Philadelphia Inclusion Network

Promoting the inclusion of infants and young children with disabilities in child care

Instructor Guidelines

ADHD / ADD

Philadelphia Inclusion Network a program of
Child and Family Studies Research Programs at
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PIN ~ Philadelphia Inclusion Network

Campbell, P.H., Milbourne, S.A., & Silverman, C. (2002). Philadelphia Inclusion Network, Participant Materials.

Campbell, P.H., Milbourne, S. (2002). Philadelphia Inclusion Network, Instructor Guidelines.

Both are available from Child and Family Studies Research Programs, TJU, OT, 130 S. 9th Street, 5th floor, Philadelphia, PA 19107, 215-503-1608. Http://jeffline.tju.edu/cfsrp

Many people have provided ideas for training activities, content, and materials and we appreciate their input, especially from Elyse Rosen, Lalita Boykin, Kathi Nash, Francine Warton, Patricia Benvenuto, and Robin Miller, teachers who support inclusive child care for families and their young children with disabilities. Mary Mikus, Jean Ann Vogelman, and other families who work for their children to be part of inclusive communities. Susan Kershman and Terry Waslow, early intervention specialists and advocates for inclusion. A special thanks to Natalie Feller and Lillian McCuen and also to the many of you who diligently and tirelessly edited the content of the materials.

April 2005

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Session Outline

Topic	Activity	Time	Cum Time
I Welcome the group Introduce yourself and talk briefly about the Philadelphia Inclusion Network (PIN). Promoting the inclusion of infants and toddlers with disabilities in child care settings is a primary purpose of PIN.		10 min.	:10
II Self Assessment & Discussion 100 Questions from Hallowell & Ratey, 1994	#1	30 min.	:40
III What are ADD and ADHD? Characteristics Diagnosis Medications Behavioral Management	#2	45 min.	1:25
Break		5 min.	1:30
IV Six Steps Method	#3	30 min.	2:00
V Resources		15 min.	2:15
VI Summing up Question & Answer		15 min.	2:30

Notes:

What you will need:

- Participant sign-in sheet
- Extra copies of the make-up assignment
- Extra copies of previous modules
- 100 Questions from Hallowell & Ratey, 1994
- NICHCY fact sheet - copies
- NICHCY Briefing Paper - copies
- Filp chart paper
- Markers

- Any additional books/resources that help parents and child care providers keep a positive perspective of the child and keep the child focused.

Session : ADHD/ADD

OVERVIEW

What this workshop should accomplish:

Attention Deficit Disorder (ADD) is officially called Attention Deficit/ Hyperactivity Disorder (AD/HD) according to the American Psychiatric Association, and is a recently identified childhood developmental disorder which, in the last five years, has been increasingly recognized as applying to adults (who were undiagnosed during their childhood years). The disorder, and its diagnosis and treatment, are widely debated. Many physicians and psychologists feel that the label is overused; others describe the disorder as being more widespread than the number of children identified. The diagnostic process used to identify ADHD will be discussed as well as medical and intervention strategies.

The causes of ADHD are not clearly known; however, the disorder is thought to have a genetic basis which effects the ways in which the brain functions to regulate behavior. Children with hyperactivity are more likely to be identified earlier, in the preschool years, than are children whose major characteristic is inattentiveness. Strategies that are helpful when working with children with ADHD and their families will be addresses.

Notes:

From this session, participants should gain understanding about:

- Identify the characteristics, diagnosis, medical and behavioral treatment of ADD and ADHD.
- Describe the parent's perspective and how that may differ from the professional view
- Identify differences in the perspectives of various "authorities" on the topic
- Identify some tools for classroom and home use
- List useful books for reference

Notes:

BACKGROUND

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Some children seem very active, running and climbing, and preferring active play. Children like this are often described as "on the go" or "fidgety" or "noisy." Other children seem to have difficulty attending or following directions; they may lose things or seem like they are not listening. These children may be described as "easily distracted" or "not paying attention." In either case, judgments such as these are made in terms of adult expectations of children's behavior -- judgments that are likely to be influenced by a number of factors including adults' knowledge of child development, cultural expectations of children's behavior, especially in terms of the age of the child, and toleration for variations in behavior. Many parents, for example, may be challenged by their children's active or inattentive behavior but may accommodate to these unique characteristics when children are preschool aged. When children reach school, these unique behavior patterns may not be compatible with teaching and learning expectations and may be less easily accommodated in the school environment.

Attention Deficit Disorder (ADD) is officially called Attention Deficit/ Hyperactivity Disorder (AD/HD) according to the American Psychiatric Association, and is a recently identified childhood developmental disorder which, in the last five years, has been increasingly recognized as applying to adults (who were undiagnosed during their childhood years). The disorder, and its diagnosis and treatment, are widely debated. Many physicians and psychologists feel that the label is overused; others describe the disorder as being more widespread than the number of children identified. A majority of the children diagnosed as having ADHD are identified in the early school years. Almost four times as many boys are diagnosed with ADHD as are girls. Children with hyperactivity are more likely to be identified earlier, in the preschool years, than are children whose major characteristic is inattentiveness. The diagnosis has four primary characteristics: (1) impulsivity; (2) distractibility; (3) short attention span;

and (4) hyperactivity. These characteristics must be present in varying degrees for a diagnosis to be made. ADHD may exist as a disorder by itself or may be seen in combination with other diagnostic labels. Learning disabilities is a primary diagnosis, for example, where children may also have characteristics of ADHD.

The causes of ADHD are not clearly known; however, the disorder is thought to have a genetic basis which effects the ways in which the brain functions to regulate behavior. Ongoing research seems to indicate that the problems may lie with the neurotransmitters that promote communication between the frontal lobes of the brain and other brain centers. Various other conditions, however, also seem to predispose a child to developing ADHD including brain infections, prenatal exposure to substances such as lead, alcohol, or drugs, or low birth weight.

Diagnostic Categories & Medical Interventions

There are three subclassifications of ADHD which are important medically because treatment varies dependent on the subclassification. ADHD -- inattentive type classifies children whose symptoms primarily involve inattention (see handout). ADHD--hyperactive type includes children whose primary symptoms involve hyperactivity or impulsivity. Children must demonstrate six of the nine criteria included in each of these subclassifications in order for a diagnosis to be made. When children have six out of nine criteria, but these come from both the inattention and distractibility/impulsivity categories, the subclassification used is ADHD -- combined. The primary medical interventions recommended are: (a) educational interventions such as behavior management; (b) counseling; and (c) medication.

Medicating children with ADHD has been controversial. The American Academy of Pediatrics (1996) has recommended that drugs may be used ***in addition to*** educational and behavioral strategies. The primary drugs used are stimulants (e.g., Ritalin, Dexedrine, and Cylert) and, as with all

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drugs, both benefits and side effects are possible. Stimulant drugs reduce hyperactivity and impulsivity and increase attention span; however the effects of drugs on learning and academic performance are mixed. Some children on Ritalin, for example, seem to improve in academic performance while others do not. When children do not show positive responses in terms of increased attention or reduced hyperactivity, other drugs may be tried. These include antidepressants (e.g. Clonidine) and, if these are unsuccessful, sometimes drugs such as Mellaril (an antipsychotic) or Tegretol (an anticonvulsant) are prescribed.

Recent estimates indicate that approximately 1% to 3% of ***all*** children in the U.S. receive stimulant medication for ADHD (Blum & Mercugliano, 1997). Also the Professional Group for Attention and Related Disorders states between 3% to 5% of school aged children are affected by AD/HD. Recent articles in the popular press (e.g., newspapers, magazines) question whether or not there is an increase in drug prescriptions related to two primary factors: (a) overall family stress levels and a corresponding inability to handle active or impulsive children or the "extra" interventions, like counseling, that may be required; and (b) managed care payment systems in combination with the relative efficiency of drugs (as opposed to longer-term interventions such as counseling).

The primary side effects of stimulant medication are mild. Loss of appetite is a primary side effect. Some children may complain of headaches or stomach aches or may be unable to sleep. With some children, medication is given only during school times and not on weekends or during the summer. This decision is made on an individual (child-by-child) basis considering factors such as a child's growth rate, impact of medication on social and peer relationships, and activities that a child may be doing during off-school hours (such as homework or attending a summer academic program).

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Six Steps to Accommodating the Needs of Children who are Active, Impulsive, or Inattentive

Many of the characteristics of children with ADHD are the same behaviors that may be demonstrated by typical young children. Hyperactivity, impulsivity, or distractibility must be a child's predominant behavior -- not just an occasional behavior that a child exhibits under some circumstances or in some situations.

1. Frame a Child's Behavior Positively

Physicians and others who work with children with impulsivity or hyperactivity (or both) suggest using a checklist (see handouts for one example) to understand a child's strengths and to help in framing a positive attitude toward children (who can be quite challenging to adults). ADHD consists of many negative labels that may get attached to children. After a while, a child may "live up" to those expectations (or labels). Having a positive attitude about children with ADHD helps them to develop positive self-esteem and attitudes about themselves. "He is interested in everything" is a more positive framework than "He is always distracted or he can't pay attention to anything!!"

2. Understand the Inter-relationships Among Temperament, Need for Dependence, and Need for Independence

Infants, toddlers, and preschoolers are learning to balance innate or inborn characteristics of temperament and the needs for both dependence and independence. Young children acquire a balance or an interdependence among these factors through "messages" that are provided by the people and circumstances in the world outside them. Positive and consistent messages are important in helping young children develop this balance. Whatever the adults in a child's life say or do sends a message to the child. Sometimes these messages conflict, leaving a child to resolve these conflicting messages in some way. Children who are hyperactive or

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impulsive are likely to rely on these types of behavior when messages conflict.

3. Conduct a Classroom Inventory

The environment of the classroom or child care setting -- your behavior and the behavior of children in the room -- can set up circumstances that range from positive and supportive to highly stressful. Few children do well in stressful environments but children who are impulsive or hyperactive may do particularly poorly. The checklist in the handouts (modified from a checklist designed by Sears & Thompson, 1998) can help you design a supportive environment.

4. Structure for Success

Organizing the environment and structuring the day to fit a child's abilities are strategies to assist an impulsive or hyperactive child to develop positive behaviors. It is easier to make changes in the daily schedule and in the environment than it is to try to get a child to cope successfully with a high number of stressful situations. The physical environment should be predictable and not overly distracting. For example, keep toys in the same location or use a reading area or a listening center to promote quietness.

Adapt/Select Activities: The classroom schedule should also be predictable and organized around the child. If you know, for example, that the child gets overactive and "set off" during gross motor times, schedule these for later in the day. Mix the activities that the child likes and does well at between activities that challenge a child. If you know that a child does better first thing in the morning, schedule activities that are challenging during those times. For example, infrequent activities such as field trips may be better in the early morning than later in the afternoon. Prepare a child for things that will happen where behavior expectations may be unfamiliar or unpredictable. Talk to the child(ren) about the trip to the firehouse that they will be taking that morning and discuss what is

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acceptable and not acceptable, keeping "the rules" short.

It should go without saying that any child who is bored may become challenging -- especially when they are making choices about what to do when they are bored. A bored child and busy adults are a mismatch. Try to figure out that a child is getting bored and offer interesting activities that will sustain a child's attention before a child figures out something on his or her own.

Adapt/Select Materials: There are many opportunities for choices in child care and education programs. If a teacher knows that a child has a tendency to throw toys, put these toys away (don't allow them to be choices) during play sessions. "Timing out" toys is a strategy that can be used when things get out of control. Rather than punishing the child for throwing, for example, give the toys "time out" on a high shelf. Various strategies may also be used to promote positive choices of toys or activities. If all the children are going to choose something with which to play, allow an impulsive child to choose, also, but to make choices from a limited range.

Adapt Requirements: Keep activities short for a child with a short attention span -- lengthening first those activities that a child does well with and keeping those that are difficult for shorter periods of time. Learning centers can help promote flexibility for a child who is impulsive or has a short attention span. Other children may spend longer periods of time in centers while you can help the child with ADHD move on to another center when their attention is diminishing.

Use Peer Assistance: Some children's personalities bring out the worst in children who are impulsive. Where possible, try to structure children's interactions so that children play or work with those children with whom they do best or increase adult supervision and interaction to promote positive

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social interactions when personalities "clash." For example, a teacher may do an activity with two children together so that positive social interactions may be modeled. This helps to build children's self-esteem and teaches positive social development. Peers who are quiet and focused often model positive behavior expectations for children who are active or distractible. Pairing children together can allow natural "modeling" to occur where the less impulsive child can model the expected behavior for the child with ADHD.

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5. Develop Positive Ways to Shape the Child's Behavior

Children who are active, impulsive, or distractible challenge adults significantly, especially when children are grouped together in situations such as child care or preschool education settings. Their behavior may impact negatively on other children and they may develop self-perceptions of being "bad", "never listening", or other negative characteristics which may begin a cycle where this type of behavior becomes both the pattern of the child and the expectation of adults. The best ways of shaping behavior are positive -- compliments, rewards, positive reminders, or more formal strategies such as charts or visual cues. Sometimes adults feel as though they are acknowledging something that a child should be able to do without attention but children with ADHD don't always have positive perceptions of themselves. By being very positive and using frequent positive messages, a child learns that he or she is liked, that they can be successful, and that what they are doing is making the people around them happy.

Catch the Child Being Good: Observe children carefully so that you can catch them and reward them when they are being good -- doing what is expected. You can then reinforce a child verbally ("I really like how you painted that bear!! John is really enjoying playing with you. You seem to be having a good time with those trucks") or with a tangible reward like a sticker or point ("I am giving you this special sticker because you helped Joshua put on his coat"). Rewarding a child frequently will help them develop awareness of what is expected and will help them learn to repeat this

behavior. Children with ADHD (and many younger children) don't get the message when it has been sent only one time, inconsistently, or infrequently so it is important to almost "overuse" this strategy for it to be repeated enough times for a child to get the "message" and the connection between what they are doing and what is expected.

Use Rewards: For younger children, rewards such as stickers or something tangible are easier for them to understand cognitively than something symbolic such as points. Using stickers or sticker charts for all children in a classroom can work (even though other children may not really "need" this strategy). A sticker chart (for example, a paper with blocks on the paper where the stickers are placed) can be used to allow a child to earn a particular reward. For younger children, the rewards should be quick (not after a whole week of "good" behavior but perhaps after half the morning) and can be extended as a child understands the system and is able to wait to get the reward. Experiment to see how frequently stickers need to be given (for example, throughout the day or just one for each activity completed successfully). Allow the stickers to be turned in for something special -- you may play on the playground with Miss Mary for 10 extra minutes at lunch time, be the person to pass out the Birthday cake for Susan's birthday, -- rather than food or a toy. When stickers result in positive social consequences, the child is also learning about getting along with other people. In cooperation with families, rewards may be something that the family provides -- a special trip to a restaurant, watch a special videotape at home, etc.

Model What You Want -- Directly & Indirectly: Children with ADHD may not have fully internalized what they are expected to do sufficiently for expected behavior to become the norm (as opposed to impulsive or other types of behavior). You can model indirectly by reinforcing -- drawing attention -- to the behavior of another child who is doing what is expected ("Look how nicely Steven is picking up his toys now that it is time for art. I like what a good helper Steven is being." or "Steven,

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I'm giving you an extra sticker because you are being such a good helper in picking up"). You may also enlist the assistance of that (or another) child to help the child who is having difficulty ("Steven you are being such a good helper. See if you can you help John so that he'll be ready for art, too"). A third strategy is more direct and involves an adult working with the child to do the task together. The teacher can, in this instance, help John, modeling for John what is expected ("Lets put the toys away together so that you can be ready for art") and using the opportunity to catch the child doing the right things ("When we work together and you put the trucks all on the bottom shelf, we get done much faster. I like that since I know you want to do art").

Provide Reminders, Cues, and Assists: Many children with ADHD have difficulty with organizing and may loose track of what comes next or what they are doing. Using a chart that shows in picture form (for young children) what is happening that day can help them to learn and follow routines. After each activity, they can cover up the picture or mark it out so that they know what is going to occur next and where they are in the day's routine. Or, this can be a chart on the blackboard, used for the whole class. Charts also help children to follow-through on responsibility and learn good habits without constant nagging.

Verbal preparation can be useful, also. Verbal preparation such as: "Now we are going to go outside and when we come in, it will be time for nap." "Tomorrow is the day we are going to visit the fire station." "Today is the day we have swimming. We will go swimming this morning after we have finished circle. What happens when we go swimming?" -- Children can then discuss/review what will occur (they will put on their coats, get on the bus, etc).. These types of strategies make routine changes less unpredictable for a child with ADHD.

Time-In: Time-out is a strategy that is too widely used in preschool settings as a way of controlling children's behavior. Many children with ADHD do not respond favorably to time-out. However, children often do not like to be

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doing nothing or having to sit quietly for a time period. Designating a chair within the room and where the other children are as the "time-in" chair allows a child to be quiet and seated without being removed from the group, room, etc. Time-in periods should be kept short for young children with ADHD (5 minutes or under). The child should be told why s/he needs to sit in the time-in chair ("I think you need to sit in the time in chair so that you can stop taking toys away from Anna"). Using time-in should be a last resort --- not a first strategy. Using positive reinforcement and rewards, modeling what the child needs to do, and providing cues are more powerful ways of changing behavior than time-in.

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6. Keep Track of Progress

Children with ADHD can be challenging -- particularly in groups of other children. Keeping track of a child's progress in a formal way can help teachers realize the extent to which a child is making progress and can also remind teachers of the importance of consistency in helping children learn skills and develop socially.

Identify about 3 or 4 things that you would like a child to do ("I want Anthony to sit through 15 minutes of opening circle." "I would like Anthony to play next to another child (like Monica) without disrupting the other child." "I want Anthony to come into the classroom and hang his coat up before throwing it on the floor"). Make your own "report card" where each day you mark off whether or not the child performed the desired goal during that day. Think about the strategies you have been using to help the child learn the desired behavior -- positive acknowledgment, stickers, other rewards, etc. Or combine this chart with the chart illustrated in the handouts and give the child a sticker to draw a star or use some other indication to also reward the child for having performed the desired behavior. Make sure to write what you want the child TO DO (not what you want the child not to do).

Periodically redo the Classroom Functioning Chart to see whether the overall environment of the classroom is becoming more positive. The more

positive the environment, the less stressful the child's behavior will be and the more effective the "climate" will be in setting expectations for what is expected not only from the child with ADHD but for all children in the room.

Summary

Children with ADHD can be very challenging for families and child care providers who care for these children on a day to day basis. It is important to remember that ADHD is in all probability a genetic disorder -- one over which a child needs to gain control. Children are not purposefully hyperactive, inattentive, or impulsive; rather these behaviors may be ways in which a child copes with the environment. For this reason, the nature and characteristics of a child's physical and social environment are critical and are the first steps that child care providers can take to assist children. Stable, predictable, nurturing, positive, supportive environments are the ones in which children do best. These types of environments make a child feel safe and respected and reduce stress, thereby also reducing the situations in which a child needs to cope with stress. Additional strategies may be used to help a child learn to organize, pay attention, and learn appropriate social behavior.

Children with ADHD who are not well-managed are at great risk for developing a poor self-concept and low self-esteem. If children learn that adults see them as "bad", "disruptive", or "inattentive", they are likely to continue to demonstrate these behaviors. Families and child care workers must work together to ensure a positive environment for the child and to support each other in responding to children's behavior in positive ways. When adults are busy and stressed themselves, coping with children's challenging behavior in positive ways can be difficult. Being positive, nurturing, non-judgmental, and non-blaming is important if children are to develop positive self-esteem, grow socially, and make friends with other children.

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Activity #1
One Hundred Questions

Purpose: This activity simulates the "school-type" demands that we too often erroneously place on very young children: sitting still, answering lots of questions, attending to dry material for a long period of time, and so on. It also suggests that all of us have some of the characteristics of ADD; so it gives the participant a feel for what ADD is.

Activity Sequence:
Use the following to introduce the activity: "Before we discuss the formal definitions of ADD/ADHD, I would like each of you to complete this set of questions. There are 100 questions in all; I will give you 15 minutes. Try to read and answer all the questions."

1. Ask everyone to complete the questionnaire all 100 questions.
2. Allow at least 15 minutes for everyone in the group to finish all the questions.
3. After everyone has finished, ask what participants liked or didn't like about the questionnaire. If no one is willing to start the discussion, ask which were their favorite or least favorite questions and why.
4. Ask the group what this questionnaire says about ADD/ADHD.

Points of Discussion:
Embedded in the questionnaire are each of the following suggestions:

- **T** That ADD/ADHD is associated in people's minds with many negative or emotionally charged characteristics; some of them may have some basis in logical explanation; others do not. For this reason, we need to look carefully at the DSM-IV definition.
- **T** That hyperactivity may or may not accompany ADD.
- **T** That the requirement that the DSM-IV characteristics must be present in more than one setting and over more than a 6-month period are important features of the diagnosis/definitions.
- **T** Discuss the wide over-diagnosis of ADD and the recent release from the American Academy of Pediatrics, emphasizing the need for symptoms over time and in several settings to qualify for diagnosis.

Hallowell, E.M. and Ratey, J.J. (1994). Driven to Distraction. New York: Touchstone. Pages 209-214.

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Length: 30 minutes

What you will need:

- 100 Questions from Hallowell & Ratey, 1994

Activity #2
What are ADD & AD/HD?

Purpose: To develop an understanding of ADD and AD/HD and the three subclassifications.

Activity Sequence:

1. Describe ADD and AD/HD and discuss causes. Refer participants to the handout, Diagnosis Criteria for AD/HD.
2. Discuss with group what the difference is between ADD and AD/HD (use information from the Background section).
3. Refer participants to the handout Diagnostic Categories and Medical Interventions. Have group break into smaller groups and match characteristics to subclassifications (15 minutes).
4. Re-group and discuss 3 subclassifications of AD/HD and their characteristics. Talk about how some characteristics are seen in more than one sub category.
5. Ask participants to describe what they know or have been told about medical interventions. Discuss treatment for ADD/AD/HD using information from the Background section.

Notes:

Length: 30 minutes

What you will need:

Handouts:
- Diagnostic Criteria for AD/HD, participant pp. 17
- Diagnostic Categories and Medical Interventions, participant pp. 18
- Press Release: American Academy of Pediatrics Releases New Guidelines for Diagnosis of AD/HD, participant pp. 19

Break

Length: 5 minutes

Diagnostic Criteria for ADHD

Inattention

Fails to give attention to detail or makes careless mistakes

Has difficulty sustaining attention

Often does not seem to listen

Often does not follow through on instructions or fails to complete tasks

Has difficulty organizing tasks and activities

Avoids or dislikes tasks that require sustained mental effort

Often loses things

Is often easily distracted

Is often forgetful

Hyperactivity / Impulsivity

Fidgets or squirms

Leaves seat when is expected to stay in seat

Runs or climbs excessively in inappropriate situations

Has difficulty in engaging in activities quietly

Often "on the go" or "driven by a motor"

Often talks excessively

Often blurts out answers before questions have been completed

Often has difficulty waiting a turn

Often interrupts or intrudes on others

Additional Criteria Include

Present for at least 6 months

Of a degree that is maladaptive and inconsistent with developmental level

Present before age 7

Present in more than one setting

Not due to PDD or a psychotic disorder or any other mental disorder

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Taken from DSM-IV (American Psychiatric Association, 1994).

Diagnostic Categories & Medical Interventions

There are three subclassifications of AD/HD which are important medically because treatment varies dependent on the subclassification. AD/HD -- inattentive type classifies children whose symptoms primarily involve inattention (see handout). AD/HD-- hyperactive type includes children whose primary symptoms involve hyperactivity or impulsivity. Children must demonstrate six of the nine criteria included in each of these subclassifications in order for a diagnosis to be made. When children have six out of nine criteria, but these come from both the inattention and distractibility/impulsivity categories, the subclassification used is AD/HD -- combined.

The primary medical interventions recommended are: (a) educational interventions such as behavior management; (b) counseling and (c) medication.

Medicating children with AD/HD has been controversial. The American Academy of Pediatrics (1996) has recommended that drugs may be used *in addition to* educational and behavioral strategies. The primary drugs used are stimulants (e.g., Ritalin, Dexedrine, and Cylert) and, as with all drugs, both benefits and side effects are possible. Stimulant drugs reduce hyperactivity and impulsivity and increase attention span; however, the effects of drugs on learning and academic performance are mixed. Some children on Ritalin, for example, seem to improve in academic performance while others do not. When children do not show positive responses in terms of increased attention or reduced hyperactivity, other drugs may be tried. These include antidepressants and if these are unsuccessful, sometimes drugs such as Mellaril (an antipsychotic) or Tegretol (an anticonvulsant) are prescribed.

The primary side effects of stimulant medication are mild. Loss of appetite is a primary side effect. Some children may complain of headaches or stomach aches or may be unable to sleep. With some children, medication is given only during school times and not on weekends or during the summer. This decision is made on an individual (child-by-child) basis considering factors such as a child's growth rate, impact of medication on social and peer relationships, and activities that a child may be doing during off-school hours (such as homework or attending a summer academic program).

Press Release

American Academy of Pediatrics
RELEASES NEW GUIDELINES FOR DIAGNOSIS OF AD/HD

Below is a news release of a policy published in the May issue of Pediatrics, the peer-reviewed scientific journal of the American Academy of Pediatrics (AAP).

For Release: May 1, 2000, 5:00 p.m. (ET)

CHICAGO - The American Academy of Pediatrics (AAP) released new recommendations today for the assessment of school-age children with attention-deficit/hyperactivity disorder (ADHD).

Research in various community and practice settings shows that between 4 and 12 percent of all school-age children may have AD/HD, making it the most common childhood neurobehavioral disorder. Children with AD/HD may experience significant functional problems such as school difficulties, academic underachievement, troublesome relationships with family members and peers, and behavioral problems.

In recent years, there has been growing interest in AD/HD as well as concerns about possible over diagnosis. In surveys among pediatricians and family physicians across the country, wide variations were found in diagnostic criteria and treatment methods for AD/HD.

The new standardized AAP guidelines were developed by a panel of medical, mental health and educational experts. The Agency for Healthcare Research and Quality provided significant research and background information for the new policy.

The new guidelines, designed for primary care physicians diagnosing AD/HD in children age 6 to 12, include the following recommendations:

- AD/HD evaluations should be initiated by the primary care clinician for children who show signs of school difficulties, academic underachievement, troublesome relationships with teachers, family

members and peers, and other behavioral problems. Questions to parents, either directly or through a pre-visit questionnaire, regarding school and behavioral issues may help alert physicians to possible AD/HD.

- In diagnosing AD/HD, physicians should use DSM-IV criteria developed by the American Psychiatric Association. These guidelines require that AD/HD symptoms be present in two or more of a child's settings, and that the symptoms adversely affect the child's academic or social functioning for at least six months.
- The assessment of AD/HD should include information obtained directly from parents or caregivers, as well as a classroom teacher or other school professional, regarding the core symptoms of AD/HD in various settings, the age of onset, duration of symptoms and degree of functional impairment.
- Evaluation of a child with AD/HD should also include assessment for co-existing conditions: learning and language problems, aggression, disruptive behavior, depression or anxiety. As many as one-third of children diagnosed with ADHD also have a co-existing condition.

Other diagnostic tests, sometimes considered positive indicators for AD/HD, have been reviewed and considered not effective. These tests include lead screening, tests for generalized resistance to thyroid hormone, and brain image studies.

Comprehensive AD/HD treatment guidelines are also in development.

The American Academy of Pediatrics is an organization of 55,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists dedicated to the health, safety and well-being of infants, children, adolescents and young adults.

Activity #3 Six Step Method

Purpose: To introduce participants to six steps that can be implemented to accommodate the needs of children who are active, impulsive, or inattentive.

Activity Sequence:

1. Remind participants that many of the characteristics of children with ADHD are the same behaviors that may be observed by typically developing young children (and adults).
2. Review the handout Six Steps to Accommodating the Needs of Children who are Active, Impulsive, or Inattentive. Have participants fill in the blank lines.
3. Discuss each of the six steps using the highlight points below and examples either pre-prepared or from the participants.

Highlights:

Step 1 ADHD consists of many negative labels that may get attached to children. After a while children may live up to those labels. Therefore, it is important to use positive descriptions and "labels" of the child to encourage the development of positive self esteem.

Step 2 Children are learning to balance innate or inborn characteristics of temperament and the need for both dependence and independence. They acquire a balance among these factors through "messages" that are provided by people and the world around them. Positive and consistent messages are important in helping develop this balance. Sometimes these messages conflict, leaving a child to resolve these conflicting messages in some way. Children who are hyperactive or impulsive are likely to rely on these types of behaviors when messages conflict.

Step 3 The child's environment - including adult and peer behavior - can set up circumstances that range from positive and supportive to highly stressful. Few children do well in stressful environments but children who are impulsive or hyperactive may do particularly poor. There for a supportive environment is necessary and can be planned using a classroom inventory.

Step 4 The environment can be organized and structured to fit a child's abilities and promote positive behaviors. For example the physical environment should be predictable and not overwhelming. Using an adaptation framework will assist in planning environmental adaptations.

Step 5 The best ways of shaping behavior are positive - compliments, rewards, etc. Children with ADHD don't always have positive self perceptions - by being very positive and using frequent positive messages, a child learns that they can be successful.

Step 6 Keeping tract of progress in a formal way can help adults realize the extent to which a child is making progress and can also be a helpful reminder to adults of the importance of consistency necessary in helping children learn skills and develop socially.

Notes:

Length: 30 minutes

What you will need:

Handout:

- Six Steps to Accommodating the Needs of Children who are Active, Impulsive, or Inattentive, participant pp. 21

Six Steps to Accommodating the Needs of Children who are Active, Impulsive, or Inattentive

Step 1: Frame a Child's Behavior _____(positively)_____

Step 2: Understand the inter-relationship among (Temperament)_____, Need for (Dependence)_____, and Need for (Independence)_____

Step 3: Conduct a _____(classroom) Inventory

Step 4: Structure the ___(environment)____ for Success using an ____(adaptation)____ Framework

Step 5: Develop ____(positive)_____ ways to shape Children's Behavior

Step 6: Keep track of ___(progress)____

Activity #4 Resources

Purpose: Introduce participants to some of the common resources related to ADD, AD/HD

Activity Sequence: (2 pages)

1. Refer participants to the attached *fact sheet from NICHCY*. Breeze through each page highlighting the content, especially page three - Tips for Parents and Tips for Teachers.

2. Have participants use a highlighted or red pen to star, underline or otherwise mark three selected resources from the *NICHCY Briefing Paper, pages 14-15.* Have volunteer participants discuss why they choose their three resources and discuss ways participants can access or acquire the resources.

3. Read the following three acronyms. Ask participants if they know the organization. Provide the web site and phone number for each and allow participants 2-3 minutes to write down the information in their handout on pp 22, References & Resources.

CHADD
NAMED *"SMARTEST WEBSITE"* FOR AD/HD
Children and Adults with Attention-Deficit/Hyperactivity Disorder
http://www.chadd.org
8181 Professional Place, Suite 201
Landover, MD 20785
(800) 233-4050

NADDA
National Attention Deficit Disorder Association
http://www.add.org
1788 Second Street, Suite 200
Highland Park, IL 60035
(847) 432-ADDA

The most up to date listing of resources may be found at

http://www.fpg.unc.edu/~scpp/nat_allies/na_resources.cfm or

www.nectac.org

Notes:

Length: 20 minutes

What you will need:

- NICHCY fact sheet - copies
- NICHCY Briefing Paper - copies
- Filp chart paper
- Markers

- Any additional books/resources that help parents and child care providers keep a positive perspective of the child and keep the child focused.

4. On flip chart paper, list of publishing companies that tend to publish books related to specific disabilities and or specific related topics such as:

   Brooks Publishing, 1-800-638-3775
   Guilford Press, 1-800-365-7006
   ADD Warehouse, 1-800-233-9273
   Random House, 1-800-733-3000

   Give participants 1-2 minutes to record the publishers in their handout pp. 22, References and Resources.

5. Discuss other types of resources, such as workshops, continuing education seminars, etc. Make a list of things to look for or ask about these resources such as:

   Who is presenting?
   What are the qualifications of the person presenting?
   What school of thought are they presenting from?
   What do I hope to learn from this person?
   Why is this person presenting information on ADD, ADHD?
   What is the overall purpose or goal of the presentation?

6. Remind participants that one of the best resources for collecting information about a particular child is talking with the child's parents and family members.

7. ONE LAST REMINDER - ENCOURAGE PARTICIPANTS TO SEEK OUT AND USE RESOURCES THAT ARE STRENGTH-BASED, POSITIVE, AND ARE PRACTICAL/APPLICABLE.

Notes:

Summing Up

This discussion will assist participants to reflect on what they learned today and will also briefly preview the next session. Be sure that all materials are collected and replaced into proper containers.

Review:

Have participants imagine that they are sharing lunch with a co-worker who is not a part of this group. The co-worker asks, "What is this training program about, anyway? What did you learn?"

Pause for at least 30 seconds. Ask participants how they would respond. Allow participants to volunteer, then ask others what they might add.

Repeat:

Date and time of the next session.

Highlights of next session:

Evaluation

Have participants complete the evaluation form “What Did You Learn Today?” and collect them.

Notes:

Length: 10 minutes

Announcement:

T

What you will need:

- What have you learned today evaluation forms

REFERENCES & RESOURCES

Barkley, Russell A. Taking Charge of ADHD: The Complete Authoritative Guide for Parents. New York: The Guilford Press.

Hallowell, Edward M. and Ratey, John J. (1994). Answers to Distraction. New York: Bantam Books.

Hallowell, Edward M. and Ratey, John J. (1994). Driven to Distraction: Recognizing and Coping with Attention Deficit Disorder from Childhood through Adulthood. New York: Touchstone.

Hartmann, Thom (1996). Beyond ADD: Hunting for Reasons in the Past & Present. Grass Valley, California: Underwood Books.

NICHCY Fact Sheet and Briefing Paper on Attention-Deficit/Hyperactivity Disorder (see attached)

Web Sites

Websites are a valuable resource for learning more about particular areas and for downloading information that can be used in training. Many websites are linked to other websites, providing easy access to related sites. However, website addresses may change. These lists are a place to begin exploring!!

The most up to date listing of resources may be found at

http://www.fpg.unc.edu/~scpp/nat_allies/na_resources.cfm or

www.nectac.org

What Did You Learn Today?

1. Did you make any changes in your classroom since the last session? Explain

2. List 2- 3 main points you learned from this session.

3. I am leaving this session with a better idea about how to:

4. What is one thing you plan to do differently in classroom before the next session?