals, typically licensed counselors or certified applied behavior analysts (ABA). Traditional BPT programs have been proven efficacious at reducing child noncompliance, reducing parental stress and increasing parental confidence (Lessard, Normandeau, & Robaey, 2016).

## Conceptual framework

The Quality-Caring Model by Joanne Duffy illustrates the important connection between professional nurse caring and quality health care outcomes (Smith & Parker, 2015). Caring relationships are the core concept in this model. These caring relationships are believed to be central to nursing clinical practice and include patient family interactions, as well as interactions with other members of the healthcare team. This model distinguishes professional caring from caring by friends or family because it requires specialized knowledge, behaviors and attitudes which are directed toward health and healing (Duffy, 2003). The Quality-Caring Model suggests that within these professional caring relationships, individual nurses carry responsibility for proficiency, purpose, and self-governing practice decisions which are within their licensed range of clinical practice to facilitate positive outcomes for their patients. This model emphasizes the

significance of professional caring performed by nurses and its effect on health outcomes. The time nurses devote to these caring relationships is considered valuable. This model also stresses the importance of continuity in the professional caring relationship (Duffy, Baldwin, & Mastorovich, 2007).

The Quality Caring Model suggests that as patients feel "cared for" through this professional caring, this cultivates a necessary positive emotion enabling them to learn new healthy behaviors, make decisions based on evidence, and ultimately assist them to move toward a healthy outcome. Positive human relationships are formed through the professional caring of nursing, which can positively influence health outcomes (Smith & Parker, 2015). Nurse practitioners diagnosing and treating patients with ADHD can create positive health care outcomes for these patients by building a caring relationship with patients, family members, and other engaged health care professionals. These relationship-centered professional encounters as described in the Quality Caring Model, occur when the nurse practitioner gathers a thorough history, assesses, diagnoses, and establishes a personalized treatment pathway for the ADHD patient. An integral part of the treatment plan for the ADHD patient may also involve other members of the healthcare team, such as educators, nutritionists, psychiatrists, and counselors who provide behavioral and educational interventions. These clinical caring processes emphasize respect and reverence for the persons and the meanings associated with illness and health. Caring relationships benefit the care provider and the individual receiving care. The Quality Caring Model suggests that combining caring and an evidence-based practice culture may create high quality positive patient outcomes that lead to patients and families providing high quality self-care (Duffy, 2003). By preserving key professional components of nursing suggested to be critical to maintaining quality of care in existing evidence, this model contributes to positive

patient outcomes (Duffy et al., 2007). Using this model provided a framework for research evaluating nurse practitioners' recommendations for the use of BPT in the treatment and management of ADHD (Appendix A).

## DNP Project Implementation

This project was a quality improvement project using a pre- and post-test design. The program evaluation was designed to improve ADHD outcomes by implementing a BPT program to increase parental knowledge of ADHD, reduce parenting stress, improve parenting confidence, decrease the occurrence of ADHD problem behaviors, improve academic performance, and improve the parent-child relationship.

### *Setting*

This project was conducted at a local private behavioral health (BH) practice in Huntsville, AL. The BH practice was opened in 2015 by a local pediatrician who wanted to expand her practice and help fill the gap in access to mental health care for her patient population. The BH practice is a satellite office associated with an urgent care, pediatric and family practice location. The average number of patients seen per day at BH is approximately 15. The BH practice is staffed with four Family Nurse Practitioners (FNPs), two physicians, one medical technologist (MT), and a front desk staff person. There is also a counselor on staff who is available three days a week to provide individual counseling for the BH patients. Full time providers rotate days between the various locations. The part-time providers are assigned a particular day exclusively at BH. The majority of personnel are women, there is only one male provider, who is the family practice physician. Full time providers typically work 32-40 hours per week. Part time providers typically work 7-14 hours per week. Providers perform ADHD evaluations and follow-ups, which consist of a comprehensive clinical interview and exam,

interpretation of continuous performance testing (CPT), review of rating scales, and providing patients with a diagnosis and treatment plan.

*Population*

A convenience sample consisting of parents of children ages 4-8 who presented for initial ADHD evaluation were recruited to participate. Participants were parents or guardians who have legal custody of the child presenting for ADHD evaluation. Institutional Review Board (IRB) approval was granted by the University of Alabama in Huntsville (UAH) IRB committee. Once IRB approval was obtained, 18 parents were recruited to participate in the BPT program. Participation was strictly voluntary. Informed consent was obtained prior to participation. Out of the 18 parents initially recruited, 8 parents participated in the BPT program, n=7 females and n=1 male. Consent to participate included completion of scales pre- and post-BPT sessions. Retrospective patients' chart review was utilized to gather data before and after completion of the BPT program. A contracted Board-Certified Behavior Analyst (BCBA) conducted weekly BPT sessions for a total of 8 one-hour group sessions. These group sessions consisted of parental education on ADHD, the importance of consistency in discipline for ADHD children, the difference between discipline versus punishment, origins of behaviors, and the use of role playing to teach and demonstrate effective parenting strategies. Incentives were provided to try to improve recruitment. The incentives were free childcare during the weekly BPT sessions, snacks during BPT sessions, and a $20 Visa gift card was awarded to participants who attended all 8 sessions to minimize dropout.

*Tools*

The Parenting Scale (PS) was the instrument (see Appendix B) chosen to evaluate the efficacy of this BPT program. The PS was developed to measure actual parental discipline

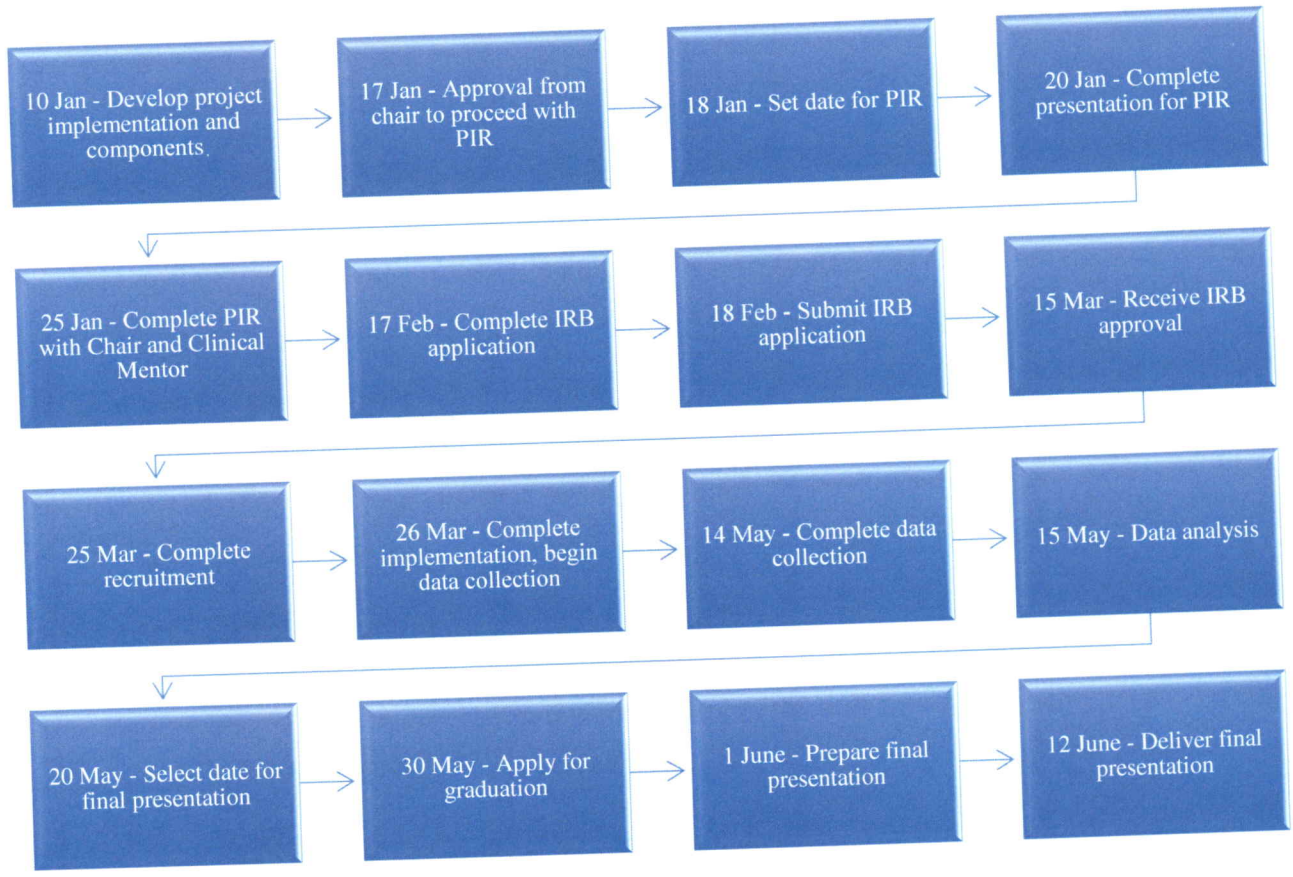
practices (Rhoades & O'Leary, 2007). Parenting practices have a profound influence on children's development and play a primary role in promoting behavior change (Heath et al., 2015). The PS is a thirty item self-report scale to determine the probability with which a parent actually uses particular discipline strategies. The scale uses three dimensions: laxness, which assesses permissive and incoherent discipline applied by parents whenever the child misbehaves; over reactivity, which measures angry, frustrated and irritable parent behaviors associated with an authoritarian behavioral style; hostility, which assesses attitudes such as grumbling and complaining, continuous scolding, and a reliance on talking even when talking is ineffective (Scarzello, Arace, & Prino, 2016). Statements about discipline strategies utilized in the PS represent the intended purpose of the instrument which is to measure parental probabilities of using specific discipline strategies in response to problem behaviors of their children. Therefore, the results can be generalized to the ADHD parent population the survey sample is representing. The survey was culturally sensitive, with clear and concise questions. The PS was distributed to parents prior to beginning and after the completion of the BPT program.

The Vanderbilt ADHD Diagnostic Rating Scale (VADRS) was published by the American Academy of Pediatrics (AAP) and the National Institute for Healthcare Quality (NIHQ) in 2002. It was designed to evaluate and standardize ADHD core symptom occurrence from both parents and teachers (Yuki, Bhagia, Mrazek, & Jensen, 2016). The Vanderbilt ADHD Diagnostic Parent Rating Scale (VADPRS) (see Appendix C) and the Vanderbilt ADHD Diagnostic Teacher Rating Scale (VADTRS) (see Appendix D) were also distributed to parents and teachers prior to beginning and after completion of the BPT program to evaluate efficacy in managing ADHD problem behaviors in both home and academic settings.

*Measures*

The principal investigator was responsible for data entry and editing, maintaining accuracy and project completion while adhering to the project's timeline. BPT effectiveness was determined by evaluating participants: Parenting Scale total score, laxness and overreactivity factor scores, and parent and teacher VADRS scores. Excel software was utilized to obtain descriptive statistics. Qualitative analysis was employed to sort and identify disclosed reasons to barriers, efficacy, and efficiency of the BPT program among this population.

*Scholarly Project Timeline*



## Evaluation

BPT effectiveness was determined by evaluating participants Parenting Scale total score, Laxness and Over reactivity factor scores, and Parent and Teacher VADRS scores. Percent change for each participant pre- and post-BPT was calculated. Excel software was utilized to obtain descriptive statistics. The Wilcoxon Rank Sum test was used to compare pre-intervention and post-intervention groups. This test was chosen because the sample size was too small to be assured the assumption of a normal distribution would be valid. Additionally, the Wilcoxon Rank Sum test is appropriate for statistical comparison when the number of pre- and post-intervention data points are not equal.

## Results

Of the eighteen participants initially recruited, eight (44.4%) agreed to participate in this BPT program. The participant sample consisted of eight parents of ADHD children (7 females and 1 male). The average age of parent participants was 33 years old (Table 1). The average child age was 6 years old (Table 1).

Age distribution did not follow any predictable pattern (Figure 1). The racial distribution of the participants was somewhat similar to the U.S. as a whole, but Hispanics were under represented (Figure 2). The participant group was well below the national educational average for the U.S., where roughly 35% have a college degree (U.S. Census Bureau, 2018). The below average education level of the participant population may be reflective of socioeconomic status, as 87.5% of the participants were covered by Medicaid, indicating their income level is near the federal poverty line or below (U.S. Department of Health & Human Services, 2019). All parent participants had a decrease in their total score on the parenting scale post BPT (Figure 3). The highest percentage change was -32.8%. This result was encouraging because it demonstrates

improved parenting strategies and potentially improved outcomes. Parent Vanderbilt symptom scores did not show a significant decrease in behavior problems post BPT (Figure 4). All participants had a decrease in Vanderbilt performance scores post BPT, with the exception of one parent who rated her child all 0s both pre- and post-BPT (Figure 5). This participant's rating did not align with the teacher performance score for this child, which was much higher, and may indicate a lack of objectivity for this participant. The decrease in performance score did not achieve significance, but the comparative value was only 2.5 points from significance, which may indicate that a more objective score from this outlier participant would have allowed demonstration of significance. Results for participant overreactivity scores demonstrated a significant decrease post-BPT (Figure 6). This is particularly encouraging as high parental overreactivity is associated with poor outcomes in ADHD children. The reduction in parent laxness scores did not demonstrate significance, but the test value was close to the comparative value, indicating a larger sample size may help demonstrate significance in follow-up studies (Figure 7).

## Discussion

This program evaluation demonstrated that BPT programs improve parenting practices. It also emphasized the importance of addressing parenting strategies in order to improve ADHD outcomes. This program evaluation also demonstrated that ADHD treatment and management should include a multidisciplinary approach in order to produce quality outcomes for the ADHD population.

There were several advantages and limitations of this program evaluation. A limitation of the program evaluation was that the chosen participants were already presenting to the clinic for ADHD evaluation, which could indicate an increased desire or drive to engage in their child's

treatment plan and create bias in the results. The time of the evaluation was only 8 weeks, which limited data collection. Another limitation was recruitment. Recruitment was a challenge. Delays were encountered and project implementation was much later than anticipated. IRB approval was granted the week prior to spring break. This made recruitment difficult because there were problems reaching parents via phone due to decreased responsiveness over the spring break holiday. Childcare was offered as an incentive for parents to attend, as well as a $20.00 Visa gift card for parents who attended all 8 sessions. Despite these incentives, it was very difficult to recruit this population. Transportation, work constraints, and conflicting spring activities for children were reasons participants gave for the inability to participate. The subjectivity of the scales also potentially limited the significance of the results which may have affected the ability to demonstrate efficacy for this BPT program in decreasing the frequency and severity of the problem behaviors of ADHD. The timing of the program in the academic year was also a limitation. It created difficulties in obtaining post-BPT Vanderbilt teacher rating scales because the teachers were reluctant to complete the VADRS teacher scales due to the ending of the academic year.

One advantage of this program evaluation was the sampling method. The use of convenience sampling was an advantage for this project because patients and parents were already presenting for ADHD evaluation and diagnosis to HBH. This provided convenient access to the desired age group and patient population. Another advantage of this program evaluation was the availability of a local BCBA who was able to facilitate and lead this training within the study budget and timeframe. It was equally advantageous to have complete stakeholder support and engagement in this research program. Office staff and the other

providers at HBH contributed to recruitment and sustainability of the research throughout the project.

## Applications to practice

ADHD is chronic, and persists into adolescence and adulthood. It is associated with various functional impairments which include poorer academic performance, reduced high school graduation rates, driving impairments, and increased rates of occupational failures, criminal legal issues, substance abuse, teenage pregnancy, and sexually transmitted diseases (Antshel, Faraone, & Gordon, 2014). Despite the fact that stimulants are effective in controlling and diminishing ADHD core symptoms, stimulants alone cannot always adequately control the problem behaviors and reduce negative outcomes for these patients. Twenty to thirty percent of children and adolescents prescribed stimulants show no response or develop significant side effects which warrant discontinuing the medication. Medication adherence is another factor which decreases as children move into adolescence affecting treatment outcomes. Clinical behavioral therapy, which includes BPT, is the most impactful non-pharmacological treatment for children and adolescents suffering from ADHD (Vierhile et al., 2009). Utilizing BPT to improve the management of ADHD problem behaviors can be valuable as an alternative or combination therapy, depending on the individual patient. Tailoring ADHD treatment and BPT interventions to the patient's specific needs could increase effectiveness of the treatment and decrease negative functional impairments associated with ADHD (Antshel, Faraone, & Gordon, 2014). Parenting children with special needs, like ADHD, is associated with increased stress levels and may negatively affect the parent-child relationship and parenting practices (Munoz-Silva et al., 2017). Additionally, these increased stress levels can increase marital discord and negatively affect overall quality of life for ADHD children and their families. Research

demonstrates the negative effects of ADHD on parent psychological adjustment and the need to employ BPT programs to improve outcomes in this population (Cappe et al., 2017). Efficacious BPT programs provide parents with increased knowledge of ADHD, skills to improve self-esteem, goal and limit setting to improve compliance, enhance the parent-child relationship, and reduce conflict in the home (Burns, 2018). The Doctorally Prepared Nurse (DNP) should continually examine parents' responses to BPT and its effect on parental contentment regarding care, in addition to parental ability to employ the techniques learned during the treatment courses. Further research is needed to determine BPT's influence on children's behavioral improvement outcomes, parent responses to therapy, and the most efficacious modality of BPT (DuPaul et al., 2017).

## Conclusion

ADHD is the most common chronic neurobehavioral disorder of childhood. Parent-child interactions are more conflictual in families with an ADHD child and ineffective parenting styles have been identified as a major causative factor of behavior problems. BPT promotes positive, reliable, dependable, and nurturing parenting interventions which can reduce the frequency and severity of problem behaviors. Consequently, BPT can decrease parental stress and reduce negative outcomes. The primary goals of implementing an evidenced based BPT program in an ADHD population are to decrease the frequency and severity of the core symptoms of ADHD and improve the parent-child relationship. This project demonstrated that parents are receptive to participation in a BPT program to improve parenting practices and improve outcomes for their ADHD children. It also demonstrates efficacy of BPT in reducing negative parenting practices and improving outcomes for this population. Doctorally prepared nurses have the opportunity to collaborate with other healthcare professionals to improve outcomes for ADHD patients and

their families. However, significant gaps exist in order to provide access to BPT programs. Medicaid and private insurance coverage for BPT is lacking. Programs are expensive and may be cost prohibitive, especially for families with low socioeconomic status. Provider resources are limited, which reduces feasibility of offering BPT programs at reduced or no cost. Therefore, policy change is necessary to increase access to BPT programs. Additionally, further research is needed to find alternative modalities for BPT that are more cost effective.

## Professional Journal

## The Journal of Pediatric Health Care (JPHC)

A. Scope of Journal:

The JPHC is a monthly scholarly, peer-reviewed journal and the official journal for the National Association of Pediatric Nurse Practitioners (NAPNAP). The target audience of the JPHC are clinicians, researchers and educators, who provide primary, acute, and specialty health care for children of newborn age through young adulthood with a family-centered focus (JPHC, 2018). The JPHC encourages submissions regarding multidisciplinary perspectives on evidence-based practice, advocacy, education, and emerging policy that are important to all healthcare professionals involved in caring for children and their families. Manuscripts must be original, unpublished works submitted for the exclusive use of the JPHC per the current author guidelines. Several types of research manuscripts may be appropriate for JPHC; however, the focus of the research must relate to NP practice (JPHC, 2018).

B. Aims of Journal:

The JPHC supports the mission of NAPNAP to lead Nurse Practitioners (NP's) in advocating for children's health care by making children's health and well-being a priority for our health care system. NAPNAP strives to empower pediatric focused APRNs and their interprofessional colleagues to improve child and family health through advocacy, leadership, professional practice, education and research. The mission of the JPHC is to help serve the information needs of NPs and other multidisciplinary members of the health care team involved in the care of children and families (JPHC,2018). Their collective vision is that all children should have access to coordinated, comprehensive, and culturally sensitive, family-centered care

that includes physical and mental health services which promote and restore healthy lifestyles (NAPNAP, 2016).

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# TABLE 1

| Patient Number | Participant Age | Race | Gender | Education level | Employment Status | Type of Insurance | Child's age | Child's Gender | BPT Parenting Scale Score | | Parent VADPRS SS/PS | | | | Teacher VADTRS SS/PS | | | | Laxness Factor Score | | Overreactivity Factor Score | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | Performance Score | | Symptom Score | | Performance Score | | Symptom Score | | | | | |
| | | | | | | | | | Pre-BPT | Post-BPT | Pre-BPT | Post-BPT | Pre-BPT | Post-BPT | Pre-BPT | Post-BPT | Pre-BPT | Post-BPT | Pre-BPT | Post-BPT | Pre-BPT | Post-BPT |
| 1001 | 28.00 | W | Female | GED | Unemployed | Medicaid | 5 | Female | 83 | 58 | 9 | 1 | 5 | 2 | 8 | | 5 | | 2 | 1.2 | 2.5 | 1.7 |
| 1002 | 32.00 | W | Female | College | Full-Time | Medicaid | 8 | Male | 108 | 102 | 13 | 1 | 1 | 12 | 19 | | 8 | | 2.6 | 3.2 | 3.6 | 2.9 |
| 1003 | 35.00 | H | Male | College | Full-Time | Medicaid | 7 | Male | 93 | 99 | 14 | 0 | 0 | 1 | | | | | 2.8 | | 2.8 | |
| 1004 | 45.00 | W | Female | College | Unemployed | Medicaid | 5 | Female | 99 | 84 | 17 | 14 | 0 | 1 | | | | | 2.45 | | 3.5 | |
| 1005 | 40.00 | AA | Female | C College | Full-Time | Private | 7 | Male | 90 | 72 | 0 | 0 | 0 | 0 | 20 | 15 | 6 | 8 | 2.5 | 1.9 | 3.6 | 2.5 |
| 1006 | 27.00 | W | Female | HS | Full-Time | Medicaid | 4 | Male | 95 | 80 | 22 | 16 | 8 | 2 | 13 | | 5 | | 2.6 | 2.3 | 3.5 | 3.1 |
| 1007 | 29.00 | W | Female | College | Unemployed | Medicaid | 5 | Male | 137 | 92 | 30 | 4 | 5 | 1 | 19 | | 3 | | 4.5 | 2.5 | 5 | 2.4 |
| 1008 | 30.00 | W | Female | College | Unemployed | Medicaid | 6 | Male | 111 | 76 | 26 | 16 | 3 | 7 | 20 | | 7 | | 3.9 | 2.3 | 3.2 | 2 |
| 1009 | | | | | | | | | | | | | | | | | | | | | | |
| 1010 | | | | | | | | | | | | | | | | | | | | | | |
| Averages | 33.25 | | | | | | 5.88 | | 85.50 | 67.33 | 15.33 | 5.83 | 3.00 | 1.17 | 16.50 | 15.00 | 5.67 | 8.00 | 2.84 | 2.22 | 3.64 | 2.52 |

TABLE 2

| Overreactivity Score | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Pre | Post | Rank Pre | Rank Post | | Pre | Post |
| 1001 | 2.5 | 1.7 | 4.5 | 1 | Count | 8 | 6 |
| 1002 | 4 | 3 | 13 | 7 | Rank Sum | 79.5 | 25.5 |
| 1003 | 2.8 | | 6 | | α = | 0.05 | |
| 1004 | 4 | | 11 | | tails | 2 | |
| 1005 | 3.6 | 2.5 | 12.5 | 4.5 | W | 25.5 | |
| 1006 | 4 | 3 | 11 | 8 | W' | 64.5 | |
| 1007 | 5 | 2.4 | 14 | 3 | Wcrit | 29 | |
| 1008 | 3 | 2 | 9 | 2 | Significance | Yes | |
| n | 8 | 6 | 8 | 6 | | | |
| SUM | 27.7 | 14.6 | 79.5 | 25.5 | | | |

TABLE 3

| Laxness Score | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Pre | Post | Rank Pre | Rank Post | | Pre | Post |
| 1001 | 2 | 1.2 | 3 | 1 | Count | 8 | 6 |
| 1002 | 3 | 3 | 10 | 12 | Rank Sum | 73.5 | 31.5 |
| 1003 | 2.8 | | 11 | | α = | 0.05 | |
| 1004 | 2 | | 6 | | tails | 2 | |
| 1005 | 2.5 | 1.9 | 7.5 | 2 | W | 31.5 | |
| 1006 | 3 | 2 | 10 | 5 | W' | 58.5 | |
| 1007 | 4.5 | 2.5 | 14 | 7.5 | Wcrit | 29 | |
| 1008 | 4 | 2 | 13 | 5 | Significance | No | |
| n | 8 | 6 | 8 | 6 | | | |
| SUM | 23.35 | 13.4 | 73.5 | 31.5 | | | |

FIGURE 1

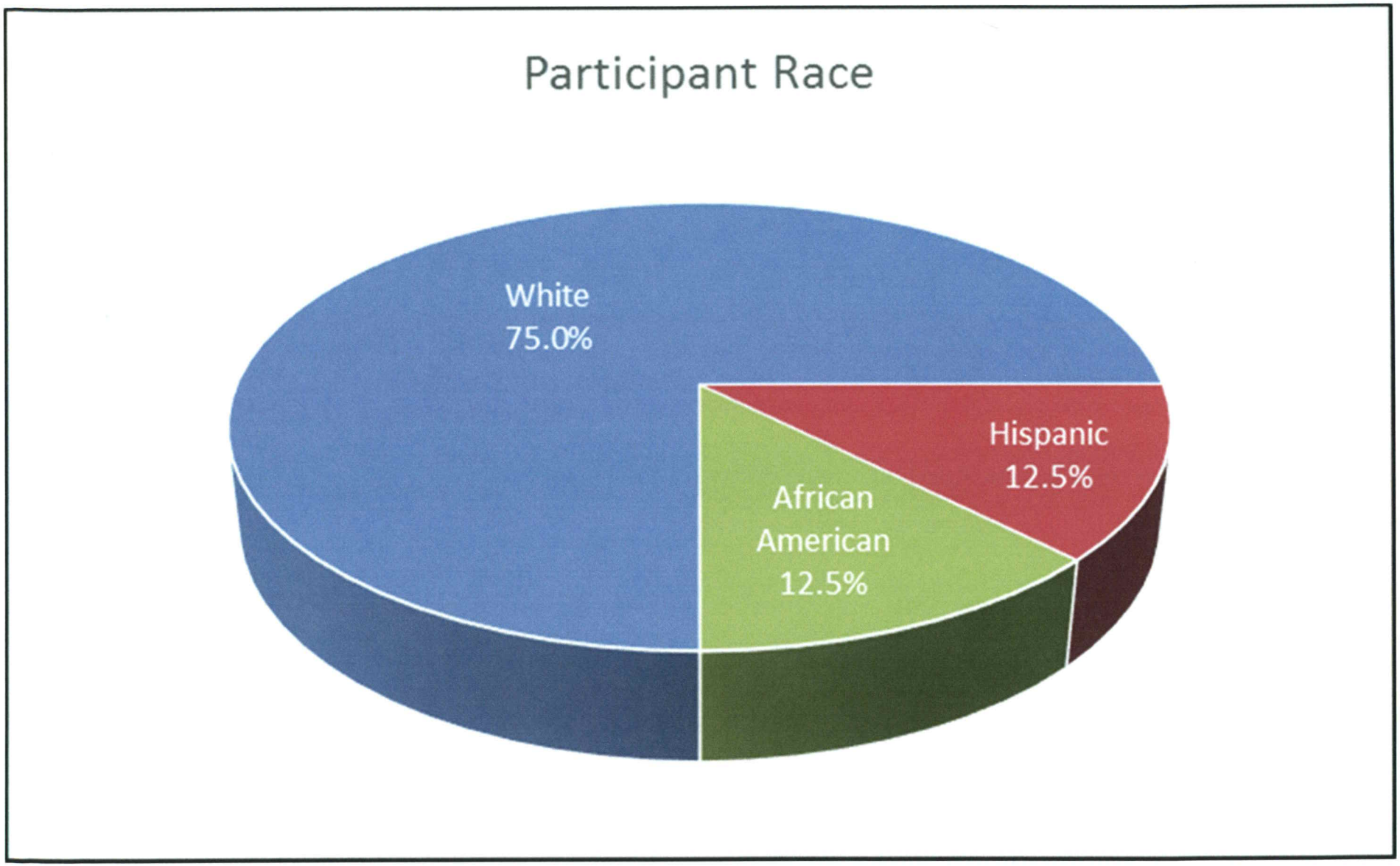

Participant Race
White
75.0%
Hispanic
12.5%
African
American
12.5%

FIGURE 2

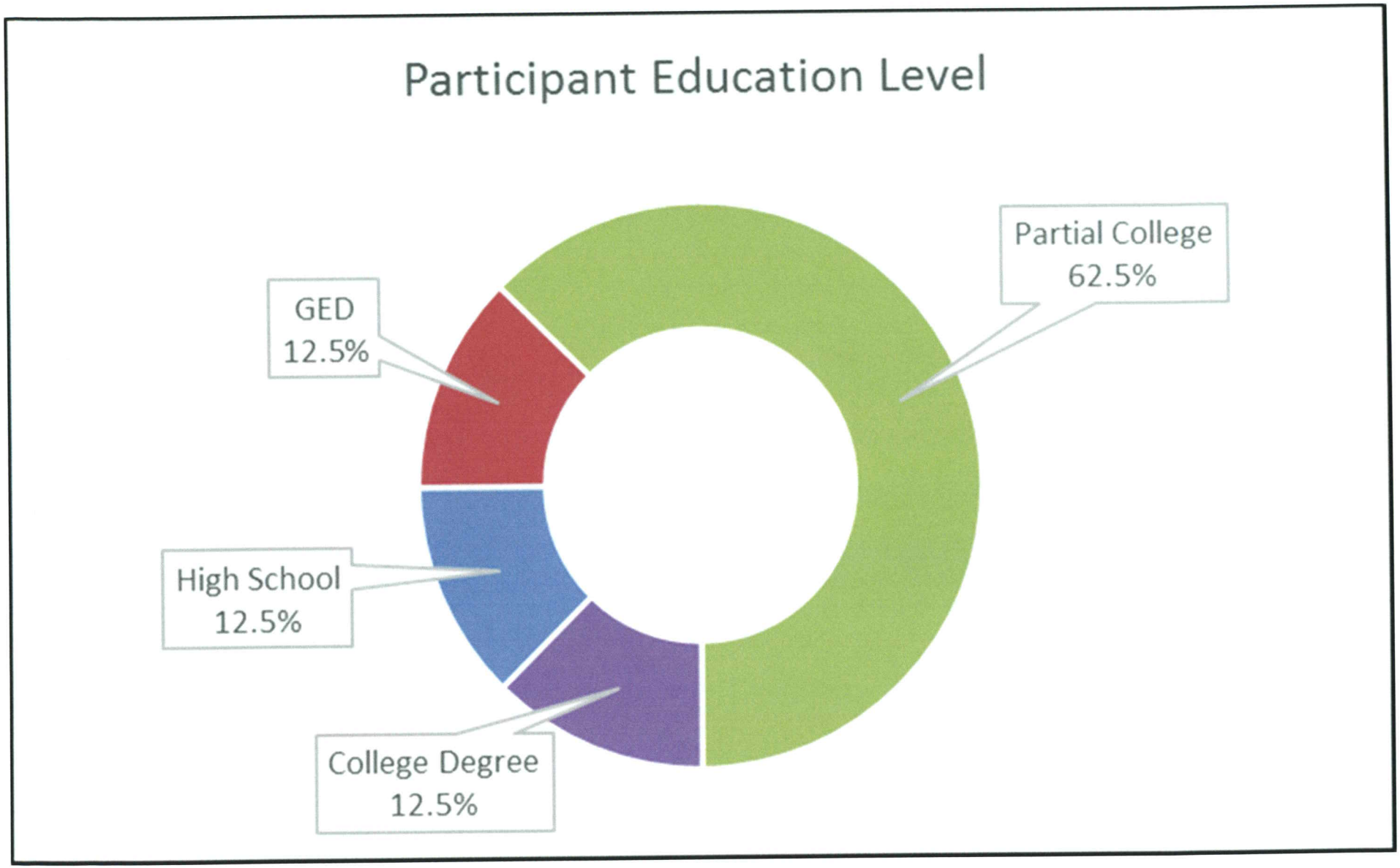

Participant Education Level
Partial College
62.5%
GED
12.5%
High School
12.5%
College Degree
12.5%

FIGURE 3

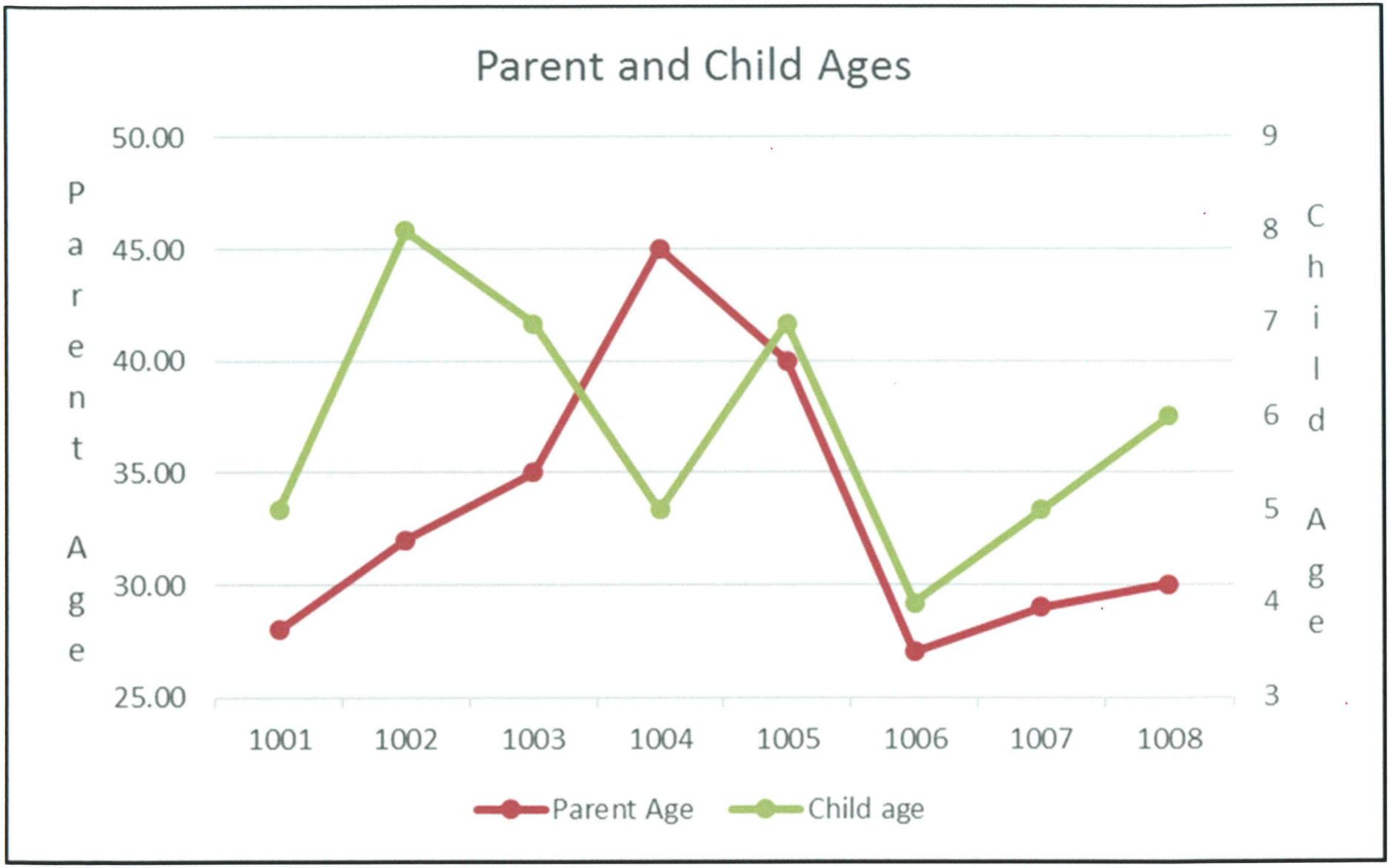

Parent and Child Ages
Parent Age
Child Age
50.00
45.00
40.00
35.00
30.00
25.00
9
8
7
6
5
4
3
1001
1002
1003
1004
1005
1006
1007
1008
Parent Age
Child age

FIGURE 4

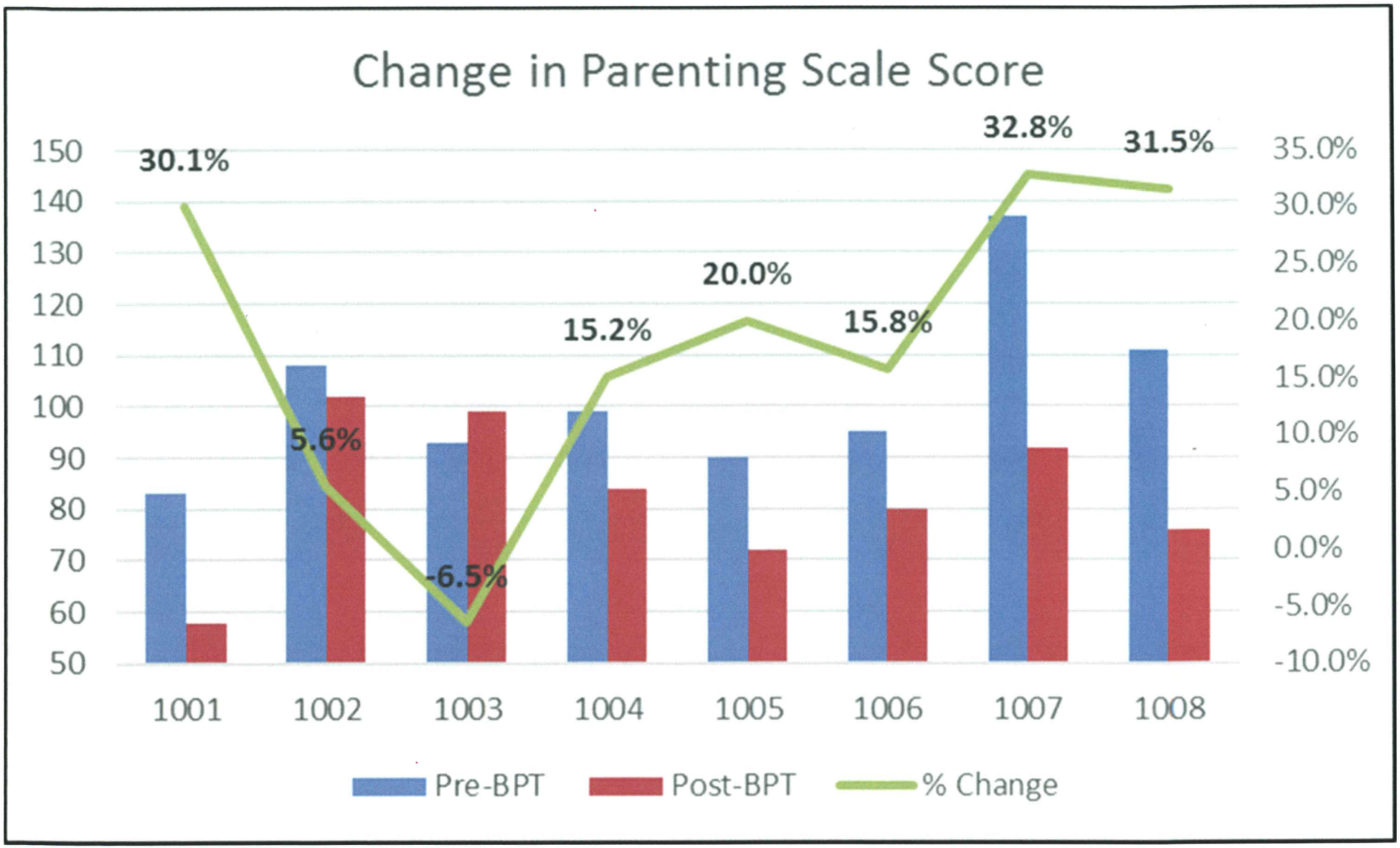

Change in Parenting Scale Score
150
140
130
120
110
100
90
80
70
60
50
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
-5.0%
-10.0%
30.1%
5.6%
-6.5%
15.2%
20.0%
15.8%
32.8%
31.5%
1001
1002
1003
1004
1005
1006
1007
1008
Pre-BPT
Post-BPT
% Change

FIGURE 5

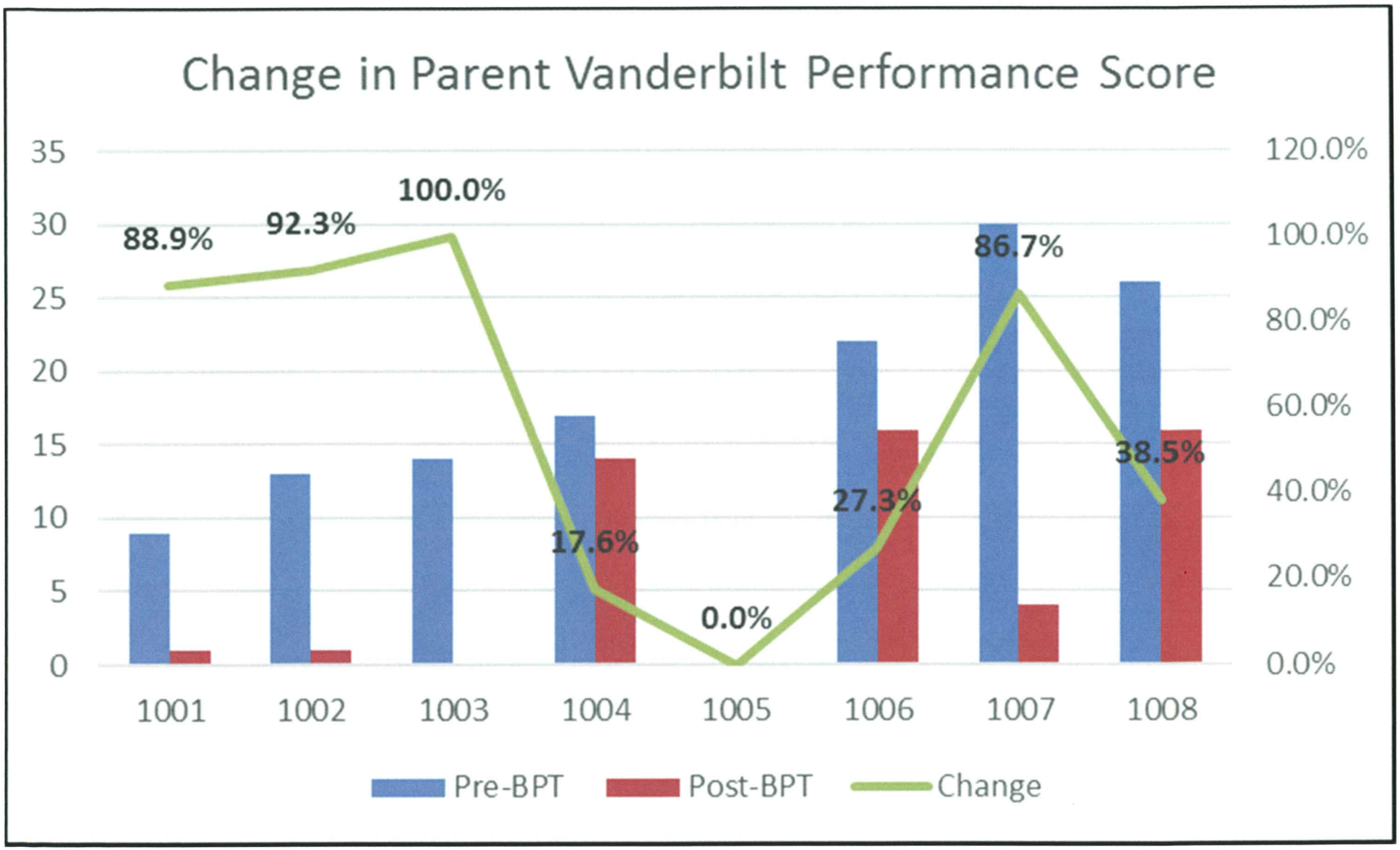
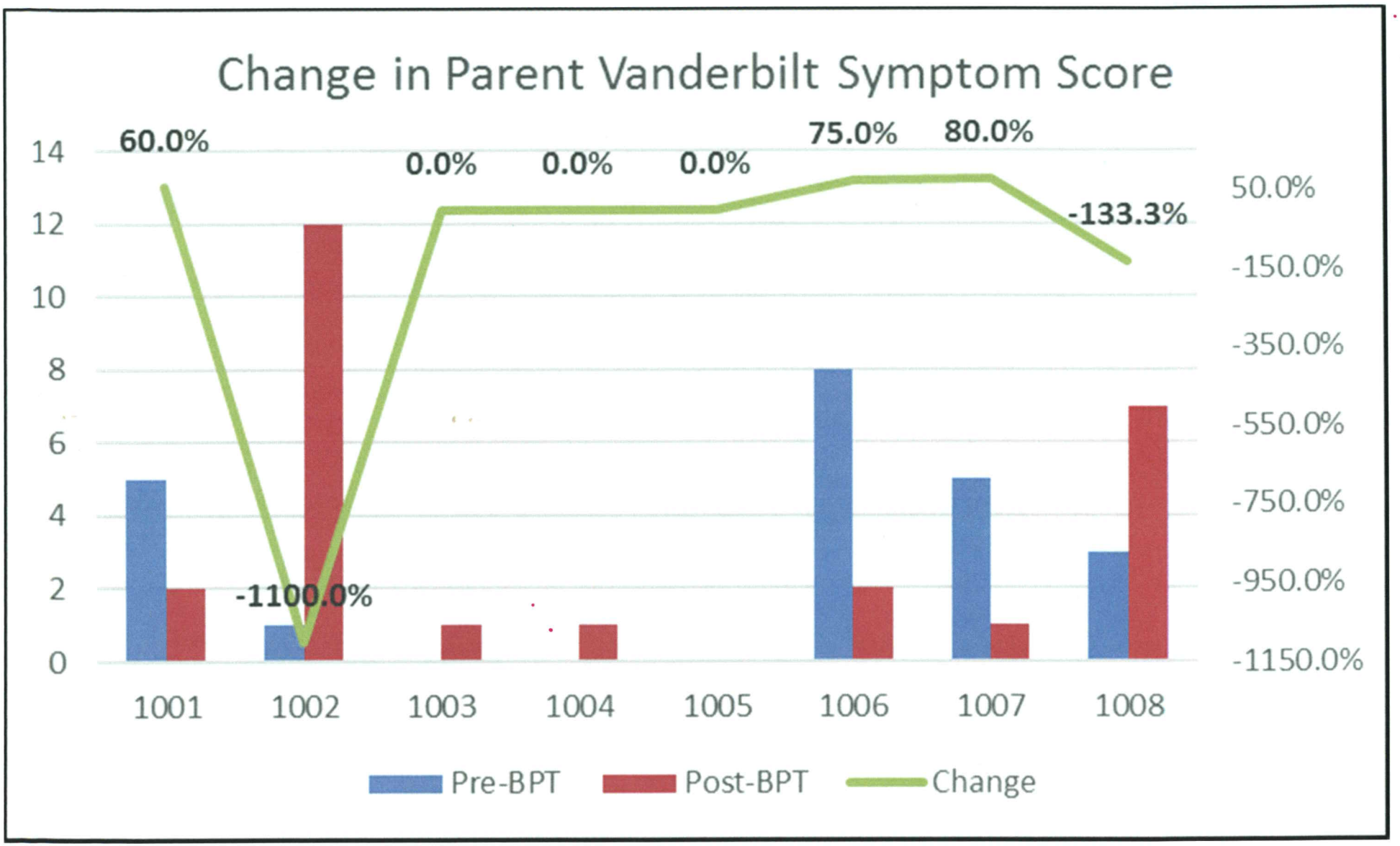
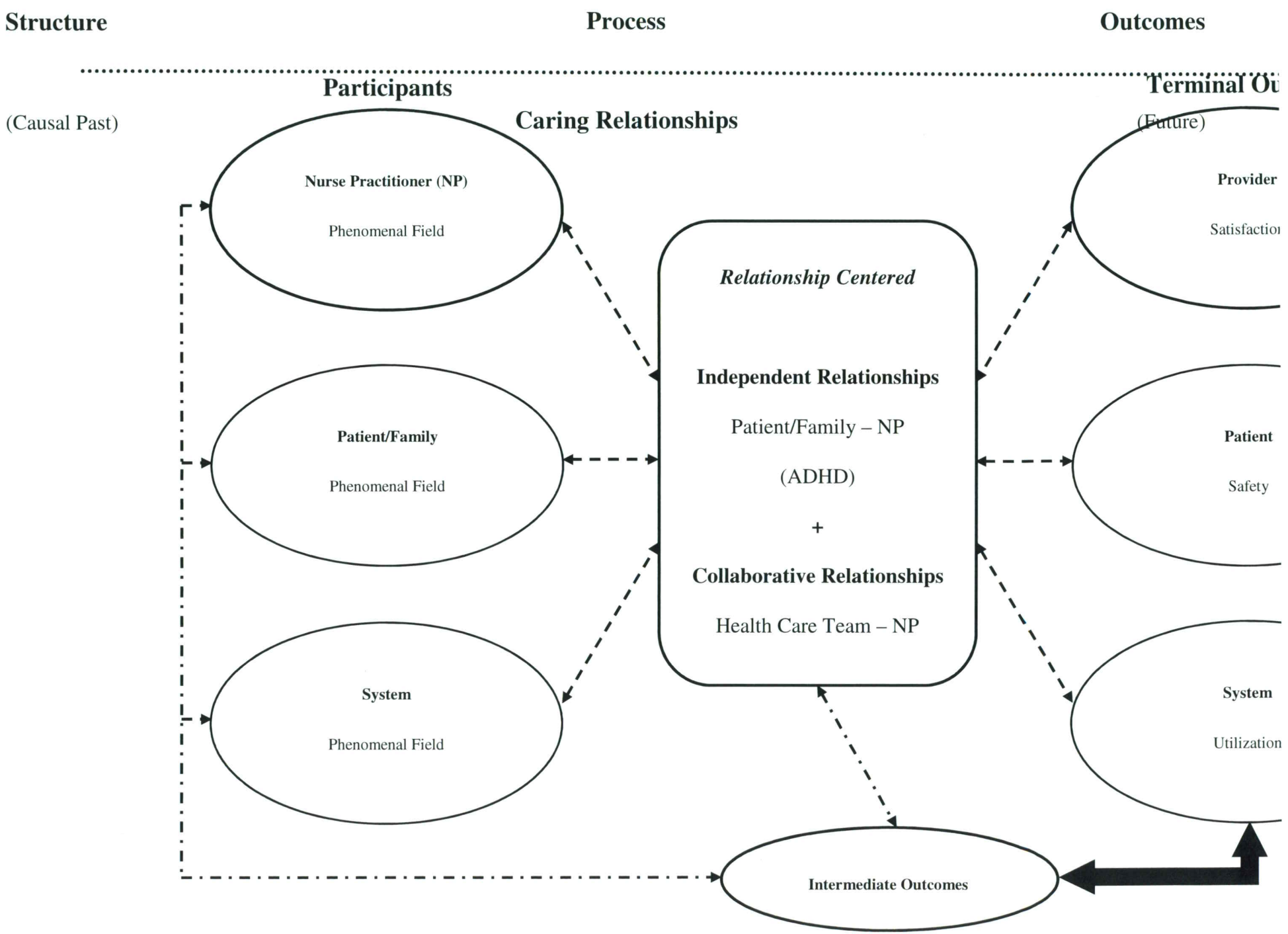

Change in Parent Vanderbilt Performance Score
35
30
25
20
15
10
5
0
120.0%
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
88.9%
92.3%
100.0%
17.6%
0.0%
27.3%
86.7%
38.5%
1001
1002
1003
1004
1005
1006
1007
1008
Pre-BPT
Post-BPT
Change

FIGURE 6


Change in Parent Vanderbilt Symptom Score
60.0%
-1100.0%
0.0%
0.0%
0.0%
75.0%
80.0%
-133.3%
14
12
10
8
6
4
2
0
50.0%
-150.0%
-350.0%
-550.0%
-750.0%
-950.0%
-1150.0%
1001
1002
1003
1004
1005
1006
1007
1008
Pre-BPT
Post-BPT
Change

APPENDIX A


Structure
Process
Outcomes
Participants
(Causal Past)
Caring Relationships
Terminal Ou
(Future)
Nurse Practitioner (NP)
Phenomenal Field
Patient/Family
Phenomenal Field
System
Phenomenal Field
Relationship Centered
Independent Relationships
Patient/Family – NP
(ADHD)
+
Collaborative Relationships
Health Care Team – NP
Provider
Satisfactio
Patient
Safety
System
Utilization
Intermediate Outcomes

APPENDIX B

Scale Developed by Susan G. O'Leary, David S. Arnold, Lisa S. Wolff, & Maureen M. Acker.
Psychology Department, Stony Brook University, Stony Brook, NY 11794-2500

Time 1 CID

Mom ○ Dad/Other ○

# *Parenting Scale*

At one time or another, all children misbehave or do things that could be harmful, are "wrong," or that parents don't like. Examples include: hitting someone, forgetting homework, having a tantrum, whining, throwing food, lying, arguing back, not picking up things, refusing to go to bed, coming home late. Parents have many different ways or styles of dealing with these types of problems. Below are items that describe some styles of parenting.

For each item, fill in the bubble that best describes your style of parenting during the ***PAST TWO MONTHS*** with the child with you here today.

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| *Ex.* | At meal time... *I let my child decide how I decide how much to eat* | ○ | ○ | ● | ○ | ○ | ○ | ○ | *I decide how much my child eats* |

***IN THE PAST TWO MONTHS***

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 1. When my child misbehaves... *I do something right away* | ○ | ○ | ○ | ○ | ○ | ○ | ○ | *I do something later* |
| 2. Before I do something about a problem... *I give my child several reminders and warnings* | ○ | ○ | ○ | ○ | ○ | ○ | ○ | *I use only one reminder or warning* |
| 3. When I'm upset or under stress... *I am picky and on my child's back* | ○ | ○ | ○ | ○ | ○ | ○ | ○ | *I am not more picky than usual* |
| 4. When I tell my child NOT to do something... *I say very little* | ○ | ○ | ○ | ○ | ○ | ○ | ○ | *I say a lot* |
| 5. When my child pesters me... *I can ignore the pestering* | ○ | ○ | ○ | ○ | ○ | ○ | ○ | *I can't ignore the pestering* |
| 6. When my child misbehaves... *I usually get into a long argument with my child* | ○ | ○ | ○ | ○ | ○ | ○ | ○ | *I don't get into an argument* |
| 7. I threaten to do things that... *I'm sure I can carry out* | ○ | ○ | ○ | ○ | ○ | ○ | ○ | *I know I won't actually do* |
| 8. I am the kind of parent that... *Sets limits on what my child is allowed to do* | ○ | ○ | ○ | ○ | ○ | ○ | ○ | *Lets my child do whatever he/she wants* |
| 9. When my child misbehaves... *I give my child a long lecture* | ○ | ○ | ○ | ○ | ○ | ○ | ○ | *I keep my talks short and to the point* |
| 10. When my child misbehaves... *I raise my voice or yell* | ○ | ○ | ○ | ○ | ○ | ○ | ○ | *I speak to my child calmly* |
| 11. If saying no doesn't work right away... *I take some other kind of action* | ○ | ○ | ○ | ○ | ○ | ○ | ○ | *I keep talking and try to get through to my child* |
| 12. When I want my child to stop doing something... *I firmly tell my child to stop* | ○ | ○ | ○ | ○ | ○ | ○ | ○ | *I coax or beg my child to stop* |
| 13. When my child is out of sight... *I often don't know what my child is doing* | ○ | ○ | ○ | ○ | ○ | ○ | ○ | *I always have a good idea of what my child is doing* |

**IN THE PAST TWO MONTHS** **Parenting Scale, page 2**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 14. After there's been a problem with my child... *I often hold a grudge* | ○ | ○ | ○ | ○ | ○ | ○ | ○ | *Things get back to normal quickly* |
| 15. When we're not at home... *I handle my child the way I do at home* | ○ | ○ | ○ | ○ | ○ | ○ | ○ | *I let my child get away with a lot more* |
| 16. When my child does something I don't like... *I do something about it every time it happens* | ○ | ○ | ○ | ○ | ○ | ○ | ○ | *I often let it go* |
| 17. When there is a problem with my child... *Things build up and I do things I don't mean to do* | ○ | ○ | ○ | ○ | ○ | ○ | ○ | *Things don't get out of hand* |
| 18. When my child misbehaves I spank, slap, grab, or hit my child... *Never or rarely* | ○ | ○ | ○ | ○ | ○ | ○ | ○ | *Most of the time* |
| 19. When my child doesn't do what I ask... *I often let it go or end up doing it myself* | ○ | ○ | ○ | ○ | ○ | ○ | ○ | *I take some other action* |
| 20. When I give a fair threat or warning... *I often don't carry it out* | ○ | ○ | ○ | ○ | ○ | ○ | ○ | *I always do what I said* |
| 21. If saying "no" doesn't work... *I take some other kind of action* | ○ | ○ | ○ | ○ | ○ | ○ | ○ | *I offer my child something nice so he/she will behave* |
| 22. When my child misbehaves... *I handle it without getting upset* | ○ | ○ | ○ | ○ | ○ | ○ | ○ | *I get so frustrated or angry that my child can see I'm upset* |
| 23. When my child misbehaves... *I make my child tell me why he/she did it* | ○ | ○ | ○ | ○ | ○ | ○ | ○ | *I say "no" or take some other action* |
| 24. If my child misbehaves and then acts sorry... *I handle the problem like I usually would* | ○ | ○ | ○ | ○ | ○ | ○ | ○ | *I let it go that time* |
| 25. When my child misbehaves... *I rarely use bad language or curse* | ○ | ○ | ○ | ○ | ○ | ○ | ○ | *I almost always use bad language* |
| 26. When I say my child can't do something... *I let my child do it anyway* | ○ | ○ | ○ | ○ | ○ | ○ | ○ | *I stick to what I said* |
| 27. When I have to handle a problem... *I tell my child I'm sorry about it* | ○ | ○ | ○ | ○ | ○ | ○ | ○ | *I don't say I'm sorry* |
| 28. When my child does something I don't like, I insult my child, say mean things, or call my child names *Never or rarely* | ○ | ○ | ○ | ○ | ○ | ○ | ○ | *Most of the time* |
| 29. If my child talks back or complains when I handle a problem... *I ignore the complaining and stick to what I said* | ○ | ○ | ○ | ○ | ○ | ○ | ○ | *I give my child a talk about not complaining* |
| 30. If my child gets upset when I say "no"... *I back down and give in to my child* | ○ | ○ | ○ | ○ | ○ | ○ | ○ | *I stick to what I said* |

## Scoring Instructions for the Parenting Scale

Each item receives a 1-7 score, where 7 is the "ineffective" end of the item.

Thus, the following items have 7 on the left side (the others on the right): 2, 3, 6, 9, 10, 13, 14, 17, 19, 20, 23, 26, 27, 30

To compute the total score, average the responses on all items.

To compute a factor score, average the responses on the items on that factor.

| | |
|---|---|
| Laxness: | 7, 8, 12, 15, 16, 19, 20, 21, 24, 26, 30 (11 items) |
| Overreactivity: | 3, 6, 9, 10, 14, 17, 18, 22, 25, 28 (10 items) |
| Verbosity: | 2, 4, 7, 9, 11, 23, 29 (7 items) |
| Items not on a factor: | 1, 5, 13, 27 (4 items) |

## Demographics, Parenting Scale & CBCL Scores for a clinic and control group

(Standard deviations are in parentheses).

| Category | Clinic Group (n=26) | Control Group (n=51) |
|---|---|---|
| Child's age (months) | 29.9 (4.5) | 28.6 (3.3) |
| Mother's age (years) | 29.6 (6.7) | 31.7 (3.9) |
| Mother's education (years) | 13.6 (1.7) | 15.5 (2.6)* |
| Family Income (thousands) | 33.4 (9.3) | 33.4 (10.2) |
| Parenting Scale Scores: | | |
| Laxness | 2.8 (1.0) | 2.4 (.8)* |
| Overreactivity: | 3.0 (1.0) | 2.4 (.7)** |
| Verbosity: | 3.4 (1.0) | 3.1 (1.0) |
| Total | 3.1 (1.7) | 2.6 (.6) |
| CBCL Externalizing Scale (T-Score) | 58.7 (10.3) | 47.7 (8.4)*** |

*p<.05, **p<.01, ***p<.001

APPENDIX C

## 'ANDERBILT ADHD DIAGNOSTIC PARENT RATING SCALE

ient Name: _____ Today's Date: _____

te of Birth: _____ Age: _____

ade: _____

:h rating should be considered in the context of what is appropriate for the age of your child.

Frequency Code: 0 = Never; 1 = Occasionally; 2 = Often; 3 = Very Often

| | | | | |
|---|---|---|---|---|
| 1. Does not pay attention to details or makes careless mistakes, such as in homework | 0 | 1 | 2 | 3 |
| 2. Has difficulty sustaining attention to tasks or activities | 0 | 1 | 2 | 3 |
| 3. Does not seem to listen when spoken to directly | 0 | 1 | 2 | 3 |
| 4. Does not follow through on instruction and fails to finish schoolwork (not due to oppositional behavior or failure to understand) | 0 | 1 | 2 | 3 |
| 5. Has difficulty organizing tasks and activities | 0 | 1 | 2 | 3 |
| 6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort | 0 | 1 | 2 | 3 |
| 7. Loses things necessary for tasks or activities (school assignments, pencils, or books) | 0 | 1 | 2 | 3 |
| 8. Is easily distracted by extraneous stimuli | 0 | 1 | 2 | 3 |
| 9. Is forgetful in daily activities | 0 | 1 | 2 | 3 |
| 10. Fidgets with hands or feet or squirms in seat | 0 | 1 | 2 | 3 |
| 11. Leaves seat when remaining seated is expected | 0 | 1 | 2 | 3 |
| 12. Runs about or climbs excessively in situations when remaining seated is expected | 0 | 1 | 2 | 3 |
| 13. Has difficulty playing or engaging in leisure activities quietly | 0 | 1 | 2 | 3 |
| 14. Is "on the go" or often acts as if "driven by a motor" | 0 | 1 | 2 | 3 |
| 15. Talks too much | 0 | 1 | 2 | 3 |
| 16. Blurts out answers before questions have been completed | 0 | 1 | 2 | 3 |
| 17. Has difficulty waiting his or her turn | 0 | 1 | 2 | 3 |
| 18. Interrupts or intrudes on others (butts into conversations or games) | 0 | 1 | 2 | 3 |
| 19. Argues with adults | 0 | 1 | 2 | 3 |
| 20. Loses temper | 0 | 1 | 2 | 3 |
| 21. Actively defies or refuses to comply with adults' requests or rules | 0 | 1 | 2 | 3 |

1

## VANDERBILT ADHD DIAGNOSTIC PARENT RATING SCALE

Each rating should be considered in the context of what is appropriate for the age of your child.

**Frequency Code: 0 = Never; 1 = Occasionally; 2 = Often; 3 = Very Often**

| | | | | |
|---|---|---|---|---|
| **22.** Deliberately annoys people | 0 | 1 | 2 | 3 |
| **23.** Blames others for his or her mistakes or misbehaviors | 0 | 1 | 2 | 3 |
| **24.** Is touchy or easily annoyed by others | 0 | 1 | 2 | 3 |
| **25.** Is angry or resentful | 0 | 1 | 2 | 3 |
| **26.** Is spiteful and vindictive | 0 | 1 | 2 | 3 |
| **27.** Bullies, threatens, or intimidates others | 0 | 1 | 2 | 3 |
| **28.** Initiates physical fights | 0 | 1 | 2 | 3 |
| **29.** Lies to obtain goods for favors or to avoid obligations ("cons" others) | 0 | 1 | 2 | 3 |
| **30.** Is truant from school (skips school) without permission | 0 | 1 | 2 | 3 |
| **31.** Is physically cruel to people | 0 | 1 | 2 | 3 |
| **32.** Has stolen items of nontrivial value | 0 | 1 | 2 | 3 |
| **33.** Deliberately destroys others' property | 0 | 1 | 2 | 3 |
| **34.** Has used a weapon that can cause serious harm (bat, knife, brick, gun) | 0 | 1 | 2 | 3 |
| **35.** Is physically cruel to animals | 0 | 1 | 2 | 3 |
| **36.** Has deliberately set fires to cause damage | 0 | 1 | 2 | 3 |
| **37.** Has broken into someone else's home, business, or car | 0 | 1 | 2 | 3 |
| **38.** Has stayed out at night without permission | 0 | 1 | 2 | 3 |
| **39.** Has run away from home overnight | 0 | 1 | 2 | 3 |
| **40.** Has forced someone into sexual activity | 0 | 1 | 2 | 3 |
| **41.** Is fearful, anxious, or worried | 0 | 1 | 2 | 3 |
| **42.** Is afraid to try new things for fear of making mistakes | 0 | 1 | 2 | 3 |
| **43.** Feels worthless or inferior | 0 | 1 | 2 | 3 |
| **44.** Blames self for problems, feels guilty | 0 | 1 | 2 | 3 |

2

## VANDERBILT ADHD DIAGNOSTIC PARENT RATING SCALE

Each rating should be considered in the context of what is appropriate for the age of your child.

**Frequency Code: 0 = Never; 1 = Occasionally; 2 = Often; 3 = Very Often**

| | | | | |
|---|---|---|---|---|
| **45.** Feels lonely, unwanted, or unloved; complains that "no one loves" him or her | 0 | 1 | 2 | 3 |
| **46.** Is sad, unhappy, or depressed | 0 | 1 | 2 | 3 |
| **47.** Is self-conscious or easily embarrassed | 0 | 1 | 2 | 3 |

## PERFORMANCE

| | Problematic | | Average | | Above Average |
|---|---|---|---|---|---|
| **Academic Performance** | | | | | |
| 1. Reading | 1 | 2 | 3 | 4 | 5 |
| 2. Mathematics | 1 | 2 | 3 | 4 | 5 |
| 3. Written expression | 1 | 2 | 3 | 4 | 5 |
| **Classroom Behavior** | | | | | |
| 1. Relationships with peers | 1 | 2 | 3 | 4 | 5 |
| 2. Following directions/rules | 1 | 2 | 3 | 4 | 5 |
| 3. Disrupting class | 1 | 2 | 3 | 4 | 5 |
| 4. Assignment completion | 1 | 2 | 3 | 4 | 5 |
| 5. Organizational skills | 1 | 2 | 3 | 4 | 5 |

3

APPENDIX D

# VANDERBILT ADHD DIAGNOSTIC TEACHER RATING SCALE

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____

Grade: _____

Each rating should be considered in the context of what is appropriate for the age of the children you are rating.

**Frequency Code: 0 = Never; 1 = Occasionally; 2 = Often; 3 = Very Often**

| | | | | |
|---|---|---|---|---|
| 1. Fails to give attention to details or makes careless mistakes in schoolwork | 0 | 1 | 2 | 3 |
| 2. Has difficulty sustaining attention to tasks or activities | 0 | 1 | 2 | 3 |
| 3. Does not seem to listen when spoken to directly | 0 | 1 | 2 | 3 |
| 4. Does not follow through on instruction and fails to finish schoolwork (not due to oppositional behavior or failure to understand) | 0 | 1 | 2 | 3 |
| 5. Has difficulty organizing tasks and activities | 0 | 1 | 2 | 3 |
| 6. Avoids, dislikes, or is reluctant to engage in tasks that require sustaining mental effort | 0 | 1 | 2 | 3 |
| 7. Loses things necessary for tasks or activities (school assignments, pencils, or books) | 0 | 1 | 2 | 3 |
| 8. Is easily distracted by extraneous stimuli | 0 | 1 | 2 | 3 |
| 9. Is forgetful in daily activities | 0 | 1 | 2 | 3 |
| 10. Fidgets with hands or feet or squirms in seat | 0 | 1 | 2 | 3 |
| 11. Leaves seat in classroom or in other situations in which remaining seated is expected | 0 | 1 | 2 | 3 |
| 12. Runs about or climbs excessively in situations in which remaining seated is expected | 0 | 1 | 2 | 3 |
| 13. Has difficulty playing or engaging in leisure activities quietly | 0 | 1 | 2 | 3 |
| 14. Is "on the go" or often acts as if "driven by a motor" | 0 | 1 | 2 | 3 |
| 15. Talks excessively | 0 | 1 | 2 | 3 |
| 16. Blurts out answers before questions have been completed | 0 | 1 | 2 | 3 |
| 17. Has difficulty waiting in line | 0 | 1 | 2 | 3 |
| 18. Interrupts or intrudes on others (eg, butts into conversations or games) | 0 | 1 | 2 | 3 |
| 19. Loses temper | 0 | 1 | 2 | 3 |
| 20. Actively defies or refuses to comply with adults' requests or rules | 0 | 1 | 2 | 3 |
| 21. Is angry or resentful | 0 | 1 | 2 | 3 |

## VANDERBILT ADHD DIAGNOSTIC TEACHER RATING SCALE

Each rating should be considered in the context of what is appropriate for the age of the children you are rating.

**Frequency Code: 0 = Never; 1 = Occasionally; 2 = Often; 3 = Very Often**

| | | | | |
|---|---|---|---|---|
| **22.** Is spiteful and vindictive | 0 | 1 | 2 | 3 |
| **23.** Bullies, threatens, or intimidates others | 0 | 1 | 2 | 3 |
| **24.** Initiates physical fights | 0 | 1 | 2 | 3 |
| **25.** Lies to obtain goods for favors or to avoid obligations (ie, "cons" others) | 0 | 1 | 2 | 3 |
| **26.** Is physically cruel to people | 0 | 1 | 2 | 3 |
| **27.** Has stolen items of nontrivial value | 0 | 1 | 2 | 3 |
| **28.** Deliberately destroys others' property | 0 | 1 | 2 | 3 |
| **29.** Is fearful, anxious, or worried | 0 | 1 | 2 | 3 |
| **30.** Is self-conscious or easily embarrassed | 0 | 1 | 2 | 3 |
| **31.** Is afraid to try new things for fear of making mistakes | 0 | 1 | 2 | 3 |
| **32.** Feels worthless or inferior | 0 | 1 | 2 | 3 |
| **33.** Blames self for problems, feels guilty | 0 | 1 | 2 | 3 |
| **34.** Feels lonely, unwanted, or unloved; complains that "no one loves" him or her | 0 | 1 | 2 | 3 |
| **35.** Is sad, unhappy, or depressed | 0 | 1 | 2 | 3 |

## PERFORMANCE

| | Problematic | | Average | Above Average | |
|---|---|---|---|---|---|
| **Academic Performance** | | | | | |
| 1. Reading | 1 | 2 | 3 | 4 | 5 |
| 2. Mathematics | 1 | 2 | 3 | 4 | 5 |
| 3. Written expression | 1 | 2 | 3 | 4 | 5 |
| **Classroom Behavioral Performance** | | | | | |
| 1. Relationships with peers | 1 | 2 | 3 | 4 | 5 |
| 2. Following directions/rules | 1 | 2 | 3 | 4 | 5 |
| 3. Disrupting class | 1 | 2 | 3 | 4 | 5 |
| 4. Assignment completion | 1 | 2 | 3 | 4 | 5 |
| 5. Organizational skills | 1 | 2 | 3 | 4 | 5 |

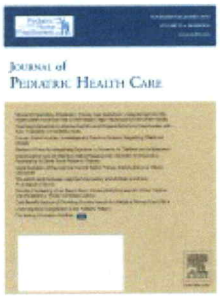
2

APPENDIX E

# JOURNAL OF PEDIATRIC HEALTH CARE

Official Publication of the National Association of Pediatric Nurse Practitioners

**AUTHOR INFORMATION PACK**



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**ISSN:** 0891-5245

## DESCRIPTION

The *Journal of Pediatric Health Care*, the official journal of the National Association of Pediatric Nurse Practitioners, provides scholarly clinical information and research regarding primary, acute and specialty **health care** for **children** of **newborn age** through **young adulthood** within a familycentered context. The *Journal* disseminates multidisciplinary perspectives on evidence-based practice and emerging policy, advocacy and educational issues that are of importance to all healthcare professionals caring for children and their families. For information regarding the submission process, please visit: http://www.jpedhc.org/content/authorinfo.

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## EDITORIAL BOARD

# GUIDE FOR AUTHORS

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All correspondence once the manuscript is submitted, including the Editor's decision and request for revision, will be by e-mail.

## PREPARATION

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Manuscripts (text, excluding references and tables) should not exceed 5000 words. Department submissions have varied word counts (see Department Manuscript Preparation below). If abbreviations cannot be avoided, use the expanded form when first mentioned and abbreviate thereafter. Use generic drug and equipment names (trade names may be listed in parentheses at the point of first mention). If it is necessary to mention a trade name for equipment, the name must be followed immediately by the manufacturer s name and city/state. Pagination should begin with the title page as page 1 and continue through the entire manuscript. To each page, add Line Numbers, a function of Microsoft Word, prior to submitting.

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**Key Words.** On the title page, provide 3 to 6 key words, using American spelling and avoiding general and plural terms and multiple concepts (avoid, for example, 'and', 'of'). These key words will be used for indexing purposes.

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Introduction: State the purpose or objective of the study, including the major hypothesis tested, if any.

Method: Describe the study design, the setting, sample, and measures used to collect data.

Results: Describe the major outcomes and statistical significance, if appropriate.

Discussion: State the significance of the results.

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## *DEPARTMENT MANUSCRIPT PREPARATION*

Department features are published in varying frequency. Queries regarding department submissions can be sent to the corresponding or department editor listed. Suggested words counts for manuscript length are listed in the department descriptions. Authors should follow the instructions for full length articles.

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**Acute & Specialty Care Case Report.** This Department features case presentations reflecting either acute or specialty care. The anonymity of patients presented should be maintained and permission obtained from the patient and or family if the patient is not de-identified. IRB approval for the presentation of case reports may be required and is the author's responsibility. Any author interested in sending a query should contact the corresponding editor at Maureen_madden@hotmail.com. See the suggested template for case report preparation. The suggested word count is 3000.

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**Research Methods.** This feature provides general research information to assist in the implementation, dissemination, and evaluation of research-based care by PNPs and usually addresses a research methodology issue. Send queries to the corresponding editor at rspartling@gsu.edu. The suggested word count is 2000 words.

## *CONTINUING EDUCATION MANUSCRIPT PREPARATION*

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Manuscripts submitted may offer varying amounts of CE credit. To be considered for CE, a manuscript must include:

1. Demonstration of the prospective author's expertise in the subject matter through experience,education, or both.

2. List 3-5 objectives, using action verbs that require readers to demonstrate their understandingof the topic (e.g., Explain the pathophysiology of...Recommend an appropriate approach...Discuss important considerations...)

3. A researched, referenced manuscript of approximately 6000 words (including objectives, tables,and posttest questions/answers). The text must provide current, advanced, testable information on clinical or professional topics.

4. Ten multiple-choice questions with 4 responses each or true/false items with the correct answersindicated. (See "Tips for Writing Test Questions.") Multiple choice questions with the correct answer of "all of the above" are not acceptable.

5. A curriculum vitae for each author should be sent to lnelsen@napnap.org upon acceptance.

6. A faculty declaration form for NAPNAP must be completed by all authors. This form can be accessedat http://www.jpedhc.org. Completed forms should be returned to lnelsen@napnap.org.

***Tips for Writing Test Questions***

Questions should measure mastery of objectives and article content. Ideally, the majority of questions should be designed for the reader to apply knowledge learned from reading the article as opposed to simple recall of information.

1. Be sure the order of questions matches the sequence of information in the article. For example,question #1 should correspond to the information that appears in the article first.

2. After you have finished writing the test, be certain that the test includes questions that relate toeach objective.

3. Make questions multiple choice or true/false with possible options labeled "a," "b," "c," "d" formultiple choice and "a" or "b" for true or false.

4. Be certain that the 3 incorrect options are not plausible.

5. Use the same terminology in the test as in the narrative. (For example, if the narrative refers onlyto "hypertension," use "hypertension," not "high blood pressure," in the test.)

6. Make sure the correct option is derived directly from the narrative and clearly defensible as thebest answer.

7. Avoid using words in the correct option that are also found in the stem (the first part of thequestion). Doing so provides "clues" to the correct answer.

8. Make sure that the options are not mutually exclusive. For example, if option "a" reads, "Slows theheart rate," and option "b" reads, "Increases the heart rate," these 2 options are mutually exclusive. The test taker can be reasonably certain that "c" and "d" are extraneous, and that either "a" or "b" is the correct answer.

9. Be sure that 1 or more of the options are not included in another option. For example, if option"a" reads, "Affects the heart rate," and option "b" reads, "Slows the heart rate," option "b" is actually included in option "a." Thus, if "b" is a correct response, "a" is also.

10. Include an answer key. The editor reserves the right to edit questions submitted for purposes ofclarity and accuracy. The editors acknowledge the challenge of constructing a posttest that is accurate and clear.

11. Posttest questions and answers should be submitted as a separate submission on EVISE.

**Continuing Education Approval Procedure**

1. The number of contact hours is assigned by the Education department of NAPNAP.

2. One member of the CE Committee not associated with the *JPHC*, who matches the profile of the average *JPHC* reader, is asked to review the article. An average of the time it takes them to read the article and complete the posttest will determine the number of contact hour(s) assigned. One contact hour equals 60 minutes.

3. CE Articles are approved for 1 year. At the discretion of the Education department, the approvaltime may be shortened depending on the stability of the article content.

For more information regarding development of learning objectives and posttest questions, please contact Laura Nelsen at lnelsen@napnap.org.

## *Peer review*

This journal operates a double blind review process. All contributions will be initially assessed by the editor for suitability for the journal. Papers deemed suitable are then typically sent to a minimum of two independent expert reviewers to assess the scientific quality of the paper. The Editor is responsible for the final decision regarding acceptance or rejection of articles. The Editor's decision is final. More information on types of peer review.

## *Double-blind review*

This journal uses double-blind review, which means the identities of the authors are concealed from the reviewers, and vice versa. More information is available on our website. To facilitate this, please include the following separately:
*Title page (with author details):* This should include the title, authors' names, affiliations, acknowledgements and any Declaration of Interest statement, and a complete address for the corresponding author including an e-mail address.
*Blinded manuscript (no author details):* The main body of the paper (including the references, figures, tables and any acknowledgements) should not include any identifying information, such as the authors' names or affiliations.

*Use of word processing software*
It is important that the file be saved in the native format of the word processor used. The text should be in single-column format. Keep the layout of the text as simple as possible. Most formatting codes will be removed and replaced on processing the article. In particular, do not use the word processor's options to justify text or to hyphenate words. However, do use bold face, italics, subscripts, superscripts etc. When preparing tables, if you are using a table grid, use only one grid for each individual table and not a grid for each row. If no grid is used, use tabs, not spaces, to align columns. The electronic text should be prepared in a way very similar to that of conventional manuscripts (see also the Guide to Publishing with Elsevier). Note that source files of figures, tables and text graphics will be required whether or not you embed your figures in the text. See also the section on Electronic artwork.
To avoid unnecessary errors you are strongly advised to use the 'spell-check' and 'grammar-check' functions of your word processor.

*Highlights*

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*Units*

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Illustrations should be numbered in the order of their mention in the text. Please refer to the Author Artwork Instructions link at the Journal's online submission system (http://www.evise.com/evise/faces/pages/navigation/NavController.jspx?JRNL_ACR=JPHC) for additional information about artwork.

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## TABLES

Each table should be submitted as a separate file. Please ensure each table file is an editable Word document. They should be numbered according to their mention in the text. A concise title describing the table's content should be supplied for each table. All footnotes should appear immediately below the table, and all abbreviations not used in the text should be defined in a footnote. If a table or any data therein have been previously published, a footnote must give full credit to the original source with permission obtained. Please send the permission and direct any questions to c.conway@elsevier.com.

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Please ensure that every reference cited in the text is also present in the reference list (and vice versa). Any references cited in the abstract must be given in full. If these references are included in the reference list they should follow the standard reference style of the journal and should include a substitution of the publication date with either 'Unpublished results' or 'Personal communication'. Citation of a reference as 'in press' implies that the item has been accepted for publication.

*Reference links*

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As a minimum, the full URL should be given. Any further information, if known (DOI, author names, dates, reference to a source publication, etc.), should also be given. Web references can be listed separately (e.g., after the reference list) under a different heading if desired, or can be included in the reference list.

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Mettam, G. R., & Adams, L. B. (2009). How to prepare an electronic version of your article. In B. S. Jones, & R. Z. Smith (Eds.), *Introduction to the electronic age* (pp. 281–304). New York: E-Publishing Inc.
Reference to a dataset:
[dataset] Oguro, M., Imahiro, S., Saito, S., & Nakashizuka, T. (2015). *Mortality data for Japanese oak wilt disease and surrounding forest composition* [Mendeley Data, v1]. Retrieved from https://doi.org/10.17632/xwj98nb39r.1

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**Ensure that the following items are present:**

One author has been designated as the corresponding author with contact details:

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- Phone numbers

All necessary files have been uploaded, and contain:

- Keywords
- All figure captions
- All tables (including title, description, footnotes) in separate, editable Word filesFurther considerations

- Manuscript has been 'spell-checked' and 'grammar-checked'
- References are in the correct format for this journal
- All references mentioned in the Reference list are cited in the text, and vice versa
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APPENDIX F

THE UNIVERSITY OF
ALABAMA IN HUNTSVILLE

| |
|---|
| ☒ Expedited (see pg 2) |
| ☐ Exempted (see pg 3) |
| ☐ Full Review |
| ☐ Extension of Approval |

March 15th 2019

Tracie Clark Morgan
Department of Nursing
University of Alabama in Huntsville

Dear Mrs. Morgan,

The UAH Institutional Review Board of Human Subjects Committee has reviewed your proposal, *Implementation of a Behavioral Parent Training Program Evaluation Proposal,* and found it meets the necessary criteria for approval. Your proposal seems to be in compliance with this institutions Federal Wide Assurance (FWA) 00019998 and the DHHS Regulations for the Protection of Human Subjects (45 CFR 46).

Please note that this approval is good for one year from the date on this letter. If data collection continues past this period, you are responsible for processing a renewal application a minimum of 60 days prior to the expiration date.

No changes are to be made to the approved protocol without prior review and approval from the UAH IRB. All changes (e.g. a change in procedure, number of subjects, personnel, study locations, new recruitment materials, study instruments, etc) must be prospectively reviewed and approved by the IRB before they are implemented. You should report any unanticipated problems involving risks to the participants or others to the IRB Chair.

If you have any questions regarding the IRB's decision, please contact me.

Sincerely,

Bruce Stallsmith
IRB Chair
Professor, Biological Sciences

## Expedited:

☐ Clinical studies of drugs and medical devices only when condition (a) or (b) is met. (a) Research on drugs for which an investigational new drug application (21 CFR Part 312) is not required. (Note: Research on marketed drugs that significantly increases the risks or decreases the acceptability of the risks associated with the use of the product is not eligible for expedited review. (b) Research on medical devices for which (i) an investigational device exemption application (21 CFR Part 812) is not required; or (ii) the medical device is cleared/approved for marketing and the medical device is being used in accordance with its cleared/approved labeling.

☐ Collection of blood samples by finger stick, heel stick, ear stick, or venipuncture as follows: (a) from healthy, nonpregnant adults who weigh at least 110 pounds. For these subjects, the amounts drawn may not exceed 550 ml in an 8 week period and collection may not occur more frequently than 2 times per week; or (b) from other adults and children, considering the age, weight, and health of the subjects, the collection procedure, the amount of blood to be collected, and the frequency with which it will be collected. For these subjects, the amount drawn may not exceed the lesser of 50 ml or 3 ml per kg in an 8 week period and collection may not occur more frequently than 2 times per week.

☐ Prospective collection of biological specimens for research purposes by noninvasive means. Examples: (a) hair and nail clippings in a nondisfiguring manner; (b) deciduous teeth at time of exfoliation or if routine patient care indicates a need for extraction; (c) permanent teeth if routine patient care indicates a need for extraction; (d) excreta and external secretions (including sweat); (e) uncannulated saliva collected either in an unstimulated fashion or stimulated by chewing gumbase or wax or by applying a dilute citric solution to the tongue; (f) placenta removed at delivery; (g) amniotic fluid obtained at the time of rupture of the membrane prior to or during labor; (h) supra- and subgingival dental plaque and calculus, provided the collection procedure is not more invasive than routine prophylactic scaling of the teeth and the process is accomplished in accordance with accepted prophylactic techniques; (i) mucosal and skin cells collected by buccal scraping or swab, skin swab, or mouth washings; (j) sputum collected after saline mist nebulization.

☐ Collection of data through noninvasive procedures (not involving general anesthesia or sedation) routinely employed in clinical practice, excluding procedures involving x-rays or microwaves. Where medical devices are employed, they must be cleared/approved for marketing. (Studies intended to evaluate the safety and effectiveness of the medical device are not generally eligible for expedited review, including studies of cleared medical devices for new indications).

☐ Research involving materials (data, documents, records, or specimens) that have been collected, or will be collected solely for nonresearch purposes (such as medical treatment or diagnosis).

☐ Collection of data from voice, video, digital, or image recordings made for research purposes.

☒ Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

## Exempt

☐ Research conducted in established or commonly accepted educational settings, involving normal educational practices, such as (a) research on regular and special education instructional strategies, or (b) research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods. The research is not FDA regulated and does not involve prisoners as participants.

☐ Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interviews, or observation of public behavior [1] in which information is obtained in a manner that human subjects cannot be identified directly or through identifiers linked to the subjects and any disclosure of the human subject's responses outside the research would NOT place the subjects at risk of criminal or civil liability or be damaging to the subject's financial standing, employability, or reputation. The research is not FDA regulated and does not involve prisoners as participants.

☐ Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement) survey procedures, interview procedures, or observation of public behavior if (a) the human subjects are elected or appointed public officials or candidates for public office, or (b) Federal statute(s) require(s) without exception that the confidentiality of the personally identifiable information will be maintained throughout the research and thereafter. The research is not FDA regulated and does not involve prisoners as participants.

☐ Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects. The research is not FDA regulated and does not involve prisoners as participants.

☐ Research and demonstration projects which are conducted by or subject to the approval of department or agency heads, and which are designed to study, evaluate, or otherwise examine: (i) public benefit or service programs; (ii) procedures for obtaining benefits or services under those programs;(iii) possible changes in or alternatives to those programs or procedures; or (iv) possible changes in methods or levels of payment for benefits or services under those programs. The protocol will be conducted pursuant to specific federal statutory authority; has no statutory requirement for IRB review; does not involve significant physical invasions or intrusions upon the privacy interests of the participant; has authorization or concurrent by the funding agency and does not involve prisoners as participants.

☐ Taste and food quality evaluation and consumer acceptance studies, (i) if wholesome foods without additives are consumed or (ii) if a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural chemical or environmental contaminant at or below the level found to be safe, by the Food and Drug Administration or approved by the Environmental Protection Agency or the Food Safety and Inspection Service of the U.S. Department of Agriculture. The research does not involve prisoners as participants.

[1] Surveys, interviews, or observation of public behavior involving children cannot be exempt.

## APPENDIX G

### Consent Form: Implementation of a Behavioral Parent Training Program Evaluation

You are invited to participate in a research study about Behavioral Parent Training. This study is designed to help us to better understand the efficacy of Behavioral Parent Training in the Treatment of ADHD.

The primary investigator (PI) is Tracie Clark Morgan, MSN, CRNP from The University of Alabama in Huntsville. This research project is being conducted by the PI for a doctoral program.

PROCEDURE TO BE FOLLOWED IN THE STUDY: Participation in this study is completely voluntary. Once written consent is given; you will be asked to participate in a behavioral parent-training (BPT) program. This program will consist of weekly 1-hour sessions for 8 weeks. You will be asked to complete the Parenting Scale (PS) prior to the initial BPT session and again at the completion of the final BPT session. This PS takes approximately 10 minutes to complete. The parenting scale will be completed immediately prior to the initial BPT program and immediately following the last session of BPT. As a part of your child's initial ADHD evaluation the VADPRS and VADTRS will be completed and uploaded into their medical record. These rating scales are used in diagnosis of ADHD and rate the child's frequency and severity of ADHD problem behaviors. They are also used routinely at follow up to evaluate treatment efficacy. The PI will review these scales from initial evaluation and compare the results to the VADPRS & VADTRS immediately following the completion of the BPT program to help determine BPT treatment efficacy in managing ADHD problem behaviors in both home and academic settings. Patient/parent demographic information will also be accessed through the EMR: child's age, gender, and type of insurance, parent's age, and education level.

DISCOMFORTS AND RISKS FROM PARTICIPATING IN THIS STUDY: Potential risks include emotional response to BPT intervention, lack of response to BPT intervention, loss of financial resources due to travel time and time spent during BPT program. All of the preceding are common risks associated with enrollment in a BPT program. If any subject is identified with emotional risks while participating in BPT, qualified personnel, either a nurse practitioner or physician will be available to talk with the participant.

EXPECTED BENEFITS: Results from his study can benefit you, your child and society by improving parent child interactions, decreasing family stress, and improving the frequency ADHD problem behaviors.

INCENTIVES AND COMPENSATION FOR PARTICIPATION: Childcare will be provided during BPT sessions. Snacks will be provided. VISA gift cards in the amount of $20 will be distributed for participants who complete all 8 1-hour sessions.

CONFIDENTIALITY OF RESULTS: Participant numbers will be used to record your data, and these numbers will be made available only to those researchers directly involved with this study, thereby ensuring strict confidentiality. This consent form will be destroyed after 3 years. The data from your session will only be released to those individuals who are directly involved in the research and only using your participant number.

FREEDOM TO WITHDRAW: You are free to withdraw from the study at any time. You will not be penalized because of withdrawal in any form. Investigators reserve the right to remove any participant from the session without regard to the participant's consent.

CONTACT INFORMATION: If you have any questions, please ask them now. If you have questions later on, you may contact the Principal Investigator Tracie Clark Morgan, in HAPPI Behavioral Health, at 256-527-1429 or at tracie.morgan@uah.edu or the faculty supervisor Dr. Louise O'Keefe, in Nursing Building 411 A, at 256-824-2445 or at Louise.Okeefe@uah.edu]. If you have questions about your rights as a research participant, or concerns or complaints about the research, you may contact the Office of the IRB (IRB) at 256.824.6992 or email the IRB chair Dr. Bruce Stallsmith at irb.@uah.edu.

If you agree to participate in our research please sign and date below.

This study was approved by the Institutional Review Board at UAH and will expire in one year from <March 15,2019>.

_____ _____

Name (Please Print) Signature Date

_____

Parent/Guardian Signature

APPENDIX H

## Permissions email correspondence from Dr. Susan O'Leary

Susan O'Leary

Attachments

Jan 16, 2019, 9:24 AM (9 days ago)

to me

You have my permission and attached is some relevant information.

Susan

Susan G. O'Leary, PhD

Emeritus Professor

Psychology Department

Stony Brook University

susan.oleary@stonybrook.edu

**On Wed, Jan 16, 2019 at 8:53 AM Tracie Morgan <tdm0010@uah.edu> wrote:**

My name is Tracie Morgan. I am a Doctorate of Nursing Practice (DNP) student at the University of Alabama in Huntsville. My DNP project focuses on the efficacy of Behavioral Parent Training (BPT) in the treatment and management of Attention Deficit Hyperactivity Disorder (ADHD). For my project, I wanted to use the Parenting Scale I would like to request your permission to utilize this tool to survey parents of participants in my DNP project., Thank you for your consideration.

Sincerely,

Tracie Clark Morgan, MSN, CRNP

Clinical Instructor

College of Nursing

University of Alabama in Huntsville

tracie.morgan@uah.edu

(o)256-824-6141

(c)256-527-1429

APPENDIX I

**NICHQ VADPRS & VADTRS Permissions:**

NICHQ Communications communications@nichq.org via nichq.onmicrosoft.com

Thu, Jan 17, 6:22 AM (8 days ago)

to Tracie, NICHQ

Hi Tracie,

Any tools currently on our site are free to the public. Please reference the National Institute for Children's Health Quality in your work and include a link the web hosting page.

Best,

Caitlin

From: Tracie Morgan <tdm0010@uah.edu>

Sent: Wednesday, January 16, 2019 7:15 PM

To: NICHQ Communications <communications@nichq.org>

Subject: VADPRS & VADTRS

Good evening. My name is Tracie Morgan. I am a Doctorate of Nursing Practice (DNP) student at the University of Alabama in Huntsville. My DNP project focuses on the efficacy of Behavioral Parent Training (BPT) in the treatment and management of Attention Deficit Hyperactivity Disorder (ADHD). For my project, I wanted to include the use of the VADPRS and the VADTRS to assess efficacy of BPT in reducing the problem behaviors of ADHD. I emailed Dr. Wolraich at mark-wolraich@ouhsc.edu to request permission to utilize these tools to survey teachers and parents of participants in my DNP project, but I have not received a response. I was wondering if you could help me obtain permissions or verify that these instruments are public domain? Thank you for your time and consideration.

Sincerely,

Tracie Clark Morgan, MSN, CRNP