*A Center Quick Training Aid ....*

# *Attention Problems in School*

This document is a hardcopy version of a resource that can be downloaded at no cost from the center's website http://smhp.psych.ucla.edu.

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# Quick Training Aids

## *Attention Problems in School*

Periodically, windows of opportunities arise for providing inservice at schools about mental health and psychosocial concerns, When such opportunities appear, it may be helpful to access one of more of our Center's *Quick Training Aids*.

Each of these offer a brief set of resources to guide those providing an inservice session. (They also are a form of quick self-tutorial and group discussion.)

Most encompass

- •key talking points for a short training session
- •a brief overview of the topic
- •facts sheets
- •tools
- •a sampling of other related information and resources

*In compiling resource material, the Center tries to identify those that represent "best practice" standards, If you know of better material, please* **let us know** *so that we can make improvements.*

This set of training aids was designed for free online access and interactive learning. It can be used online and/or downloaded at http://smhp.psych.ucla.edu - go to Quick Find and scroll down in the list of "QuickFind to Center Developed Responses" to *Attention Problems*. Besides this Quick Training Aid, you also will find a wealth of other resources on this topic.

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# I. Brief Overview

## A. Labeling Troubled and Troubling Youth: The Name Game

From *Addressing Barriers to Learning* Newsletter, Vol. 1 (3), Summer 1996.

## B. Attention Problems & Motivation

## C. Information About The NICHCY Briefing Paper on Attention-Deficit/Hyperactivity Disorder

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# A. Labeling Troubled and Troubling Youth: The Name Game

From *Addressing Barriers to Learning* Newsletter, *Vol.1(3), Summer 1996.*

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*She's **depressed.***

*That kid's got an **attention deficit hyperactivity disorder**.*

*He's **learning disabled.***

What's in a name? Strong images are associated with diagnostic labels, and people act upon these images. Sometimes the images are useful generalizations; sometimes they are harmful stereotypes. Sometimes they guide practitioners toward good ways to help; sometimes they contribute to "blaming the victim" -- making young people the focus of intervention rather than pursuing system deficiencies that are causing the problem in the first place. In all cases, diagnostic labels can profoundly shape a person's future.

Youngsters manifesting emotional upset, misbehavior, and learning problems commonly are assigned psychiatric labels that were created to categorize internal disorders. Thus, there is increasing use of terms such as ADHD, depression, and LD. This happens despite the fact that the problems of most youngsters are not rooted in internal pathology. Indeed, many of their troubling symptoms would not have developed if their environmental circumstances had been appropriately different.

### *Diagnosing Behavioral, Emotional, and Learning Problems*

The thinking of those who study behavioral, emotional, and learning problems has long been dominated by models stressing *person* pathology. This is evident in discussions of cause, diagnosis, and intervention strategies. Because so much discussion focuses on person pathology, diagnostic systems have not been developed in ways that adequately account for psychosocial problems.

As a result, comprehensive *formal* systems used to classify problems in human functioning convey the impression that all behavioral, emotional, or learning problems are instigated by internal *pathology*. Some efforts to temper this notion see the pathology as a vulnerability that only becomes evident under stress. However, most differential diagnoses of children's problems are made by focusing on identifying one or more disorders (e.g., oppositional defiant disorder, attention-deficit/hyperactivity disorder, or adjustment disorders), rather than first asking: *Is there a disorder? Bias* toward labeling problems in terms of *personal* rather than *social causation* is bolstered by factors such as (a) *attributional bias* --a tendency for observers to perceive others' problems as rooted in stable personal dispositions (Miller & Porter, 1988) and (b) *economic and political influences* -- whereby society's current priorities and other extrinsic forces shape professional practice (Becker, 1963; Chase, 1977; Hobbs, 1975; Schact, 1985).

Overemphasis on classifying problems in terms of personal pathology skews theory, research, practice, and public policy. One example is seen in the fact that comprehensive classification systems do not exist for environmentally caused problems or for psychosocial problems (caused by the transaction of internal and environmental factors).

### *A Broad View of Human Functioning*

Before the 1920s, dominant thinking saw human behavior as determined primarily by person variables, especially inborn characteristics. As behaviorism gained in influence, a strong competing view arose. Behavior was seen as shaped by environmental influences, particularly the stimuli and reinforcers one encounters.

Today, human functioning is viewed in *transactional* terms -- as the product of a reciprocal interplay between person and environment (Bandura, 1978). However, prevailing approaches to labeling and addressing human problems still create the impression that problems are determined by *either* person or environment variables. This is both unfortunate and unnecessary -- unfortunate because such a view limits progress with respect to research and practice, unnecessary because a transactional view encompasses the position that problems may be caused by person, environment, or both. This broad paradigm encourages a comprehensive perspective of cause and correction.

There is considerable irony in all this because so many practitioners who use prevailing diagnostic labels understand that most problems in human functioning result from the interplay of person and environment. To counter nature *versus* nurture biases in thinking about problems, it's helps to approach all diagnosis guided by a broad perspective of what determines human behavior.

> *There is a substantial community-serving component in policies and procedures for classifying and labeling exceptional children and in the various kinds of institutional arrangements made to take care of them. "To take care of them" can and should be read with two meanings: to give children help and to exclude them from the community*.
> Nicholas Hobbs

To illustrate the nature of transactional thinking, let's look at learning problems. In teaching a lesson, a classroom teacher will find some students learn easily, and some do not; some misbehave, some do not. Even a good student may appear distracted on a given day.

Why the differences?

A common sense answer suggests that each student brings something different to the situation and therefore experiences it differently. And that's a pretty good answer -- as far as it goes. What gets lost in this simple explanation is the essence of the reciprocal impact student and situation have on each other -- resulting in continuous change in both.

To clarify the point: For purposes of the present discussion, any student can be viewed as bringing to each situation *capacities and attitudes* accumulated over time, as well as *current states of being and behaving*. These "person" variables transact with each other and also with the environment (Adelman & Taylor, 1993).

At the same time, the situation in which students are expected to function not only consists of *instructional processes and content*, but also the *physical and social context* in which instruction takes place. Each part of the environment also transacts with the others.

Obviously, the transactions can vary considerably and can lead to a variety of outcomes. Observers noting student capacities and attitudes may describe the outcomes in terms of *desired, deviant, disrupted, or delayed functioning*. Any of these outcomes may *primarily* reflect the impact of person variables, environmental variables, or both.

***Toward a Broader Framework***

The need to address a wider range of variables in labeling problems is clearly seen in efforts to develop multifaceted systems. The multiaxial classification system developed by the American Psychiatric Association in its *Diagnostic and Statistical Manual of Mental Disorders* -- DSM IV represents the dominant approach (American Psychiatric Association, l994). This system does include a dimension acknowledging "psychosocial stressors." However, this dimension is used mostly to deal with the environment as a contributing factor, rather than as a primary cause.

The following conceptual example illustrates a broad framework that offers a useful *starting* place for classifying behavioral, emotional, and learning problems in ways that avoid overdiagnosing internal pathology. As outlined in the accompanying figure, such problems can be differentiated along a continuum that separates those caused by internal factors, environmental variables, or a combination of both.

Problems caused by the environment are placed at one end of the continuum and referred to as Type I problems. At the other end are problems caused primarily by pathology within the person; these are designated as Type III problems. In the middle are problems stemming from a relatively equal contribution of environmental and person sources, labelled Type II problems.

To be more specific: In this scheme, diagnostic labels meant to identify *extremely* dysfunctional problems *caused by pathological conditions within a person* are reserved for individuals who fit the Type III category. Obviously, some problems caused by pathological conditions within a person are not manifested in severe, pervasive ways, and there are persons without such pathology whose problems do become severe and pervasive. The intent is not to ignore these individuals. As a first categorization step, however, it is essential they not be confused with those seen as having Type III

problems.

At the other end of the continuum are individuals with problems arising from factors outside the person (i.e., Type I problems). Many people grow up in impoverished and hostile environmental circumstances. Such conditions should be considered first in hypothesizing what *initially* caused the individual's behavioral, emotional, and learning problems. (After environmental causes are ruled out, hypotheses about internal pathology become more viable.)

To provide a reference point in the middle of the continuum, a Type II category is used. This group consists of persons who do not function well in situations where their individual differences and minor vulnerabilities are poorly accommodated or are responded to hostilely. The problems of an individual in this group are a relatively equal product of person characteristics and failure of the environment to accommodate that individual.

There are, of course, variations along the continuum that do not precisely fit a category. That is, at each point between the extreme ends, environment-person transactions are the cause, but the degree to which each contributes to the problem varies. Toward the environment end of the continuum, environmental factors play a bigger role (represented as E<--->p). Toward the other end, person variables account for more of the problem (thus e<--->P).

Clearly, a simple continuum cannot do justice to the complexities associated with labeling and differentiating psychopathology and psychosocial problems. Furthermore, some problems are not easily assessed or do not fall readily into a group due to data limitations and comorbidity. However, the above conceptual scheme shows the value of starting with a broad model of cause. In particular, it helps counter the tendency to jump prematurely to the conclusion that a problem is caused by deficiencies or pathology within the individual and thus can help combat the trend toward blaming the victim (Ryan, 1971). It also helps highlight the notion that improving the way the environment accommodates individual differences may be a sufficient intervention strategy.

### *Addressing the Full Range of Problems*

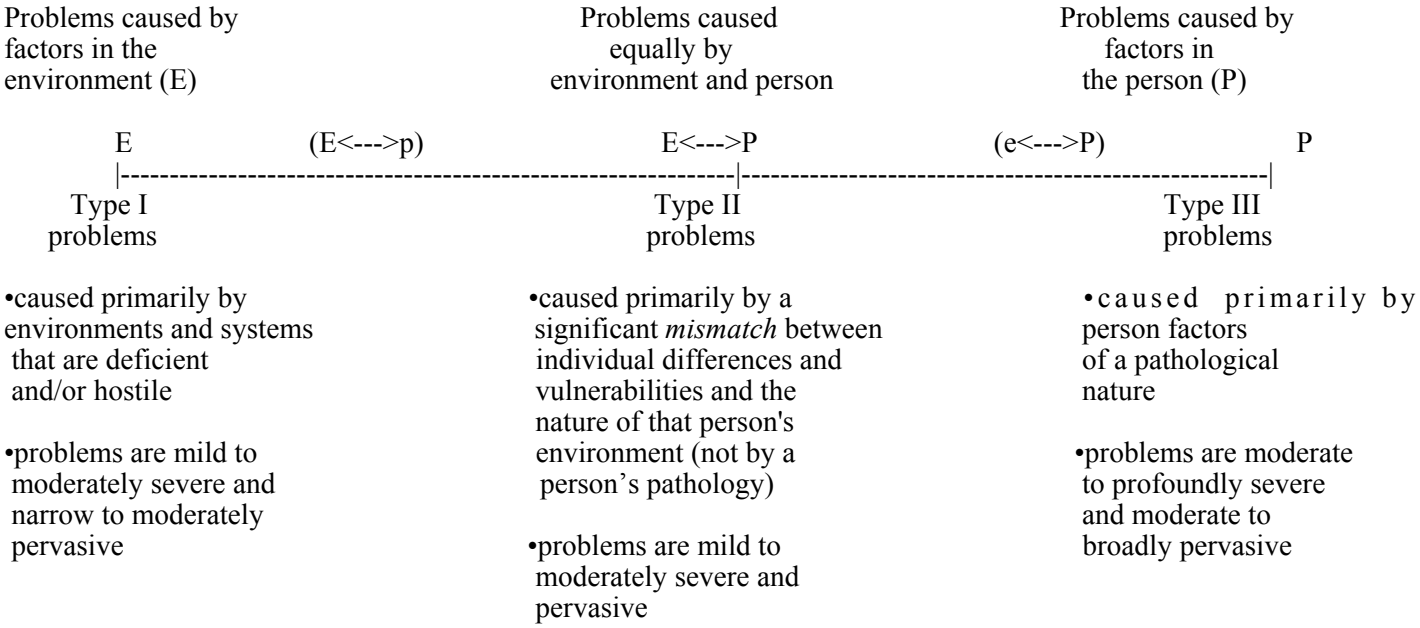
When behavior, emotional, and learning problems are labeled in ways that overemphasize internal pathology, the helping strategies used primarily are some form of clinical/remedial intervention. For the most part, such interventions are developed and function in relative isolation of each other. Thus, they represent another instance of using piecemeal and fragmented strategies to address complex problems. One result is that an individual identified as having several problems may be involved in programs with several professionals working independently of each other. Similarly, a youngster identified and treated in special infant and pre-school programs who still requires special support may cease to receive appropriate help upon entering school. And so forth.

Amelioration of the full continuum of problems, illustrated above as Type I, II, and III problems, generally requires a comprehensive and integrated programmatic approach. Such an approach may require one or more mental health, physical health, and social services. That is, any one of the problems may require the efforts of several programs, concurrently and over time. This is even more likely to be the case when an individual has more than one problem. And, in any instance where more than one program is indicated, it is evident that interventions should be coordinated and, if feasible, integrated.

To illustrate the comprehensive range of programs needed to address Type I, II, and III problems, a continuum is outlined on the following page.

The continuum ranges from programs for primary prevention (including the promotion of mental health) and early-age intervention -- through those for addressing problems soon after onset -- on to treatments for severe and chronic problems. With respect to *comprehensiveness*, the range of programs highlights that many problems must be addressed developmentally and with a range of programs -- some focused on individuals and some on environmental systems, some focused on mental health and some on physical health, education, and social services. With respect to concerns about *integrating* programs, the continuum underscores the need for concurrent interprogram linkages and for linkages over extended periods of time.

**Problems Categorized on a Continuum Using a Transactional View of the Primary Locus of Cause**




In this conceptual scheme, the emphasis in each case is on problems that are beyond the early stage of onset.

***Concluding Comments***

As community agencies and schools struggle to find ways to finance programs for troubled and troubling youth, they continue to tap into resources that require assigning youngsters labels that convey severe pathology. Reimbursement for mental health and special education interventions is tied to such diagnoses. This fact dramatically illustrates how social policy shapes decisions about who receives assistance and the ways in which problems are addressed. It also represents a major ethical dilemma for practitioners. That dilemma is not whether to use labels, but rather how to resist the pressure to inappropriately use those labels that yield reimbursement from third party payers.

A large number of young people are unhappy and emotionally upset; only a small percent are clinically depressed. A large number of youngsters behave in ways that distress others; only a small percent have ADHD or a conduct disorder. In some schools, the majority of students have garden variety learning problems; only a few have learning disabilities. Thankfully, those suffering from true internal pathology (those referred to above as Type III problems) represent a relatively small segment of the population. Society must never stop providing the best services it can for such individuals and doing so means taking great care not to misdiagnose others whose "symptoms" may be similar but are caused to a significant degree by factors other than internal pathology (those referred to above as Type I and II problems). Such misdiagnoses lead youngsters behave in ways that distress others; only a small percent have ADHD or a conduct disorder. In some schools, the majority of students have garden variety learning problems; only a few have learning disabilities. Thankfully, those suffering from true internal pathology (those referred to above as Type III problems) represent a relatively small segment of the population. Society must never stop providing the best services it can for such individuals and doing so means taking great care not to misdiagnose others whose "symptoms" may be similar but are caused to a significant degree by factors other than internal pathology (those referred to above as Type I and II problems). Such misdiagnoses lead to policies and practices that exhaust available resources in serving a relatively

small percent of those in need. That is a major reason why there are so few resources to address the barriers interfering with the education and healthy development of so many youngsters who are seen as troubled and troubling.

Establishing a comprehensive, integrated approach is excruciatingly hard. Efforts to do so are handicapped by the way interventions are conceived and organized and the way professionals understand their functions. Conceptually, intervention rarely is envisioned comprehensively. Organizationally, the tendency is for policy makers to mandate and planners and developers to focus on specific programs. Functionally, most practitioners and researchers spend most of their time working directly with specific interventions and samples and give little thought or time to comprehensive models or mechanisms for program development and collaboration. Consequently, programs to address physical, mental health, and psychosocial problems rarely are coordinated with each other or with educational programs.

Limited efficacy seems inevitable as long as the full continuum of necessary programs is unavailable; limited cost effectiveness seems inevitable as long as related interventions are carried out in isolation of each other. Given all this, it is not surprising that many in the field doubt that major breakthroughs can occur without a comprehensive and integrated programmatic thrust. Such views have added impetus to major initiatives are underway designed to restructure community health and human services and the way schools operate (Adelman, in press; Adler & Gardner, 1994; Center for the Future of Children Staff, 1992; Hodgkinson, 1989; Taylor & Adelman, 1996).

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**From Primary Prevention to Treatment of Serious Problems: A Continuum of Community-School Programs to Address Barriers to Learning and Enhance Healthy Development**

*Intervention Continuum* — *Examples of Focus and Types of Intervention* (Programs and services aimed at system changes and individual needs)

**Primary prevention**

1. Public health protection, promotion, and maintenance to foster opportunities, positive development, and wellness
   - economic enhancement of those living in poverty (e.g., work/welfare programs)
   - safety (e.g., instruction, regulations, lead abatement programs)
   - physical and mental health (incl. healthy start initiatives, immunizations, dental care, substance abuse prevention, violence prevention, health/mental health education, sex education and family planning, recreation, social services to access basic living resources, and so forth)

2. Preschool-age support and assistance to enhance health and psychosocial development
   - systems' enhancement through multidisciplinary team work, consultation, and staff development
   - education and social support for parents of preschoolers
   - quality day care
   - quality early education

**Early-after-onset intervention**

- appropriate screening and amelioration of physical and mental health and psychosocial problems

3. Early-schooling targeted interventions
   - orientations, welcoming and transition support into school and community life for students and their families (especially immigrants)
   - support and guidance to ameliorate school adjustment problems
   - personalized instruction in the primary grades
   - additional support to address specific learning problems
   - parent involvement in problem solving
   - comprehensive and accessible psychosocial and physical and mental health programs (incl. a focus on community and home violence and other problems identified through community needs assessment)

4. Improvement and augmentation of ongoing regular support
   - enhance systems through multidisciplinary team work, consultation, and staff development
   - preparation and support for school and life transitions
   - teaching "basics" of support and remediation to regular teachers (incl. use of available resource personnel, peer and volunteer support)
   - parent involvement in problem solving
   - resource support for parents-in-need (incl. assistance in finding work, legal aid, ESL and citizenship classes, and so forth)
   - comprehensive and accessible psychosocial and physical and mental health interventions (incl. health and physical education, recreation, violence reduction programs, and so forth)
   - Academic guidance and assistance
   - Emergency and crisis prevention and response mechanisms

5. Other interventions prior to referral for intensive and ongoing targeted treatments
   - enhance systems through multidisciplinary team work, consultation, and staff development
   - short-term specialized interventions (including resource teacher instruction and family mobilization; programs for suicide prevention, pregnant minors, substance abusers, gang members, and other potential dropouts)

**Treatment for severe/chronic problems**

6. Intensive treatments
   - referral, triage, placement guidance and assistance, case management, and resource coordination
   - family preservation programs and services
   - special education and rehabilitation
   - dropout recovery and follow-up support
   - services for severe-chronic psychosocial/mental/physical health problems

# B. Attention Problems and Motivation

Excerpted from *An Introductory Packet on Attention Problems: Interventions and Resources*, The Center for Mental Health in Schools.

Many individuals with learning problems are described not only as learning disabled, but also as hyperactive, distractable, impulsive, behavior disordered, and so forth. Their behavior patterns are seen as interfering with efforts to remedy their learning problems, and the conclusion often is that such interfering behaviors have to be eliminated or minimized in order to pursue instruction. The focus has been on any actions of an individual that compete with instruction.

Besides trying to reduce the frequency of disruptive actions directly, programs have been designed to alter such behavior by improving

- impulse control
- selective attention
- sustained attention and follow-through
- perseverence
- frustration tolerance
- social awareness and skills

Variations in focus derive from the ways in which interfering behaviors are viewed. Some professionals see the problems as a skill deficiency and have tried to improve the situation through instruction. Others see the problem as a matter of control and have addressed it through the use of control techniques. For those children diagnosed as hyperactive or as having attention deficit disorders with hyperactivity, a number of controversial nonpsychoeducational interventions also have been advocated (such as the use of stimulant drugs or special diets to avoid chemical additives in food).

Current work in psychology has brought renewed attention to motivation as a central concept in understanding learning and attention problems. This work is just beginning to find its way into applied fields and programs.

Although motivation has always been a concern to those who work with learning problems, the stress is usually on how to use extrinsic to mobilize the learner and maintain participation. There is a recent emphasis on the relationship of learning problems to deficiencies in intrinsic motivation. The general content focus has been on

- increasing feelings of self-determination
- increasing feelings of competence and expectations of success
- increasing feelings of interpersonal relatedness
- increasing the range of interests and satisfactions related to learning

In response to concerns about deficiencies in intrinsic motivation, remedial activities have been directed at improving

- awareness of personal motives and true capabilities
- learning to set valued and appropriate goals
- learning to value and to make appropriate and satisfying choices
- learning to value and accept responsibility for choice

Information about:

## The NICHCY Briefing Paper: Attention-Deficit/Hyperactivity Disorder

(Fowler, M., FSI4, 3rd Edition, April 2002)

The National Information Center for Children and Youth with Disabilities (NICHCY) has prepared this briefing paper as an aid to parents, teachers and other service providers in developing an understanding of the nature and causes of AD/HD, as well as what they can do to facilitate the identification and treatment of the disorder. The first section defines AD/HD, including a discussion of the general behavioral symptoms, specific subtypes and research on the neurobiological causes. The separate diagnostic criteria are reviewed for inattention, hyperactivity, and impulsivity as put forth by the Diagnostic and Statistical manual of Mental Disorders, IV-TR (DSM-IV-TR). This section also provides a review of how deficits in these three areas may manifest as specific behavioral problems for school aged youth. The author provides a series of recommended steps for gathering clinical information when evaluating a child for the disorder, as well as information regarding if and how parents should go about having their child evaluated for AD/HD.

The next section of the paper describes the various recommended modalities of treatment for AD/HD, including descriptions of 1) parent/child/teacher education about AD/HD, 2) medication, 3) behavioral therapies, and 4) educational interventions. Several behavioral strategy suggestions are provided for parents and significant others as a guide to help them increase desirable behaviors, and minimize problem behaviors.

The third section of this resource addresses the specific school-related difficulties which may hinder the learning process for children with AD/HD. Various educational programs targeted at increasing academic success are described, including descriptions of special education services, and the processes for determining eligibility for these services. Suggestions for teachers as to how they can promote learning for students with AD/HD by adjusting the curriculum, adapting the classroom environment, and encouraging specific behaviors which aid in the learning process.

The final sections provide a general wrap-up of how teachers, parents and significant others may help children to meet the challenges of AD/HD by working to bolster certain protective factors, and lists several references and resources to contact for further information.

Full Document Available Free On-line:
PDF: http://www.nichcy.org/pubs/factshe/fs14.pdf
Text:http://www.nichcy.org/pubs/factshe/fs14txt.htm

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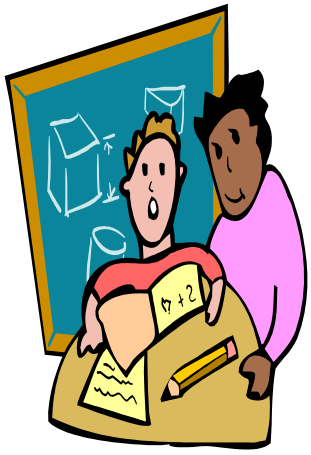


## D. The Backlash Against ADHD and Stimulants

Children exhibit symptoms of inattentiveness, hyperactivity, and impulsiveness along a continuum. Despite the fact that scientific research can inform our choices, where the boundary between ADHD and typical childhood behavior is located ultimately a political and social choice, not a scientific one. No amount of clinical research, therefore, can resolve this question for us. Moreover, to the extent that the boundary between sickness and health is, in the case of mental disorders such as ADHD, demarcated without the ability to reference objective clinical signs or indicators of illness, debates about underdiagnosis or overdiagnosis invariably tap into society's ambivalence about mental disorders. Criticisms of ADHD are criticisms both of the limits clinical knowledge and of the extra-clinical forces that influence diagnostic decision making.

Because the symptoms of ADHD are often most evident in the school setting, where adults make sometimes tremendous demands on children, some critics worry that the identification of children with the disorder is drive more by the wants and expectations of teachers, parents, and school administrators than by the needs of the students. More important, because ADHD can be treated with pharmaceutical drugs, other critics worry (for good reason) about the influence of corporate profit-seeking motives on the diagnosis of children. ADHD is among the most visible and controversial mental disorders, in short because it is a vehicle through which many controversial social and political trends can be criticized.

In the middle of this confusion are the parents of children with ADHD. They must decide whether to accept the label of the disorder, and they must choose which of the many forms of treatment and school-based interventions to pursue: behavioral therapy alone, medication alone, medication in combination with behavioral therapy, which medication

II. Fact Sheets/Practice notes

A. The Broad Continuum of Conduct and Behavioral Problems

1. Developmental Variations
2. Problems
3. Disorders

B. Fact Sheet: Attention-Deficit/Hyperactivity Disorder in Children and Adolescents
(http://www.mentalhealth.org/publications/allpubs/CA-0008/CA-0008.pdf).

C. Practice Notes: ADD Look-Alikes: Same Symptoms but Different Problems

D. Practice Notes: Medication and Attention- Deficit / Hyperactivity Disorder
http://www.nimh.nih.gov/publicat/adhd.cfm

E. IDEA '97 Regulations - Children with "ADD/ADHD" - Excerpted from the Dept. of Education:
http://www.ed.gov/offices/OSERS/Policy/IDEA/Brief-6.html

# *A. The Broad Continuum of Attention Problems*

3 Facts Sheets:

**(1)** Developmental Variations

**(2)** Problems

**(3)** Disorders

The American Academy of Pediatrics has produced a manual for primary care providers that gives guidelines for psychological behaviors that are within the range expected for the age of the child, problems that may disrupt functioning but are not sufficiently severe to warrant the diagnosis of a mental disorder, and disorders that do meet the criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders (4th ed.) of the American Psychiatric Association.

The pediatric manual provides a way to describe problems and plan interventions without prematurely deciding that internal pathology is causing the problems. The manual's descriptions are a useful way to introduce the range of concerns facing parents and school staff. Therefore, these descriptions provide the bases for the following presentation of attention problems commonly seen in school settings.

# (1) Developmental Variations: Behaviors within the Range of Expected Behaviors for That Age Group*

## DEVELOPMENTAL VARIATION

**Hyperactive/Impulsive**

**Variation**

Young children in infancy and in the pre-school years are normally very active and impulsive and may need constant supervision to avoid injury. Their constant activity may be stressful to adults who do not have the energy or patience to tolerate the behavior.

During school years and adolescence, activity may be high in play situations and impulsive behaviors may normally occur, especially in peer pressure situations.

High levels of hyperactive/impulsive behavior do not indicate a problem or disorder if the behavior does not impair functioning.

## COMMON DEVELOPMENTAL PRESENTATIONS

**Infancy**
Infants will vary in their responses to stimulation. Some infants may be overactive to sensations such as touch and sound and may squirm away from the caregiver, while others find it pleasurable to respond with increased activity.

**Early Childhood**
The child runs in circles, doesn't stop to rest, may bang into objects or people, and asks questions constantly.

**Middle Childhood**
The child plays active games for long periods. The child may occasionally do things impulsively, particularly when excited.

**Adolescence**
The adolescent engages in active social activities (e.g., dancing) for long periods, may engage in risky behaviors with peers.

## SPECIAL INFORMATION

Activity should be thought of not only in terms of actual movement, but also in terms of variations in responding to touch, pressure, sound, light, and other sensations. Also, for the infant and young child, activity and attention are related to the interaction between the child and the caregiver, e.g., when sharing attention and playing together.

Activity and impulsivity often normally increase when the child is tired or hungry and decrease when sources of fatigue or hunger are addressed.

Activity normally may increase in new situations or when the child may be anxious. Familiarity then reduces activity.

Both activity and impulsivity must be judged in the context of the caregiver's expectations and the level of stress experienced by the caregiver. When expectations are unreasonable, the stress level is high, and/or the parent has an emotional disorder (especially depression ...), the adult may exaggerate the child's level of activity/impulsivity.

Activity level is a variable of temperament (...).The activity level of some children is on the high end of normal from birth and continues to be high throughout their development.

*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care*. (1996) American Academy of Pediatrics.

Note: Dots (...) indicate that the material has been abridged at that point or that the original text refers to another section of the resource that is not included in this guide.

# (2) Problems--Behaviors Serious Enough to Disrupt Functioning with Peers, at School, at Home, but Not Severe Enough to Meet Criteria of a Mental Disorder.*

## PROBLEM

**Hyperactive/Impulsive**

**Behavior Problem**

These behaviors become a problem when they are intense enough to begin to disrupt relationships with others or begin to affect the acquisition of age-appropriate skills. The child displays some of the symptoms listed in the section on ADHD predominantly hyperactive/impulsive subtype. However, the behaviors are not sufficiently intense to qualify for a behavioral disorder such as ADHD, or of a mood disorder (see section on Sadness and Related Symptoms), or anxiety disorder (see section on Anxious Symptoms).

A problem degree of this behavior is also likely to be accompanied by other behaviors such as negative emotional behaviors or aggressive/oppositional behaviors.

## COMMON DEVELOPMENTAL PRESENTATIONS

**Infancy**
The infant squirms and has early motor development with increased climbing. Sensory underreactivity and overreactivity as described in developmental variations can be associated with high activity levels.

**Early Childhood**
The child frequently runs into people or knocks things down during play, gets injured frequently, and does not want to sit for stories or games.

**Middle Childhood**
The child may butt into other children's games, interrupts frequently, and has problems completing chores.

**Adolescence**
The adolescent engages in “fooling around" that begins to annoy others and fidgets in class or while watching television.

## SPECIAL INFORMATION

In infancy and early childhood, a problem level of these behaviors may be easily confused with cognitive problems such as limited intelligence or specific developmental problems (...). However, cognitive problems and hyperactive/ impulsive symptoms can occur simultaneously.

A problem level of these behaviors may also be seen from early childhood on, as a response to neglect (...), physical/sexual abuse (...), or other chronic stress, and this possibility should be considered.

* Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care* (1996). American Academy of Pediatrics.

Note: Dots (...) indicate that the material has been abridged at that point or that the original text refers to another section of the resource that is not included in this guide.

# (3) Disorders that Meet the Criteria of a Mental Disorder as Defined by the Diagnostic and Statistical Manual of the American Psychiatric Association (Edition 4, 1994)

## DISORDER

**Attention-Deficit/Hyperactivity Disorder**

**Predominantly Hyperactive-Impulsive Type**

This subtype should be used if six (or more) of the following symptoms of hyperactivity-impulsivity (but fewer than six symptoms of inattention [...) have persisted for at least 6 months. They present before the age of 7 years. The symptoms need to be present to a significantly greater degree than is appropriate for the age, cognitive ability, and gender of the child, and the symptoms should be present in more than one setting (e.g., school and home).

Hyperactive-impulsive symptoms:

These symptoms must be present to a degree that is maladaptive and inconsistent with developmental level, resulting in significant impairment.

***Hyperactivity***
- often fidgets with hands/feet or squirms in seat
- often leaves seat in classroom or in other situations in which remaining seated is expected
- often runs about or climbs excessively in situation in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
- often has difficulty playing or engaging in leisure activities quiet ly
- is often "on the go" or often acts as if "driven by a motor"
- often talks excessively

***Impulsivity***
- often blurts out answers before questions are completed
- often has difficulty awaiting turn
- often interrupts or intrudes on others

* Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care* (1996). American Academy of Pediatrics.

Note: Dots (...) indicate that the material has been abridged at that point or that the original text refers to another section of the resource that is not included in this guide.

## COMMON DEVELOPMENTAL PRESENTATIONS

**Infancy**
The infant squirms frequently and has early motor development with excessive climbing. The infant has a hard time focusing on people or objects and squirms constantly. The infant does not organize purposeful gestures or behavior. The infant may show interest in gross motor activities such as excessive climbing but may also have difficulties in motor planning and sequencing (imitating complex movements). However, these behaviors are nonspecific and a disorder diagnosis is extremely difficult to make in this age group.

**Early Childhood**
The child runs through the house, jumps and climbs excessively on furniture, will not sit still to eat or be read to, and is often into things.

**Middle Childhood**
The child is often talking and interrupting, cannot sit still at meal times, is often fidgeting when watching television, makes noise that is disruptive, and grabs from others.

**Adolescence**
The adolescent is restless and fidgety while doing any and all quiet activities, interrupts and “bugs" other people, and gets into trouble frequently. Hyperactive symptoms decrease or are replaced with a sense of restlessness.

## SPECIAL INFORMATION

Specific environmental situations and stressors often make a significant contribution to the severity of these behaviors, though they are seldom entirely responsible for a disorder-level diagnosis of these behaviors. Situations and stressors that should be systematically assessed include:

Marital discord/divorce (...)
Physical abuse/sexual abuse (...)
Mental disorder of parent (...)
Other family relationship problems (...)

Difficulties with cognitive/adaptive skills, academic skills, and speech and language skills often lead to frustration and low self-esteem that contribute to the severity of these behaviors. These conditions may also co-exist with ADHD and therefore should be systematically assessed.

## DISORDER, CONTINUED

**Predominantly Hyperactive-Impulsive Type, Continued**

Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years. Some impairment from the symptoms is present in two or more settings (e.g., at school and at home). There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning. The symptoms do not occur exclusively during the course of an autistic disorder (see following differential diagnostic information), and are not better accounted for by another mental disorder (see following differential diagnosis information).

**Combined Type**

This subtype should be used if criteria, six (or more) symptoms of hyperactivity-impulsivity and six (or more) of the symptoms of the inattention (...), have persisted for at least 6 months.

**Attention-Deficit/Hyperactivity Disorder, NOS**

(see DSM-IV Criteria ...)

## COMMON DEVELOPMENTAL PRESENTATIONS

## SPECIAL INFORMATION

Specific environmental situations and stressors often make a significant contributions to the severity of these behaviors, though they are seldom entirely responsible for a disorder-level diagnosis of these behaviors. Situations and stressors that should be systematically assessed include:

Marital discord/divorce, (...)
Physical abuse/sexual abuse, (...)
Mental disorder of parent, (...)
Other family relationship problems, (...)
Loss/bereavement, (...)

Difficulties with cognitive/adaptive skills, academic skills, and speech and language skills often lead to frustration and low self-esteem that both contribute to the severity of these behaviors. These conditions may also co-exist with ADHD and therefore should be systematically assessed.

* Adapted from The Classification of Child and Adolescent Mental Diagnoses in Primary Care (l996). American Academy of Pediatrics

Note: Dots (...) indicate that the material has been abridged at that point or that the original text refers to another section of the resource that is not included in this guide.

# Diagnostic criteria for Attention-Deficit/Hyperactivity Disorder

In contrast to *developmental variations* expected within the range of expected behaviors for the age group and to *behaviors serious enough to disrupt functions (but not severe enough to meet criteria of a mental disorder*)

A. Either (1) or (2)

(1) six (or more) of the following symptoms of inattention have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

*Inattention*

(a) often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities
(b) often has difficulty sustaining attention in tasks or play activities
(c) often does not seem to listen when spoken to directly
(d) often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)
(e) often has difficulty organizing tasks and activities
(f) often avoids, dislikes or is reluctant to engage in tasks that require sustained mental efforts (such as schoolwork or homework)
(g) often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools
(h) is often easily distracted by extraneous stimuli
(i) is often forgetful in daily activities

(2) six (or more) of the following symptoms of hyperactivity-impulsivity have persisted or at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

*Hyperactivity*

(a) often fidgets with hands or feet or squirms in seat
(b) often leaves seat in classroom in other situations in which remaining seated is expected
(c) often runs about or climbs excessively in situations in which is it inappropriate ...
(d) often has difficulty playing or engaging in leisure activities
(e) is often "on the go" or often acts as if "driven by a motor"
(f) often talks excessively

*Impulsivity*

(g) often blurts out answers before questions have been completed
(h) often has difficulty awaiting turn
(i) often interrupts or intrudes on others (e.g., butts into conversations or games)

B. Some hyperactivity-impulsive or inattentive symptoms that caused impairment were present before age 7 years

C. Some impairment from the symptoms is present in two or more settings (e.g., at school [or work] and at home).

D. There must be clear evidence of clinically significant impairment in social, academic, or occupations functioning...

From the American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders.* Fourth Edition. Washington, DC. American Psychiatric Association, 1994.

## B. Attention-Deficit/Hyperactivity Disorder in Children and Adolescents

*This is one of a series of fact sheets on the mental, emotional, and behavior disorders that can appear in childhood or adolescence. The Center for Mental Health Services extends appreciation to the National Institute of Mental Health for contributing to the preparation of this fact sheet. Any questions or comments about its contents may be directed to the CMHS National Mental Health Services Knowledge Exchange Network (KEN)--see contact information below.*

**What Is Attention-Deficit/Hyperactivity Disorder?** Young people with attention-deficit/hyperactivity disorder typically are overactive, unable to pay attention, and impulsive. They also tend to be accident prone. Children or adolescents with attention- deficit/hyperactivity disorder may not do well in school or even fail, despite normal or above-normal intelligence. Attention- deficit/hyperactivity disorder is sometimes referred to as ADHD.

**What Are the Signs of Attention-Deficit/Hyperactivity Disorder?** There are actually three different types of attention- deficit/hyperactivity disorder, each with different symptoms. The types are referred to as inattentive, hyperactive-impulsive, and combined attention-deficit/hyperactivity disorder.

Children with the inattentive type:
- have short attention spans;
- are easily distracted;
- do not pay attention to details;
- make lots of mistakes;
- fail to finish things;
- are forgetful;
- don't seem to listen; and
- cannot stay organized.

Children with the hyperactive-impulsive type:
- fidget and squirm;
- are unable to stay seated or play quietly;
- run or climb too much or when they should not;
- talk too much or when they should not;
- blurt out answers before questions are completed;
- have trouble taking turns; and
- interrupt others.

In this fact sheet, "Mental Health Problems" for children and adolescents refers to the range of all diagnosable emotional, behavioral, and mental disorders. They include depression, attention-deficit/hyperactivity disorder, and anxiety, conduct, and eating disorders. Mental health problems affect one in every five young people at any given time. "Serious Emotional Disturbances" for children and adolescents refers to the above disorders when they severely disrupt daily functioning in home, school, or community. Serious emotional disturbances affect 1 in every 10 young people at any given time.

*Combined attention-deficit/hyperactivity disorder*, the most common type, is a combination of the inattentive and the hyperactive-impulsive types. A diagnosis of one of the attention-deficit/hyperactivity disorders is made when a child has a number of the above symptoms, and the symptoms began before the age of 7 and lasted at least 6 months. Generally, symptoms have to be seen in at least two different settings (for example, at home and at school) before a diagnosis is made.

**How Common Is Attention-Deficit/Hyperactivity Disorder?** Attention-deficit/hyperactivity disorder is found in as many as 1 in every 20 children. Studies have shown that boys with attention-deficit/hyperactivity disorder outnumber girls with the disorder about three to one.[1]

Children and adolescents with attention-deficit/hyperactivity disorder are at risk for many other disorders. About half of all young people with attention-deficit/hyperactivity disorder also have oppositional or conduct disorder, and about a fourth have an anxiety disorder. As many as one-third have depression, and about one-fifth have a learning disability. Sometimes a child or adolescent will have two or more of these disorders in addition to attention-deficit/hyperactivity disorder. Also, children with attention-deficit/hyperactivity disorder are at risk for

developing personality disorders and substance abuse disorders when they are adolescents or adults.

Attention-deficit/hyperactivity disorder is a major reason why children are referred for mental health care. Boys are more likely to be referred for treatment than girls, in part because many boys with attention-deficit/ hyperactivity disorder also have conduct disorder. The mental health services and special education required by children and adolescents with attention-deficit/hyperactivity disorder cost millions of dollars each year. Underachievement and lost productivity can cost these young people and their families even more.

**What Causes Attention-Deficit/Hyperactivity Disorder?** Many causes of attention-deficit/ hyperactivity disorder have been studied, but no one cause seems to apply to all young people with the disorder. There is strong evidence that genetic factors are important. But other factors such as viruses, harmful chemicals in the environment, problems during pregnancy or delivery, or other things that impair brain development may play a role as well.

**What Help Is Available for Families?** Many treatments-some with good scientific basis, some without-have been recommended for children and adolescents with attention-deficit/hyperactivity disorder. The best proven treatments are medication and behavior treatments.

## Medication

The most widely used drugs for treating attention-deficit/hyperactivity disorder are stimulants, such as amphetamine (Dexedrine, Dextrostat, Desoxyn), methylphenidate (Ritalin), and pemoline (Cylert). Stimulants increase the activity in parts of the brain that are underactive in children and adolescents with attention-deficit/hyperactivity disorder. Experts believe that this is why stimulants improve attention and reduce impulsive, hyperactive, or aggressive behavior. Individuals may respond better to one medication than to another. For example, clonidine (Catapres) is often used, although its effectiveness has not been clearly shown. A few antidepressants may also work for some patients. Tranquilizers like thioridazine (Mellaril) have also been shown to work for some young people. Care must be used in prescribing and monitoring all medication.

Like most medications, those used to treat attention- deficit/hyperactivity disorder have side effects. When taking these medications, some children may lose weight, have a smaller appetite, and temporarily grow more slowly. Others may have trouble falling asleep. However, many doctors believe the benefits of medication outweigh the possible side effects. Side effects that do occur can often be handled by reducing the dosage.

## Behavior Treatment

Behavior treatments include:

- teaching parents and teachers how to manage and modify the child's or adolescent's behavior, such as rewarding good behavior;
- a daily report card to link the home and school efforts (where the parent rewards the child or adolescent for good school performance and behavior);
- summer and Saturday programs;
- special classrooms that use intensive behavior modification; and
- specially trained classroom aides.

It is clear that both stimulants and behavior treatment can be helpful in the short run (a few weeks or months). However, it is not clear how long the benefit lasts. The Federal Government's National Institute of Mental Health is supporting research on the long-term benefits of various treatments as well as research to find out whether medication and behavior treatment are more effective when combined. There is also research on new medicines and other new treatments. Other Federal agencies carrying out research on attention-deficit/hyperactivity disorder include the Center for Mental Health Services and the Department of Education.

A child or adolescent in need of treatment or services and his or her family may need a plan of care based on the severity and duration of symptoms. Optimally, this plan is developed with the family, service providers, and a service coordinator, who is referred to as a case manager. Whenever possible, the child or adolescent is involved in decisions.

Tying together all the various supports and services in a plan of care for a particular child and family is commonly referred to as a "system of care." A system of care is designed to improve the child's ability to function in all areas of life-at home, at school, and in the community. For a fact sheet on systems of care, call 1.800.789.2647.

In a "System of Care," local organizations work in teams-with families as critical partners-to provide a full range of services to children and adolescents with serious emotional disturbances. The team strives to meet the unique needs of each young person and his or her family in or near their home. These services should also address and respect the culture and ethnicity of the people they serve. (For more information on systems of care, call 1.800.789.2647.)

## Can Attention-Deficit/Hyperactivity Disorder Be Prevented?

Because there are so many suspected causes of attention- deficit/hyperactivity disorder, prevention may be difficult. However, it always is wise to obtain good prenatal care and stay away from alcohol, tobacco, and other harmful chemicals during pregnancy and to get good general health care for the child. These recommendations may be particularly important if attention-deficit/hyperactivity disorder is suspected in other family members. Knowing that attention- deficit/hyperactivity disorder is in the family can alert parents to take early action to prevent bigger problems.

## What Else Can Parents Do?

When it comes to attention-deficit/hyperactivity disorder, parents and other caregivers should be careful not to jump to conclusions. A high energy level alone in a child or adolescent does not mean that he or she has attention-deficit/hyperactivity disorder. The diagnosis depends on whether the child or adolescent can focus well enough to complete tasks that suit his or her age and intelligence. This ability is most likely to be noticed by a teacher. Therefore, input from teachers should be taken seriously.

If parents or other caregivers suspect attention-deficit/hyperactivity disorder, they should:

- Make an appointment with a psychiatrist, psychologist, child neurologist, or behavioral pediatrician for an evaluation. (Check with the child's doctor for a referral.)
- If the young person is diagnosed with attention- deficit/hyperactivity disorder, be patient. The disorder may take a long time to improve.
- Instill a sense of competence in the child or adolescent. Promote his or her strengths, talents, and feelings of self-worth.
- Remember that failure, frustration, discouragement, low self- esteem, and depression, in many cases, cause more problems than the disorder itself.
- Get accurate information from libraries, hotlines, or other sources.
- Ask questions about treatments and services.
- Talk with other families in the community.
- Find family network organizations.
- It is important that people who are not satisfied with the mental health care they are receiving to discuss their concerns with the provider, to ask for information, and/or to seek help from other sources.

[1] This estimate provides only a rough gauge of the prevalence rates (number of existing cases in a defined time period) for this disorder. The National Institute of Mental Health is currently engaged in a nationwide study to determine with greater accuracy the prevalence of mental disorders among children and adolescents. This information is needed to increase understanding of mental health problems and to improve the treatments and services that help young people who are affected by these conditions.

CMHS Knowledge Exchange Network:
Website: http://www.mentalhealth.org/publications/allpubs/ca-0008/default.asp ; E-mail: ken@mentalhealth.org

# C. ADD Look-Alikes: Same Symptoms but Different Problems

***From an article by Servio Carroll, National Association of School Psychologists Communique Special Edition, March 1997 (volume 25, no. 6; insert)***

## Guidelines for Educators

***Background***

*Due to the wide variety of psychomedical and biomedical problems that can be mistaken for Attention Deficit Disorder (ADD), or that may coexist with ADD, it is always essential for a child to be carefully evaluated. Medical specialists are working to develop a more precise idea of which hyperactive children and adolescents really have ADD and which have look-alike problems that only resemble this disorder. Look-alike ADD children may fulfill the diagnostic criteria for ADD but have a completely different problem and, therefore, should receive a different diagnosis. These ADD look-alikes are important to distinguish because their long-term course and treatment may be quite different from children with classical ADD. There are several psychomedical problems or medical disorders that can mimic ADD, resulting in an ADD look-alike child.*

***Depression***

*Depression is certainly common in adolescents and children, just as it is in adults. While it may seem unlikely that a depressed person would be "hyper" (since many depressed people seem to talk and think slowly and move with great effort), some inattentive children with impulsive and hyperactive behavior are actually depressed. These children may just have passing symptoms of depressed mood (e.g., feeling blue or demoralized) or more persistent or even chroni- cally bad moods (dysthymic disorder), or have the psychiatric diagnosis of depression with its accompanying physical changes (major depression). Even though these children may have prominent ADD-like symptoms, treating their depression is more successful than treating the ADD symptoms.*

***Stress-induced***

*Anxiety states caused by environmental stress may present as ADD. Certain children living in a stressful home situation or adolescents dealing with social or academic pressures may look like they have ADD. Obviously, helping them cope with the stress in their lives is preferable to the use of stimulant medications. Even mild stress can produce symptoms that mimic ADD.*

***Biologically-based Anxiety Disorders***

*Certain medical disorders such as separation anxiety disorder or obsessive compulsive disorder are treated quite differently from ADD--even though many of the symptoms of these disorders may look the same as ADD symptoms. However, stimulants often worsen the symptoms of these anxiety disorders, which are better treated with different medications and approaches.*

***Child Abuse or Neglect***

*In certain circumstances, the victims of sexual abuse, physical abuse or neglect can present with symptoms of ADD. Even after a limited period of abuse or neglect, these children may continue to show symptoms that are difficult to distinguish from ADD.*

***Bipolar Disorders***

*Another biomedical condition that may mimic ADD is the family of bipolar disorders. The most severe version of bipolar disorder in adults is manic-depressive illness, but most common bipolar disorders are more mild. Bipolar disorders in children and adolescents can present with impulsivity, inattention and hyper-activity, along with overly strong feelings or an overbearing manner, irritability or unprovoked hostility, and often difficulty in "getting going" in the morning. It is only the more severe*

*forms of bipolar disorder in adolescents and children that show amazingly energized and lengthy temper tantrums with gross destructiveness during their brief or lengthy rages. About half of boys (and perhaps a quarter of the girls) with bipolar disorders fulfill diagnostic criteria for ADD, but bipolar disorder tends to appear in families in which depression or bipolar disorder has emerged before. Although stimulants can sometimes help these children with bipolar disorder, stimulants often make the symptoms worse and can be quite risky. Lithium and other medications can be much more helpful.*

***Schizophrenia***

*Schizophrenia is a serious biomedical disorder that can include ADD symptoms. Children with schizophrenia are relatively uncommon, typically come from families in which schizophrenia has emerged before, and represent an extremely small fraction of the children with ADD symptoms. Again, stimulant medications can be risky for these children, and other medications and treatments are strongly preferable.*

***Other Medical Disorders***

*Certain medical disorders of sleep (or arousal), malfunctions of the thyroid gland and excessive lead ingestion may also present with symptoms that are typically seen in children with ADD.*

***Summary: Cautions in Diagnosis and Treatment***

*Look-alike ADD children may fulfill the diagnostic criteria for ADD but have a completely different problem and, therefore, should receive a different diagnosis. All of the above conditions may cause a child to behave impulsively and show difficulties in attention and hyperactivity that are hard (and perhaps impossible in some instances) to distinguish from ADD. Particularly if a child's situation is worsening with age, it is important to consider the possibility that ADD may not be the sole or even primary problem. Also, if the ADD is associated with bad dreams, bad moods or disturbing thoughts, or if there is a family medical history of psychiatric disorders, then it is important to be sure that mimicking disorders and additional problems are not present.*

*If a medical or other psychiatric disorder is presenting as ADD, a treatment that merely improves the ADD symptoms may leave a residue of untreated behavioral problems, mood abnormalities or disorders of physiology. In these cases, even if stimulants are helpful or if environmental changes improve the child's self control, it is critical to make sure that the other (and perhaps more serious) problems are not left to smolder. Given the variety of disorders that can be mistaken for ADD, or that may co-exist with ADD, a comprehensive evaluation of the child is always important. Numerous problems must be contemplated, assessed and "ruled out" before a diagnosis of ADD can be made. It is no longer sufficient to start treatment for ADD based on observations of "tuning out" or misbehavior. This disorder needs a psycho-medical evaluation that matches our growing awareness of the complexity that goes by the simple name of ADD.*

***Resources***

*Barkley, R. (1990). Attention Deficit Hyperactivity Disorder: A handbook for diagnosis and treatment. New York: The Guilford Press.*

*DuPaul, G.J., & Stoner, G. (1994). ADHD in the schools: Assessment and intervention strategies. New York: Guilford Press.*

*Servio Carroll, NCSP, is a school psychologist and crisis team member in Sheridan, WY*

# D. Medication and Attention Deficit-Hyperactivity Disorder

(Excerpted from the National Institute of Mental Health: http://www.nimh.nih.gov/publicat/adhd.cfm)

Cylert is available in one form, which naturally lasts 5 to 10 hours. Ritalin and Dexedrine come in short-term tablets that last about 3 hours, as well as longer-term preparations that last through the school day. The short-term dose is often more practical for children who need medication only during the school day or for special situations, like attending church or a prom, or studying for an important exam. The sustained-release dosage frees the child from the inconvenience or embarrassment of going to the office or school nurse every day for a pill. The doctor can help decide which preparation to use, and whether a child needs to take the medicine during school hours only or in the evenings and on weekends, too.

Other types of medication may be used if stimulants don't work or if the ADHD occurs with another disorder. Antidepressants and other medications may be used to help control accompanying depression or anxiety. In some cases, antihistamines may be tried. Clonidine, a drug normally used to treat hypertension, may be helpful in people with both ADHD and Tourette's syndrome. Although stimulants tend to be more effective, clonidine may be tried when stimulants don't work or can't be used. Clonidine can be administered either by pill or by skin patch and has different side effects than stimulants. The doctor works closely with each patient to find the most appropriate medication.

Some doctors recommend that children be taken off a medication now and then to see if the child still needs it. They recommend temporarily stopping the drug during school breaks and summer vacations, when focused attention and calm behavior are usually not as crucial. These "drug holidays" work well if the child can still participate at camp or other activities without medication.

Children on medications should have regular checkups. Parents should also talk regularly with the child's teachers and doctor about how the child is doing. This is especially important when a medication is first started, re-started, or when the dosage is changed.

## The Medication Debate

As useful as these drugs are, Ritalin and the other stimulants have sparked a great deal of controversy. Most doctors feel the potential side effects should be carefully weighed against the benefits before prescribing the drugs. While on these medications, some children may lose weight, have less appetite, and temporarily grow more slowly. Others may have problems falling asleep. Some doctors believe that stimulants may also make the symptoms of Tourette's syndrome worse, although recent research suggests this may not be true. Other doctors say if they carefully watch the child's height, weight, and overall development, the benefits of medication far outweigh the potential side effects. Side effects that do occur can often be handled by reducing the dosage.

It's natural for parents to be concerned about whether taking a medicine is in their child's best interests. Parents need to be clear about the benefits and potential risks of using these drugs. The child's pediatrician or psychiatrist can provide advice and answer questions.

Another debate is whether Ritalin and other stimulant drugs are prescribed unnecessarily for too many children. Remember that many things, including anxiety, depression, allergies, seizures, or problems with the home or school environment can make children seem overactive, impulsive, or inattentive. Critics argue that many children who do not have a true attention disorder are medicated as a way to control their disruptive behaviors. Careful assessment and ongoing monitoring by a mental health professional may help to counter these concerns.

# E. IDEA '97 Regulations - Children with "ADD/ADHD"

(Excerpted from the Dept. of Education: http://www.ed.gov/offices/OSERS/Policy/IDEA/Brief-6.html)

**Adding "ADD/ADHD" to the list of eligible conditions under "OHI."**
The definition of "child with a disability" in the Part B regulations has been amended to add "attention deficit disorder" ("ADD") and "attention deficit hyperactivity disorder" ("ADHD") to the list of conditions that could render a child eligible for Part B services under the "other health impairment" ("OHI") category.

**Many children with ADD/ADHD have been eligible under Part B** — consistent with the Department's long-standing policy related to serving these children.

In 1991, the Department issued a memorandum entitled "Clarification of Policy to Address the Needs of Children with [ADD] within General and/or Special Education," which was jointly signed by the Assistant Secretaries of OCR, OESE, and OSERS.

**The substance of the 1991 policy clarification was included in the NPRM**, and, specifically in Note 5 following §§300.7 (definition of "child with a disability") -- to ensure that school administrators, teachers, parents, and other members of the general public would be fully aware that some children with ADD/ADHD are eligible under Part B. (Adding that interpretation to the NPRM was consistent with the Department's plan to include all major long-term policy interpretations related to Part B in a single regulatory document, along with the new provisions added by the IDEA Amendments of 1997.)

**The 1991 policy interpretation clarified that --**

- ALL CHILDREN WITH ADD/ADHD CLEARLY ARE NOT ELIGIBLE under Part B to receive special education and related services -- just as all children who have one or more of the other conditions listed under the "other health impairment" category are not necessarily eligible (e.g., children with a heart condition, asthma, diabetes, and rheumatic fever)."
- TO BE ELIGIBLE UNDER PART B, A CHILD WITH ADD/ADHD (as with all other children covered under this part) must meet a two-pronged test of eligibility (i.e., have a condition that meets one of the disability categories listed under §§300.7, and need special education and related services because of that disability).
- CHILDREN WITH ADD/ADHD ARE A DIVERSE GROUP. Some children with ADD/ADHD may be eligible under other disability categories if they meet the criteria for those disabilities, while other children may not be eligible under Part B, but might qualify under section 504 of the Rehabilitation Act.

**Department's 1991 policy memorandum not fully implemented**.

From the public comments received on the NPRM related to ADD/ADHD (and the Department's experience in administering Part B), it is clear that the 1991 policy is not being fully and effectively implemented.

**Ensuring that eligible children with ADD/ADHD receive Part B services**.

To ensure that each child with ADD/ADHD who meets the eligibility criteria under Part B receives special education and related services in the same timely manner as other children with disabilities, it is important to

1. add "ADD/ADHD" to the list of conditions that could render a child eligible under this part, and
2. appropriately address (in Attachment 1 to the final regulations) the large number of comments received on this topic.

**Clarifying "limited strength, vitality, or alertness" under "OHI."**

The final regulations also clarify that the term "limited strength, vitality, or alertness" in the definition of "OHI" (when applied to children with ADD/ADHD) includes "a child's heightened alertness to environmental stimuli that results in limited alertness with respect to the educational environment." (This clarification was included in note 5 following §§300.7 of the NPRM, based on the Department's previous interpretation of the term as it applies to children with ADD/ADHD).

**Including "ADD/ADHD" not a new requirement**.

Including "ADD" and "ADHD" as potentially eligible conditions under the Part B regulations does not add a new requirement. It simply codifies the Department's long-standing policy related to serving these children.

## III. Tools/Handouts

### A. Practice Parameters for Attention-Deficit/Hyperactivity Disorder Assessment and Treatment.

(Excerpts from the *Journal of the American Academy of Child & Adolescent Psychiatry*)

### B. Clinical Practice Guideline: Diagnosis and Evaluation of the Child with Attention-Deficit/Hyperactivity Disorder

Excerpted from *Pediatrics* 2000; 105: 1158-70.

*Excerpts from:*

# Practice Parameters for Attention-Deficit/Hyperactivity Disorder Assessment and Treatment

*...as developed by the American Academy of Child & Adolescent Psychiatry*

[See the Journal of the American Academy of Child & Adolescent Psychiatry, (1997, Oct), 36(10 Suppl):85S-121S]

## CHILDREN AGED 6 TO 12 YEARS

I. Initial evaluation (a complete psychiatric assessment is indicated; see Practice Parameters for the Psychiatric Assessment of Children and Adolescents [American Academy of Child and Adolescent Psychiatry, 1995]).

A. Interview with parents.

1. Child's history.
   a. Developmental history.
   b. DSM-IV symptoms of ADHD.
      i. Presence or absence (may use symptom or criterion checklist).
      ii. Development and context of symptoms and resulting impairment, including school (learning, academic productivity, and behavior), family, and peers.
   c. DSM-IV symptoms of possible alternate or comorbid psychiatric diagnoses.
   d. History of psychiatric, psychological, pediatric, or neurological treatment for ADHD; details of medication trials.
   e. Areas of relative strength (e.g., talents and abilities).
   f. Medical history.
      i. Medical or neurological primary diagnosis (e.g., fetal alcohol syndrome, lead intoxication, thyroid disease, seizure disorder, migraine, head trauma, genetic or metabolic disorder, primary sleep disorder).
      ii. Medications that could cause symptoms (e.g., phenobarbital, antihistamines, theophylline, sympathomimetics, steroids).
2. Family history.
   a. ADHD, tic disorders, substance-use disorders, CD, personality disorders, mood disorders, obsessive-compulsive disorder and other anxiety disorders, schizophrenia.
   b. Developmental and learning disorders.
   c. Family coping style, level of organization, and resources.
   d. Past and present family stressors, crises, changes in family constellation.
   e. Abuse or neglect.

B. Standardized rating scales completed by parents.

C. School information from as many current and past teachers as possible.

1. Standardized rating scales.
2. Verbal reports of learning, academic productivity, and behavior.
3. Testing reports (e.g., standardized group achievement tests, individual evaluations).
4. Grade and attendance records.
5. Individual Educational Plan (IEP), if applicable.
6. Observations at school if feasible and if case is complex.

D. Child diagnostic interview: history and mental status examination.

1. Symptoms of ADHD (note: may not be observable during interview and may be denied by child.)

2. Oppositional behavior.
3. Aggressive behavior.
4. Mood and affect.
5. Anxiety.
6. Obsessions or compulsions.
7. Form, content, and logic of thinking and perception.
8. Fine and gross motor coordination.
9. Tics, stereotypies, or mannerisms.
10. Speech and language abilities.
11. Clinical estimate of intelligence.

E. Family diagnostic interview.
1. Patient's behavior with parents and siblings.
2. Parental interventions and results.

F. Physical evaluation.
1. Medical history and examination within past 12 months or more recently if the clinical condition has changed.
2. Documentation of health history, immunizations, screening for lead level, etc.
3. Measurement of lead level (if not already done) only if history suggests pica or environmental exposure.
4. Documentation or evaluation of visual acuity.
5. Documentation or evaluation of hearing acuity.
6. Further medical or neurological evaluation as indicated.
7. In preparation for pharmacotherapy.
a. Baseline documentation of height, weight, vital signs, and abnormal movements.
b. ECG before TCA or clonidine.
c. Consider EEG before TCA or bupropion, if indicated.
d. Liver function studies before pemoline.

G. Referral for additional evaluations if indicated.
1. Psychoeducational evaluation (administered individually).
a. IQ.
b. Academic achievement.
c. Learning disorders.
2. Neuropsychological testing.
3. Speech and language evaluation.
4. Occupational therapy evaluation.
5. Recreational therapy evaluation.

II. Psychiatric differential diagnosis.
A. ODD.
B. CD.
C. Mood disorders - depression or mania.
D. Anxiety disorders.
E. Tic disorder (including Tourette's disorder).
F. Pica.
G. Substance use disorder.
H. Learning disorder.
I. Pervasive developmental disorder.
J. Mental retardation or borderline intellectual functioning.

III. Treatment planning.

A. Establish target symptoms and baseline impairment (rating scales may be useful).

B. Consider treatment for comorbid conditions.

C. Prioritize modalities to fit target symptoms and available resources.

1. Education about ADHD.
2. Classroom placement and resources.
3. Medication.
4. Other modalities may assist with remaining target symptoms.

D. Monitor multiple domains of functioning.

1. Learning in key subjects (achievement tests, classroom tests, homework, classwork).
2. Academic productivity (homework, classwork).
3. Emotional functioning.
4. Family interactions.
5. Peer relationships.
6. If on medication, appropriate monitoring of height, weight, vital signs, and relevant laboratory parameters.

E. Reevaluate efficacy and need for additional interventions.

F. Maintain long-term supportive contact with patient, family, and school.

1. Ensure compliance with treatment.
2. Address problems at new developmental stages or in response to family or environmental changes.

IV Treatment.

A. Education of parents, child, and significant adults.

B. School interventions.

1. Ensure appropriate class placement and availability of needed resources (e.g., tutoring).
2. Consult or collaborate with teachers and other school personnel.
    a. Information about ADHD.
    b. Educational techniques.
    c. Behavior management.
3. Direct behavior modification program when possible and if problems are severe in school setting.

C. Medication.

1. Stimulants.
2. Bupropion.
3. TCAs.
4. Other antidepressants.
5. Clonidine or guanfacine (primarily as an adjunct to a stimulant).
6. Neuroleptics—risks usually exceed benefits in treatment of ADHD; consider carefully before use.
7. Anticonvulsants-few data support use in the absence of seizure disorder or brain damage.

D. Psychosocial interventions.

1. Parent behavior modification training.
2. Referral to parent support group, such as CHADD.
3. Family psychotherapy if family dysfunction is present.
4. Social skills group therapy for peer problems.
5. Individual therapy for comorbid problems, not core ADHD.
6. Summer day treatment.

E. Ancillary treatments.

1. Speech and language therapy.
2. Occupational therapy.
3. Recreational therapy.

F. Dietary treatment rarely useful.

G. Other treatments are outside the realm of the usual practice of child and adolescent psychiatry and are not recommended.

## CHILDREN AGED 3 TO 5 YEARS

Same protocol as above, except for the following:

I. Evaluation.
   A. Higher index of suspicion for neglect, abuse, or other environmental factors.
   B. More likely to require evaluation of lead level.
   C. More likely to require evaluation of:
      1. Speech and language disorders.
      2. Cognitive development.

II Treatment.
   A. Increased emphasis on parent training.
   B. Highly structured preschool.
   C. Additive-free diet occasionally may be useful.
   D. If medications are used, exercise more caution, use lower doses, and monitor more frequently.

## ADOLESCENTS

Same protocol as for children aged 6 to 12 years, except for the following:

I. Higher index of suspicion for comorbidity with:
   A. CD.
   B. Substance-use disorder.
   C. Suicidality.

II Teacher reports less useful in middle and high school than in grammar school.

III. Patient must participate actively in treatment.

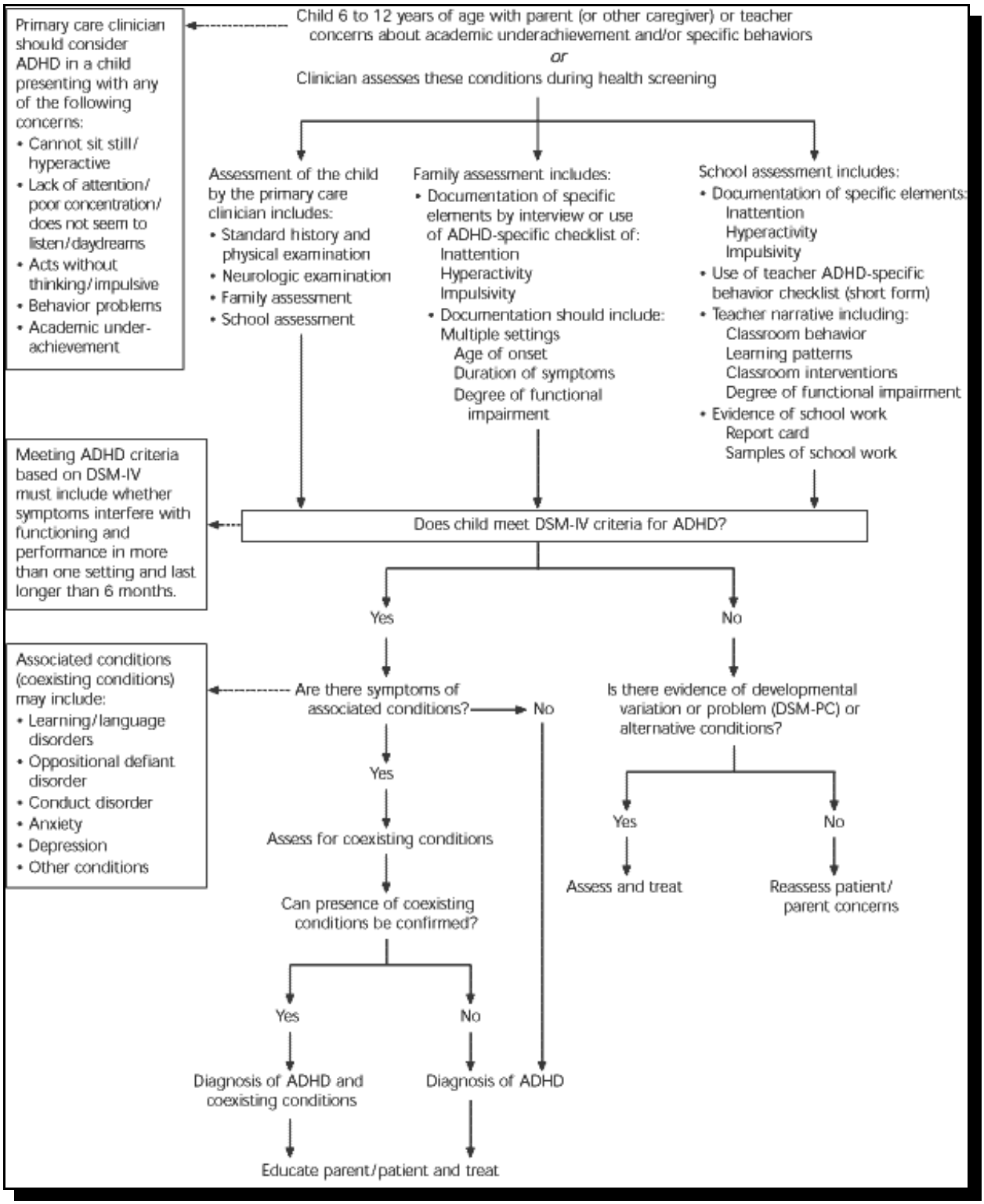
IV. Increased risk of medication abuse by patient or peers.

V. Greater need for vocational evaluation, counseling, or training.

VI. Evaluate patient's safe driving practices.

# Clinical Practice Guideline: Diagnosis and Evaluation of the Child with Attention-Deficit/Hyperactivity Disorder

(Excerpted from *Pediatrics* 2000; 105: 1158-70)



# IV. Intervention Strategies / Model Programs

## A. 504 Accommodations Checklist

http://www.come-over.to/FAS/IDEA504.htm

## B. Mental Health: A Report of the Surgeon General

(Excerpted from National Institute of Mental Health, 1999)

## C. NIMH Research on Treatment for Attention Deficit Hyperactivity Disorder (ADHD): The Multimodal Treatment Study - Questions and Answers

(excerpted from http://www.nimh.nih.gov/events/mtaqa.cfm)

# 504 ACCOMMODATION CHECKLIST

http://www.come-over.to/FAS/IDEA504.htm

If you have a child that does not qualify for special education but has a mental or physical impairment which substantially limits one or more major life activities, including learning, that child still may qualify for special help in a regular classroom setting under section 504.

The following is a list of accommodations that may help your child succeed in the classroom. The list can be used as a reference for parents and school personnel.

## PHYSICAL ARRANGEMENT OF ROOM

- ? seating student near the teacher
- ? seating student near a positive role model
- ? standing near the student when giving directions or presenting lessons
- ? avoiding distracting stimuli (air conditioner, high traffic area, etc.)
- ? increasing distance between desks

## LESSON PRESENTATION

- ? pairing students to check work
- ? writing key points on the board
- ? providing peer tutoring
- ? providing visual aids, large print, films
- ? providing peer notetaker
- ? making sure directions are understood
- ? including a variety of activities during each lesson
- ? repeating directions to the student after they have been given to the class: then have him/her repeat and explain directions to teacher
- ? providing written outline
- ? allowing student to tape record lessons
- ? having child review key points orally
- ? teaching through multi-sensory modes, visual, auditory, kinestetics, olfactory
- ? using computer-assisted instruction
- ? accompany oral directions with written directions for child to refer to blackboard or paper
- ? provide a model to help students, post the model and refer to it often
- ? provide cross age peer tutoring
- ? to assist the student in finding the main idea underlying, highlighting, cue cards, etc.
- ? breaking longer presentations into shorter segments

## ASSIGNMENTS/WORKSHEETS

- ? giving extra time to complete tasks
- ? simplifying complex directions
- ? handing worksheets out one at a time
- ? reducing the reading level of the assignments
- ? requiring fewer correct responses to achieve grade (quality vs. quantity)
- ? allowing student to tape record assignments/homework
- ? providing a structured routine in written form
- ? providing study skills training/learning strategies
- ? giving frequent short quizzes and avoiding long tests
- ? shortening assignments; breaking work into smaller segments
- ? allowing typewritten or computer printed assignments prepared by the student or dictated by the student and recorded by someone else if needed.
- ? using self-monitoring devices
- ? reducing homework assignments
- ? not grading handwriting
- ? student should not be allowed to use cursive or manuscript writing
- ? reversals and transpositions of letters and numbers should not be marked wrong, reversals or transpositions should be pointed out for corrections
- ? do not require lengthy outside reading assignments
- ? teacher monitor students self-paced assignments (daily, weekly, bi-weekly)
- ? arrangements for homework assignments to reach home with clear, concise directions
- ? recognize and give credit for student's oral participation in class

**(Cont.)**

**TEST TAKING**

? allowing open book exams
? giving exam orally
? giving take home tests
? using more objective items (fewer essay responses)
? allowing student to give test answers on tape recorder

? giving frequent short quizzes, not long exams
? allowing extra time for exam
? reading test item to student
? avoid placing student under pressure of time or competition

**ORGANIZATION**

? providing peer assistance with organizational skills
? assigning volunteer homework buddy
? allowing student to have an extra set of books at home
? sending daily/weekly progress reports home
? developing a reward system for in-schoolwork and homework completion
? providing student with a homework assignment notebook

**BEHAVIORS**

? use of timers to facilitate task completion
? structure transitional and unstructured times (recess, hallways, lunchroom, locker room, library, assembly, field trips, etc.)
? praising specific behaviors
? using self-monitoring strategies
? giving extra privileges and rewards
? keeping classroom rules simple and clear
? making "prudent use" of negative consequences
? allowing for short breaks between assignments
? cueing student to stay on task (nonverbal signal)
? marking student's correct answers, not his mistakes
? implementing a classroom behavior management system
? allowing student time out of seat to run errands, etc.
? ignoring inappropriate behaviors not drastically outside classroom limits
? allowing legitimate movement
? contracting with the student
? increasing the immediacy of rewards
? implementing time-out procedures

*Excepted from...*

# Mental Health: A Report of the Surgeon General

(Excerpted from National Institute of Mental Health, 1999)
http://www.surgeongeneral.gov/library/mentalhealth/home.html
http://www.surgeongeneral.gov/library/mentalhealth/pdfs/C3.pdf (to download entire document in sections)

## Treatment

The American Academy of Child and Adolescent Psychiatry (AACAP) published "practice parameters" (i.e., guidelines for clinical practice) on the diagnosis and treatment of ADHD.These practice parameters evolved out of research relating to two major types of treatment: pharmacological treatment and psychosocial treatment, particularly behavioral modification, as well as multimodal treatment, the combination of psychosocial and pharmacological treatments.

### Pharmacological Treatment

*Psychostimulants*

Pharmacological treatment with psychostimulants is the most widely studied treatment for ADHD. Psychostimulants are highly effective for 75 to 90 percent of children with ADHD. These medications have their greatest effects on symptoms of hyperactivity, impulsivity, and inattention and the associated features of defiance, aggression, and oppositionality. They also improve classroom performance and behavior and promote increased interaction with teachers, parents, and peers...

### Psychosocial Treatment

Important options for the management of ADHD are psychosocial treatments, particularly in the form of training in behavioral techniques for parents and teachers. Behavioral techniques, which are described more fully below, typically employ "time-out," point systems and contingent attention (adults reinforcing appropriate behavior by paying attention to it). Psychosocial treatments are useful for the child who does not respond to medication at all or for whom the therapeutic benefits of the medication have wom off and for the child who responds only partially to medication or cannot tolerate medication. In addition, some families express a strong preference not to use medication. Even children who are receiving medication may continue to have residual ADHD symptoms or symptoms from other disorders, such as oppositional defiant disorder or depression, which make specialized child management skills necessary and helpful (see next section, Multimodal Treatments). Furthermore, children with ADHD can present a challenge that puts significant stress on the family. Skills training for parents can help reduce this stress on parents and siblings.

*Behavioral Approaches*

The main psychosocial treatments for ADHD are behavioral training for parent and teacher, as well as systematic programs of contingency management...

A number of studies have compared parent training (Gittelman et al., 1980; Firestone et al., 1986; Hom et al., 1987, 1990, 1991; Pelham et al., 1988) or schoolbased behavioral modification (Gittelinan et al., 1980; Pelham et al., 1988) with the use of stimulants. Most of the studies are of outpatient behavioral therapy programs in which parents meet in groups and are taught behavioral techniques such as time out, point systems, and contingent attention. Teachers are taught similar classroom strategies, as well as the use of a daily report card for parents that evaluates the child's in-school behavior. The improvements in the symptoms of ADHD achieved with psychosocial treatments are not as large as those found with psychostimulants (Pelham et al., 1998). Behavioral interventions tend to improve targeted behaviors or skills but are not as helpful in reducing the core symptoms of inattention, hyperactivity, or impulsivity...

*Cognitive-Behavioral Therapy*

Cognitive-behavioral therapy (CBT), primarily training in problem solving and social skills, has not been shown to provide clinically important changes in behavior and academic performance of children with ADHD (Pelham et al., 1998). However, CBT might be helpful in treating symptoms of accompanying disorders such as oppositional defiant disorder, depression, or anxiety disorders (Abikoff, 1985; Hinshaw & Ehardt, 1991; Lochman, 1992).

*Psychoeducation*

Although there are no studies evaluating the efficacy of psychoeducation as a treatment modality for ADHD, providing information to parents, children, and teachers about ADHD and treatment options is considered critical in the development of a comprehensive treatment plan (AACAP, 1991).

*Multimodal Treatments*

Many researchers and families have long suspected that multimodal treatment-medication used together with multiple psychosocial interventions in multiple settings-should be more effective than medication alone. Multimodal treatment has thus been used in the absence of empirical support (Hechtman, 1993). To determine whether multimodal treatment is indeed effective, the recent NIMH Multimodal Treatment Study of ADHD (called the MTA Study) examined three experimental conditions: medication management alone, behavioral treatment alone, or a combination of medication and behavioral treatments. The study compared the effectiveness of these three treatment modes with each other and with standard care provided in the community (the control group). The behavioral treatment condition consisted of parent training, a school intervention, and a summer treatment program. The NITA Study was also designed to determine the relative benefits of these treatments over time (Richters et al., 1995). All subjects were treated for 14 months and then followed for an additional 22 months.

Results of the MTA Study comparing the 14-month outcomes of 579 children randon-dy assigned to one of the four treatment conditions were presented in the fall of 1998 (MTA Cooperative Group, 1998). At 14 months, medication and the combination treatment were generally more effective than the behavioral treatment alone or the control treatment. Notably, the combined treatment resulted in significant improvement over the control condition in six outcome areas-social skills, parent child relations, internalizing (e.g., anxiety) symptoms, reading achievement, oppositional and/or aggressive symptoms, and parent and/or consumer satisfaction-whereas the single forms of treatment (medication or behavior therapy) were each superior to the control condition in only one to two of these domains. The conclusions from this major study are that carefully managed and monitored stimulant medication, alone or combined with behavioral treatment, is effective for ADHD over a period of 14 months. Addition of behavioral treatment yields no additional benefits for core ADHD symptoms but appears to provide some additional benefits for non-ADHDsymptom outcomes.

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Richters, J. E., Arnold, L. E., Jensen, P. S., Abikoff, H., Conners, C. K., Greenhill, L. L., Hechtman, L., Hinshaw, S. P., Pelham, W. E., & Swanson, J. M. (1995). NIMH collaborative multisite multimodal treatment study of children with ADHD: I. Background and rationale. *Journal of the American Academy of Child and Adolescent Psychiatry, 34*, 987—1000.

# NIMH Research on Treatment for Attention Deficit Hyperactivity Disorder (ADHD): The Multimodal Treatment Study - Questions and Answers

http://www.nimh.nih.gov/events/mtaqa.cfm

What is the best kind of help we can offer children with ADHD over a longer term?

*The Multimodal Treatment Study of Children with Attention Deficit Hyperactivity Disorder*

Up-to-date information concerning the long-term safety and comparative effectiveness of its treatments is urgently needed...The MTA study demonstrates for the first time the safety and relative effectiveness of these two treatments (including a behavioral therapy-only group), alone and in combination, for a time period up to 14 months, and compares these treatments to routine community care. The children involved in the study will be tracked into adolescence to document and evaluate long-term outcomes.

...long-term combination treatments as well as medication-management alone are both significantly superior to intensive behavioral treatments and routine community treatments in reducing ADHD symptoms...these differential benefits extend as long as 14 months.

What the MTA study has demonstrated is that on average, carefully monitored medication management with monthly follow-up is more effective than intensive behavioral treatment for ADHD symptoms, for periods lasting as long as 14 months. All children tended to improve over the course of the study, but they differed in the relative amount of improvement, with the carefully done medication management approaches generally showing the greatest improvement.

...Therefore, medication alone is not necessarily the best treatment for every child, and families often need to pursue other treatments, either alone or in combination with medication.

...the MTA study findings suggest that many children can often acquire these abilities when given the opportunity. Children treated with effective medication management... manifested substantially greater improvements in social skills and peer relations than children in the community comparison group after 14 months. This important finding indicates that symptoms of ADHD may interfere with their learning of specific social skills.

## V. Additional Resources

### QuickFinds related to Attention Problems in School

- AD/HD

## Quick Find On-line Clearinghouse

TOPIC: Attention Deficit Hyperactivity Disorder (ADHD)

The following represents a sample of information to get you started and is not meant to be exhaustive. (Note: Clicking on the following links causes a new window to be opened. To return to this window, close the newly opened one.)

**Center Developed Documents, Resources and Tools**

**Guides to Practice**

- **Common Psychosocial Problems of School-Aged Youth**

**Introductory Packet**

- **Attention Problems: Interventions and Resources**
- **Learning Problems and Learning Disabilities**

**Newsletters**

- **Revisiting Learning Problems and Learning Disabilities**
- **Re-engaging Students in Learning at School**

**Quick Training Aid**

- **Attention Problems in School**

**Resource Aid Packet**

- **Students and Psychotropic Medications**

**Other Relevant Documents, Resources, and Tools on the Internet**

**Diagnosis and Treatment**

- **ADHD coaching**
- **"Barriers to Detection, Help-Seeking, and Service Use for Children with ADHD Symptoms" (2003) R. Bussing, et al. Journal of Behavioral Health Services & Research 30(2) 176-189**
- **Diagnosis and Evaluation of the Child with Attention-Deficit/Hyperactive Disorder**
- **Follow up studies on the Multimodal Treatment Study of Children with Attention Deficit Hyperactivity Disorder** (2007) Journal of the American Academy of Child and Adolescent Psychiatry.
- **A process for developing community consensus regarding the diagnosis and management of attention-deficit/hyperactivity disorder (2005) J. Meschan & M. Earls, Pediatrics, 115, 97-104**
- **Treatment Services for Children with ADHD: A National Perspective**
- **Identifying and Treating Attention Deficit Hyperactivity Disorder: A Resource for School and Home** (US Department of Education)
- **Medication Treatment of ADD and ADHD: Myths and Realities**
- **Who receives a diagnosis of attention-deficit/hyperactivity disorder in the United States Elementary School Population?**

**Facts and Information**

- **Attention Deficit Disorder and ADHD: Briefing Paper (by NICHCY)**
- **Attention Deficit Disorder and ADHD (Schoolbehavior.com)**
- **Attention Deficit Disorder and ADHD: Fact Sheet (by NICHCY)**
- **Mental Health: A Report of the Surgeon General - Attention-Deficit/Hyperactivity Disorder**
- **Mental Health in the United States: Prevalence of Diagnosis and Medication Treatment for Attention-Deficit/Hyperactivity Disorder**
- **National Estimates and Factors Associated with Medication Treatment for Childhood Attention Deficit/Hyperactivity Disorder (2007) S. Visser, et al., Pediatrics, 199, S99-S106**
- **National Trends in the Use of Psychotropic Medication of Children (2002)**

**General**

- **Attention Deficit Disorder and ADHD: Diagnostic Criteria**
- **Attention-Deficit/Hyperactivity Disorder: An Educational Cultural Model**
- **Attention Deficit Hyperactivity Disorder in Children**
- **Behavioral Treatment for ADHD: A General Overview**
- **Children and Adolescents with Attention-Deficit/Hyperactivity Disorder**
- **Evaluation Guidelines for ADHD and Attention Deficit Disorder**
- **Educational Rights for Children with Attention Deficit Disorder or ADHD**
- **Fragmented Care for Inner-City Minority Children with Attention-Deficit/Hyperactivity Disorder (2005) J. Guevara, et al, *Pediatrics, 116(4)* e512-517**
- **Peer Relationships and ADHD** also in Spanish (from CDC)
- **Understanding ADHD: Examining Racial Differences (#150)**
- **What is ADHD?: A General Overview**
- **What is Attention Deficit Hyperactivity Disorder?** (from NIH)

**Guides**

- **"American Academy of Pediatrics: ADHD A Complete and Authoritative Guide"**
- **Attention Deficit Disorders: A Guide for Teachers**
- **Guidelines for Primary Care Physicians for Treatment of ADHD**
- **Helping Children and Youth With Attention-Deficit/Hyperactivity Disorder: Systems of Care** (from SAMHSA)
- **How to Reach and Teach ADD/ADHD Children - Table of Contents**
- **Instability of the DSM-IV subtypes of ADHD from Preschool hrough Elementary School**
- **The Child with ADHD: Using the AAP Clinical Practice Guideline**
- **The Instruction of Children with ADHD** (from US dept. of ED)
- **Obtaining Educational Services for Children with ADHD**

**Related Agencies and Websites**

- **Attention Deficit Disorder/ADHD Information & Assessment Services**
- **The Attention Deficit Information Network, Inc. (AD-IN)**
- **National Resource Center on AD/HD**

**Relevant Publications That Can Be Obtained through Libraries**

- **"A Comparison of treatments in children with ADHD" By Huffman, Grace B. (2000). In *American Family Physician* May, 61(9): p2839.**

- **"A conceptual model of child psychopathology: Implications for understanding attention deficit hyperactivity disorder and treatment efficacy." Rapport, Mark D.; Chung, Kyong-Mee; Shore, Gail; Isaacs, Patti . *Journal of Clinical Child Psychology*. Lawrence Erlbaum Assoc: US, 2001 Mar. 30 (1): p. 48-58.**
- **"Age-Dependent decline of symptoms of Attention Deficit Hyperactivity Disorder: Impact of Remission Definition and Symptom Type" By Biederman, Joseph; Mick, Eric; Faraone, Stephen V. (2000). In *American Journal of Psychiatry* May, 157(5): p816 (3 pages).**
- **"Assessing attention-deficit/hyperactivity disorder." Anastopoulos, Arthur D.; Shelton, Terri L. Kluwer Academic/Plenum Publishers: New York, NY, US, 2001. xvi, 349pp.**
- **"Attention-deficit/hyperactivity disorder." Casat, Charles D.; Pearson, Deborah A.; Casat, Jeanette Pierret. In: H. Booney Vance, Ed; Andres Pumariega, Ed. Clinical assessment of child and adolescent behavior. John Wiley & Sons, Inc: New York, NY, US, 2001. p. 263-306 of xvi, 557pp.**
- **"Attention-deficit/hyperactivity disorder: Clinical features." Solanto, Mary V. In: Mary V. Solanto, Ed; Amy Frances Torrance Arnsten, Ed; et al. Stimulant drugs and ADHD: Basic and clinical neuroscience.. Oxford University Press: New York, NY, US, 2001. p. 3-30 of xii, 410pp.**
- **"Children with attention-deficit/hyperactivity disorder: Peer relationships and peer-oriented interventions." Mrug, Sylvie; Hoza, Betsy; Gerdes, Alyson C. In: Douglas W. Nangle, Ed; Cynthia A. Erdley, Ed. The role of friendship in psychological adjustment. Jossey-Bass Inc, Publishers: San Francisco, CA, US, 2001. p. 51-77 of 112pp. Series title: New directions for child and adolescent development, No. 91.**
- **"Clinical effects of stimulant medication in ADHD." Greenhill, Laurence L. In: Mary V. Solanto, Ed; Amy Frances Torrance Arnsten, Ed; et al. Stimulant drugs and ADHD: Basic and clinical neuroscience.. Oxford University Press: New York, NY, US, 2001. p. 31-71 of xii, 410pp.**
- **"Comorbidity of Attention Deficit Hyperactivity Disorder with early- and late-onset Bipolar Disorder" By Sachs, Gary S.; Baldassano, Claudia F.; Truman, Christine J.; and Guille, Constance (2000). In *American Journal of Psychiatry* March, 157(3): p466 (3 pages).**
- **"Does My Child Need Ritalin? Stimulants are still the most effective treatment for ADHD. The challenge is to use them wisely." (2000). In *Newsweek* April, 135(17): p81.**
- **"Evidence-Based Psychological Treatments for Attention-Deficit/Hyperactivity Disorder" By Pelham, William E., Jr. and Fabiano, Gregory A.(2008). In *Journal of Clinical Child and Adolescent Psychology (37)*:1. 184-214.**
- **"Fighting an unknown enemy: ADHD" By Eldridge, Ken (2000). In *Education Digest* Feb, 65(5): p7 (3 pages).**
- **"Findings from the NIMH Multimodal Treatment Study of ADHD (MTA): Implications and applications for primary care providers. "Jensen, Peter S.; Hinshaw, Stephen P.; Swanson, James M.; Greenhill, Laurence L.; Conners, C. Keith; Arnold, L. Eugene; Abikoff, Howard B.; Elliott, Glen; Hechtman, Lily; Hoza, Betsy; March, John S.; Newcorn, Jeffrey H.; Severe, Joanne B.; Vitiello, Benedetto; Wells, Karen; Wigal, Timothy. *Journal of Developmental & Behavioral Pediatrics*. Lippincott Williams & Wilkins: US, 2001 Feb. 22 (1): p. 60-73.**
- **"Homework success for children with ADHD: A family-school intervention program." Power, Thomas J.; Karustis, Janes L.; Habboushe, Dina F. The Guilford Press: New York, NY, US, 2001. xviii, 232pp. Series title: The Guilford school practitioner series.**
- **"Making sense of Ritalin" By Pekkanen, John (2000) In *Reader's Digest* Jan, 156(933): p152 (7 pages).**
- **"Medicating Children" By Mayes, Rick; Bagwell, Catherine; Erkulwater, Jennifer. Harvard University Press (2009).**
- **"Power parenting for children with ADD/ADHD: A practical parent's guide for managing**

**difficult behaviors" (2000) Review In *Adolescence* Spring, 35(137): p223.**

- **"Social functioning and emotional regulation in the Attention Deficit Hyperactivity Disorder subtypes" By Maedgen, Jennifer W. and Carlson, Caryn L (2000). In *Journal of Clinical Child Psychology* March, 29(1): p30 (13 pages).**
- **"Treating children and adolescents with attention-deficit/hyperactivity disorder."Anastopoulos, Arthur D.; Klinger, Erika E.; Temple, E. Paige. In: Jan N. Hughes, Ed; Annette Marie La Greca, Ed; et al. Handbook of psychological services for children and adolescents.. Oxford University Press: New York, NY, US, 2001. p. 245-266 of x, 485pp.**
- **"Treatment outcomes with low income children and adolescents with attention deficit." Ralph, Norbert B.; Oman, Douglas; Forney, Willard .*Children & Youth Services Review*. Elsevier Science Inc: US, 2001 Feb. 23 (2): p. 145-167**
- **"Visual behaviour of ADHD children during an attention test: an almost forgotten variable" By Borger, Norbert and Moore, Jaap van der (2000). In *Journal of Child Psychology and Psychiatry and Allied Disciplines* May, 41(4): p525 (8 pages).**
- **"What does the MTA study tell us about effective psychosocial treatment for ADHD?" Greene, Ross W.; Ablon, J. Stuart . *Journal of Clinical Child Psychology*. Lawrence Erlbaum Assoc: US, 2001 Mar. 30 (1): p. 114-121.**

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**We hope these resources met your needs. If not, feel free to contact us for further assistance. For additional resources related to this topic, use our search page to find people, organizations, websites and documents. You may also go to our technical assistance page for more specific technical assistance requests.**

**If you haven't done so, you may want to contact our sister center, the Center for School Mental Health at the University of Maryland at Baltimore.**

**If our website has been helpful, we are pleased and encourage you to use our site or contact our Center in the future. At the same time, you can do your own technical assistance with "The fine Art of Fishing" which we have developed as an aid for do-it-yourself technical assistance.**

# Originals
# for
# Overheads

The following can be copied to overhead transparencies
to assist in presenting this material.

A. Problems categorized on a Continuum Using a Transactional View of the Primary Locus of Cause

B. The Broad Continuum of Attention Problems

C. What are the Signs of *Attention-Deficit/Hyperactivity Disorder*?

D. 504 Accommodation Checklist

# Problems Categorized on a Continuum Using a Transactional View of the Primary Locus of Cause

Problems caused by factors in the environment (E)

Problems caused equally by environment and person

Problems caused by factors in the person (P)

E (E<--->p) E<--->P (e<--->P) P

|----------|----------|

Type I problems

Type II problems

Type III problems

•caused prim arily by environments and systems that are deficient and/or hostile

•problem s are mild to moderately severe and narrow to moderately pervasive

•caused prim arily by a significant *mismatch* between individual differences and vulnerabilities and the nature of that person's environment (not by a person's pathology)

•problem s are mild to moderately severe and pervasive

•caused prim arily by person factors of a pathological nature

•problem s are moderate to profoundly severe and moderate to broadly pervasive

In this conceptual scheme, the emphasis in each case is on problems that are beyond the early stage of onset.

# *The Broad Continuum of Attention Problems*

## Developmental Variations: Behaviors within the Range of Expected Behaviors for That Age Group*

**Early Childhood**
The child runs in circles, doesn't stop to rest, may bang into objects or people, and asks questions constantly.

**Middle Childhood**
The child plays active games for long periods. The child may occasionally do things impulsively, particularly when excited.

**Adolescence**
The adolescent engages in active social activities (e.g., dancing) for long periods, may engage in risky behaviors with peers.

## Problems--Behaviors Serious Enough to Disrupt Functioning with Peers, at School, at Home, but Not Severe Enough to Meet Criteria of a Mental Disorder.*

**Early Childhood**
The child frequently runs into people or knocks things down during play, gets injured frequently, and does not want to sit for stories or games.

**Middle Childhood**
The child may butt into other children's games, interrupts frequently, and has problems completing chores.

**Adolescence**
The adolescent engages in “fooling around" that begins to annoy others and fidgets in class or while watching television.

* Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care* (1996). American Academy of Pediatrics.

# Diagnostic criteria for Attention-Deficit/Hyperactivity Disorder

In contrast to *developmental variations* expected within the range of expected behaviors for the age group and to *behaviors serious enough to disrupt functions (but not severe enough to meet criteria of a mental disorder*)

> **Six (or more) of the following symptoms**

> **Have persisted for at least 6 months**

> **To a degree that is maladaptive and inconsistent with developmental level:**

> **Symptoms present before age 7**

> **Impairment in two settings (e.g, home/school)**

***Inattention*** e.g. careless mistakes, difficulty sustaining attention, does not seem to listen, does not follow through, has difficulty organizing tasks and activities, reluctant to engage, loses things, distracted by extraneous stimuli, forgetful in daily activities

***Hyperactivity*** e.g fidgets, squirms, leaves seat, runs or climbs excessively, difficulty playing, "on the go", talks excessively

***Impulsivity*** e.g., blurts out, difficulty awaiting turn, butts into conversations or games

From the American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders.* Fourth Edition. Washington, DC. American Psychiatric Association, 1994.

***To maintain a broad perspective of the reforms needed to address barriers to learning, we organize our thinking and materials around the following three categories:***

## Systemic Concerns

- Policy issues related to mental health in schools
- Mechanisms and procedures for program/service coordination
  - Collaborative Teams
  - School-community service linkages
  - Cross disciplinary training and interprofessional education
- Comprehensive, integrated programmatic approaches (as contrasted with fragmented, categorical, specialist oriented services)
- Issues related to working in rural, urban, and suburban areas
- Restructuring school support service
  - Systemic change strategies
  - Involving stakeholders in decisions
  - Staffing patterns
  - Financing
  - Evaluation, Quality Assurance
  - Legal Issues
- Professional standards

## Programs and Process Concerns

- Clustering activities into a cohesive, programmatic approach
  - Support for transitions
  - Mental health education to enhance healthy development & prevent problems
  - Parent/home involvement
  - Enhancing classrooms to reduce referrals (including prereferral interventions)
  - Use of volunteers/trainees
  - Outreach to community
  - Crisis response
- Staff capacity building & support
  - Cultural competence
  - Minimizing burnout
- Interventions for student and family assistance
  - Screening/Assessment
  - Enhancing triage & ref. processes
  - Least Intervention Needed
  - Short-term student counseling
  - Family counseling and support
  - Case monitoring/management
  - Crisis and violence prevention
  - Confidentiality
  - Record keeping and reporting
  - School-based Clinics

## Psychosocial Problems

- Drug/alcoh. abuse
- Depression/suicide
- Grief
- Dropout prevention
- Learning problems
- School adjustment (including newcomer acculturation)
- Pregnancy prevention/support
- Eating problems (anorexia, bulim.)
- Physical/Sexual Abuse
- Neglect
- Gangs
- Self-esteem
- Relationship problems
- Anxiety
- Disabilities
- Gender and sexuality
- Reactions to chronic illness

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