November 2015

AD/HD

Ohio Coalition for the Education of Children with Disabilities

The Ohio Coalition for the Education of Children with Disabilities (OCECD) is a statewide, nonprofit organization that serves families of infants, toddlers, children and youth with disabilities in Ohio, and agencies who provide services to them. OCECD works through the coalition efforts of more than 35 parent and professional disability organizations which comprise the Coalition.

Established in 1972 and staffed primarily by parents of children and adults with disabilities, persons with disabilities, and education professionals, the Coalition's mission is to ensure that every Ohio child with special needs receives a free, appropriate, public education in the least restrictive environment to enable that child to reach his/her highest potential. Throughout Ohio, the Coalition's services reach families of children and youth, birth through twenty-six, with all disabilities.

OCECD's programs help parents become informed and effective representatives for their children in all educational settings. In addition, youth are assisted to advocate for themselves. Through knowledge about laws, resources, rights and responsibilities, families are better able to work with agencies to ensure that appropriate services are received for the benefit of their sons and daughters.

OHIO COALITION FOR THE EDUCATION OF CHILDREN WITH DISABILITIES

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Revised 11/2015. Price $10.00 – One copy FREE to parents in Ohio as supplies are available.

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ATTENTION-DEFICIT/HYPERACTIVITY DISORDER

Introduction:

Historically attention disorders may be documented as far back as the 1880's in stories about "Fidgety Phil." This behavior disorder has been identified by terms, such as, Minimal Brain Dysfunction, Attention Deficit Disorder With and Without Hyperactivity, Attention Deficit Hyperactivity Disorder, Undifferentiated Attention Deficit Disorder, and Attention Deficit Disorder.

In 2000, the American Psychiatric Association adopted the name Attention-Deficit/Hyperactivity Disorder (AD/HD). (DSM-IV-TR) Many continue to use the term ADD for those diagnosed as predominantly inattentive and ADHD for those diagnosed as predominantly hyperactive or impulsive. The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) was published May 27, 2013.

There are an estimated 1.5 to 2.5 million children with AD/HD in the United States. These children make up about 3-5 percent of a school's student population. Boys are diagnosed almost ten times more often than girls. Girls tend to be more inattentive and their symptoms are dismissed as those of a day dreamer. Although symptoms change with age, research studies reaffirm that children do not "outgrow" their AD/HD.

What are the Diagnostic Features of AD/HD?

According to the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision (DSM-IV-TR), the essential feature of Attention-Deficit/Hyperactivity Disorder is a "persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequently displayed and more severe than is typically observed in individuals at a comparable level of development (Criterion A)."

Symptoms must be present before the age of 7 (Criterion B). Impairment or symptoms must be present in at least two settings, for example, at home and at school (Criterion C). There must be "clear evidence of interference with developmentally appropriate social, academic, or occupational functioning (Criterion D). The disturbance cannot better be accounted for by another mental disorder, such as, a mood disorder, anxiety disorder, autism, etc. (Criterion E).

Diagnosing AD/HD can be frustrating because there is no definitive way to test for it. It cannot be diagnosed by a blood test, electroencephalogram reading, CAT scan, PET scan, X-ray, or psychological test score. It is a neurological condition that involves problems with attention, hyperactivity and impulsivity. Research now is revealing that it may not be disorder of attention but rather a function of developmental failure in the brain circuitry that monitors inhibition and self-control. Children with AD/HD typically exhibit behavior that is classified as poor sustained attention or hyperactivity/impulsivity.

As a result, DSM-IV-TR lists three subtypes of AD/HD:

- Attention-Deficit/Hyperactivity Disorder, Combined Type
- Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type
- Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type

Most children and adolescents with the disorder have the Combined Type. If symptoms do not meet the full criteria for the disorder, the child should be diagnosed with Attention-Deficit/Hyperactivity Disorder Not Otherwise Specified.

Although some children may be diagnosed with only AD/HD, the U.S. Department of Education reported that research studies have documented anywhere from seven to ninety-two percent of children with AD/HD also have learning disabilities. Likewise, children with AD/HD are more likely to have co-existing or comorbid psychiatric disorders, such as, anxiety, bipolar disorder, mood disorder. Obsessive Compulsive Disorder (OCD) and Oppositional Defiant Disorder (ODD), etc.

AD/HD MYTHS

Public perceptions of AD/HD are full of myths, misconceptions and misinformation. Many still assert that the disorder either does not exist or that it is the result of parents who have not learned how to manage their unruly or disorganized children. Others believe that children are misdiagnosed purposely due to parents wanting an academic advantage so that their children do well on high-stakes tests. There is no evidence-based research that supports any of these allegations. (Teeter Ellison, 2003).

Myth #1 AD/HD is Not a Real Disorder

The National Institute of Health, the Surgeon General of the United States, the United States Department of Education and an international community of clinical researchers, psychiatrists and physicians, concur that AD/HD is a valid disorder with severe, lifelong consequences. (NIMH, 2008)

Myth #2 AD/HD is a Childhood Disorder

The notion that individuals outgrew AD/HD has been dispelled by long-term studies showing that anywhere from 70-80 percent of children with AD/HD exhibit symptoms into adolescence and young adulthood. (Barkley, 2000)

Myth #3 AD/HD is Over-Diagnosed

Changes in special education legislation in the early 1990s increased general awareness of AD/HD as a handicapping condition and provided the legal basis for diagnosis and treatments in the school setting. These legal mandates have increased the number of school-based services available to children with AD/HD and may have inadvertently led some to conclude the AD/HD is a new disorder that is over-diagnosed. (Teeter Ellison, 2003)

Myth #4 Children with AD/HD are Over-Medicated

"Most researchers believe that much of the increased use of stimulants reflects better diagnosis and more effective treatment of a prevalent disorder." (Surgeon General's Report, 2001, p. 149 as cited by Teeter Ellison, 2003)

Myth #5 Poor Parenting Caused AD/HD

This myth may be the most difficult to dispel because parenting characteristics do exacerbate AD/HD and increase the risk for the child to develop comorbid disorders. Barkley's research in 1998 concluded that AD/HD could no longer be based solely or even primarily on social factors, such parental characteristics, child management or home environment (p. 176). Related to this myth are parental beliefs that their children are responsible for their AD/HD symptoms. This may result in punitive parenting practices. (Barkley, 2000)

Myth #6 Girls Have Less Severe AD/HD Than Boys

According to the Surgeon General's Report on Mental Health (2001), girls are less likely to receive a diagnosis of and treatment for AD/HD compared to boys. Girls tend to have lower rates of hyperactivity and externalizing disorders than boys. Girls with AD/HD have more issues with severe internalizing disorders, such as, anxiety, depression, and low self-esteem.

Myth #7 They Just Need to Try Harder

What exactly does try harder mean? How does the teacher know how hard the child is trying? What if the child is trying harder but trying "wrong?" When a child is told to try harder, and believes that he/she already is trying as hard as they can, is can be very frustrating. It is not about trying harder, but trying different. Therefore, evaluate and determine what the child is not getting, what the child needs to be successful, and then write an appropriate IEP or Section 504 plan based on those unique needs. A teacher or parent would never tell a blind child that if they tried harder they could see; therefore, do not expect trying harder will eliminate AD/HD or a learning disability.

Myth #8 Let Him Fail. Once the child sees the consequences, he will be motivated to do better.

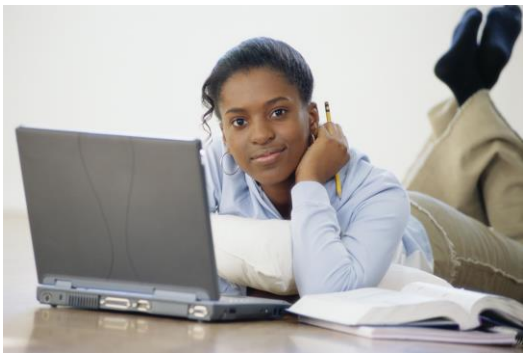
For children with AD/HD, the child may not fully comprehend the consequences of failing and many of these students already have experienced a succession of failures. Schools and parents who take this "let him fail" approach are pointing the finger of accountability at the child rather than at themselves. If experiencing failure was the answer, the child would have gotten it the first or second time he failed. The child with AD/HD needs supports and strategies to succeed. (Lowe, 2005)

Myth #9 Punishing the Child Will Make Him Do Better

How many parents and schools have punished the AD/HD child because of their disability? Has the AD/HD child been denied recess because of unfinished work due to being inattentive? Has the AD/HD child been given detentions for uncompleted assignments? If the goal is to help the AD/HD child to succeed, do not punish them for behaviors related to their disability. Realize that children with AD/HD struggle every moment of every day just to remember what they are supposed to be doing. Punishing a child with AD/HD for their disability related behaviors is like punishing a child in a wheelchair for not walking.

Myth #10 The AD/HD Child Will Never Go to College, So Why Bother.

Each year, more high school students with AD/HD and learning disabilities are furthering their education at the postsecondary level. Legal mandates under Section 504 have promoted the development of support services for both two and four-year college students. Under Section 504, postsecondary students with documented disabilities, such as AD/HD, may request modifications, accommodations and/or auxiliary aids that will enable them to participate in and benefit from all postsecondary educational programs and activities.



Securing Special Education or Educational Accommodations

There are two federal laws that guarantee a Free Appropriate Public Education (FAPE) and provide services and accommodations to eligible students with disabilities in the United States. They are:

1. Individuals with Disabilities Act 2004 (known as IDEA or IDEIA)
2. Section 504 of the Rehabilitation Act of 1973 (known as Section 504)

Both laws state that children with disabilities must be educated, as much as possible, with children who do not have disabilities. When the state law and federal law are different, the schools must follow the federal law, unless the state law provides the child with more protection. How do parents, professionals and teachers determine which law is best for the child?

There is no "best" choice. The child's needs and degree of impairment determine whether Section 504 or IDEA is appropriate when selecting and implementing instructional strategies for a child with AD/HD.

Section 504

As a general rule, if a child is eligible for services under IDEA, he or she qualifies for protections under Section 504. However, not all students covered by Section 504 are eligible for IDEA services. If the child diagnosed with AD/HD does not need special education services, the child will not qualify for an IEP under IDEA; however, the child may qualify for accommodations under Section 504 of the Rehabilitation Act of 1973. In late 2008, Congress passed the Americans with Disabilities Act Amendents Act (ADAAA). This new law became effective on January 21, 2009. This law included a conforming amendment to Section 504 which broadened the interpretation of who can qualify for services. As a result, more students now may be eligible for services under Section 504.

To be eligible for services under Section 504, the child must have a physical or mental impairment that substantially limits at least one major life activity. Major life activities include: eating, sleeping, walking, standing, lifting, bending, concentrating, thinking, communicating, learning, reading, writing, performing math calculations, working, caring for oneself, and performing manual tasks. Denial of eligibility cannot be based on mitigating circumstances. For a child with AD/HD, the effect of medication cannot be used to deny eligibility. The new law clarifies that an impairment that substantially limits one major life activity does not need to limit other major life activities when determining 504 eligibility; for example, if the child's impairment substantially limits reading, it does not have to limit learning in order to be eligible for 504 services.

Other opportunities for students to received accommodations under Section 504:

- when a student is determined to no longer need an IEP;
- when a student is evaluated and determined ineligible under IDEA for special education services;
- when a student is found eligible for an IEP but the student's parents refuse to consent to the provision of special education services; or
- when parents decide to revoke consent for special education services after initial consent and delivery of IEP services (Cortiella, 2010)

School related problems that may qualify a child with AD/HD for 504 interventions:

- Performing below ability level
- Noncompliance to rules/discipline problems
- Incomplete assignments
- Difficulty following directions
- Disorganization
- Poor handwriting
- Poor note taker
- Poor test-taking skills
- Off-task behavior (Illes, 2007)

Behavioral Accommodations for a student with AD/HD may include:

- Daily notes home
- Behavior contracts
- Incentive/reward programs
- Anger management training
- Peer buddy for recess or transitioning between classrooms

Academic Accommodations for a student with AD/HD may include:

- Reduced quantity of work/focus on quality
- Designated note taker
- Alternate way to complete written assignments and tests (orally)
- Reduced homework
- Untimed tests
- Peer tutor
- Organizational monitoring
- Assistive technology (laptop, calculators)

If interested in a more complete list, call 1-844-382-5452 to request a free copy of OCECD's Section 504 publication or go to our website, www.ocecd.org.

If the school refuses to consider Section 504 accommodations, they must provide the parents with a copy of their due process rights under 504. School districts are required to have a 504 Coordinator and employ procedural safeguards regarding the identification, evaluation, or educational placement because of a disability. Parents must be told about these procedures.

If the school district is unable to provide this information, please contact the Office for Civil Rights 1-216-522-4970.

For students with AD/HD who need simple accommodations or minor changes to their academic day, a Section 504 plan may be the appropriate choice. Section 504, unlike IDEA, does not ensure that a child with a disability will receive an educational program based upon the child's unique needs that will provide the child with educational benefit or prepare the child for post-secondary employment and independent living.

Individualized Education Program (IEP)

Federal law requires public schools to provide every student with a "free appropriate public education" (FAPE) in the least restrictive environment (LRE). Even though Federal law requires public schools to provide services to eligible student with AD/HD, it often is up to the parents to work with the school to set up these services and accommodations and to monitor their child's progress.

Here is a step-by-step walk through the special education process.

Step 1: Get an Accurate Evaluation

Write a letter to your school requesting an initial evaluation. Send your letter by certified mail with a green return card so that you have proof of delivery. Should the school district deny your request or you disagree with the school's findings, you may arrange for a private evaluation or an independent educational evaluation (IEE). In some cases, the school may have to pay for the IEE. Parents also will receive a copy of the Ohio's procedural safeguard notice: *Whose IDEA Is This?*

Note: A private assessment with a recommendation for IEP services will not initiate an IEP for your child. You must contact the school, in writing, and request an initial evaluation to determine whether or not your child is eligible for special education. This often holds true for obtaining Section 504 services. See sample letter on next page.

Date you write your letter **(Include month, day and year)**

Full Name of Person to whom you are writing **(the Principal or the Special Education Director)**
Person's Title **(Principal, Special Education Director)**
Name of School
Full Address of School

Dear **(Use their title [Dr.; Mr.; Mrs.; Ms.] and last name):**

I am writing to request that my son/daughter, (child's name), be evaluated for special education and related services. I am concerned that (child's name) is having problems in school and I believe he/she may need special services in order to learn. (Child's name) is in the ____ grade at (name of school). (Teacher's name) is his/her teacher.

Specifically, I am concerned because (child's name) does/does not (give a few specific examples of your child's problems at school).

We have tried the following to help (child's name): (If you or the school have done anything extra to help your child, briefly state it here).

This letter serves as my request and consent for an evaluation of my child. Please provide me the name and telephone number of the person who will be forwarded this letter and who will be coordinating the evaluation. You can send me the information or call me during the day at (daytime telephone number).

Thank you for your prompt attention to my request. I look forward to hearing from you within five school days of the date you receive this letter.

Sincerely,

Your Full Name
Full Address
Daytime Telephone Number

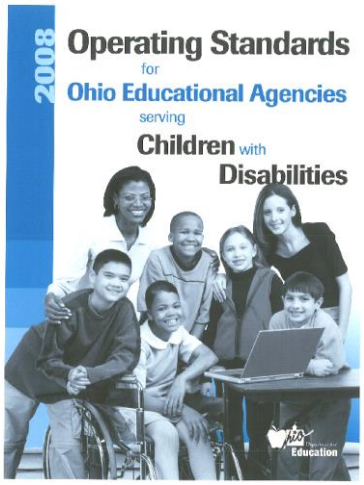
Step 2: Meet with the Evaluation Team

Following the evaluation, the evaluation team will prepare the Evaluation Team Report (ETR). The parent or guardian will meet with the evaluation team to discuss the results and decide whether or not the child needs special education services to address how AD/HD impacts the child's ability to learn.

Step 3: Category of Eligibility

A child with AD/HD may qualify for special education under the IDEA category "Other Health Impairment (OHI). If the child has a significant reading problem or significant math issues, the child may qualify for Specific Learning Disability (SLD). Remember that the category for qualifying for an IEP does not limit the services that are provided. The IEP is "individualized" and must address *all* identified academic and functional needs of the student.

Step 4: Develop the Individualized Education Program (IEP)



Once the child qualifies for an IEP, the parent or guardian will meet with their child's IEP team to develop the IEP. The IEP will specify the child's educational goals and how those goals will be met in the least restrictive environment (LRE). LRE generally refers to the regular education classroom.

Goals must be specific, measurable and achievable. For example, the IEP must explain exactly how the child will be taught to stop interrupting the teacher. Unless strategies are specified, there is no way to guarantee proper implementation or to monitor progress.

The *Operating Standards for Ohio Educational Agencies serving Children with Disabilities* explains in detail the IEP and procedural safeguards. To print a free copy; http://www.ode.state.oh.us/GD/Templates/Pages/ODE/ODEDetail.aspx?page=3&TopicRelationID=968&ContentID=28143&Content=93404

Step 5: Insist on a Customized Plan

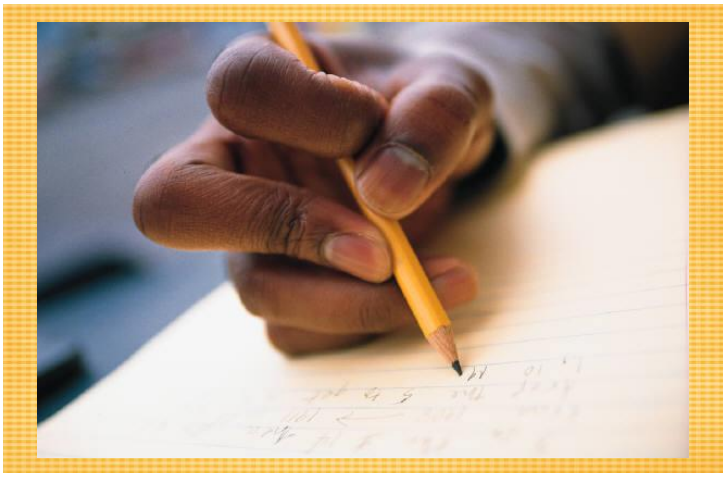
The IEP team cannot write the IEP based only on existing programs. IDEA requires the plan to be based on the child's identified needs as described in the ETR.

Step 6: Monitor Your Child's Progress

Be sure the IEP includes how and when Progress reports will be provided to the parent. Ohio law mandates that the parent receive progress reports at the same time grade cards are issued. However, the IEP can specify more frequent reporting. If your child is not making progress, do not wait until the IEP team meets for the annual IEP review. Whenever the IEP no longer is providing education benefit, call an IEP team meeting to discuss reviewing the current IEP goals and objectives and making revisions.

Step 7: Documentation

Put all requests, concerns and thank you's in writing and keep copies on file. After each IEP meeting or school conference, send a letter summarizing the main points and who you spoke with. A recent Supreme Court decision underscored the importance of keeping written records. The Court ruled that, in a due process hearing, the legal burden of proving that the IEP failed to meet a child's needs fell on the parents. In law, oral conversations, promises, or commitments never happened. Best advice is to Document, Document, Document!



Behavioral Interventions/Modifications

Children with AD/HD often need behavioral interventions at school and at home. At school, interventions assist the child in modifying behaviors to eliminate disciplinary action that takes time away from classroom time and the lesson being presented. Intervention techniques at school and at home may include:

- Praise appropriate behavior immediately.
- Use a variety of words to praise appropriate behavior
- Be consistent and be sincere (U.S. Dept of Education, Teaching Children with Attention Deficit Hyperactivity Disorder, 2008, p.21)

If these interventions are not effective at school, the need for a written Behavior Modification Plan may be the next step.

IDEA lists **five special factors that the IEP team must consider** in the development, review, and revision of each child's IEP. **Factor #1—the IEP team must "in the case of a child whose behavior impedes the child's learning or that of others, consider the use of positive behavioral interventions and supports, and other strategies, to address that behavior".** (NICHCY, December 2010) IDEA thus makes it very clear that children must be evaluated in all areas related to the suspected disability, including behavior.

In order to set up a positive behavior modification plan, the school and parents need to understand problem behaviors, such as, where and when do they occur and what purpose do they serve for the child. What a child does and why he does it may not be related but they may serve the same function—to get adult attention. The process of identifying problematic behaviors begins with a **functional behavioral assessment (FBA).** The parent may request a FBA any time if the child's behaviors are becoming worse or the IEP team cannot explain to the parent why the problem behaviors are happening. During the FBA process, the school staff may talk with both the parent and the child to collect data. They may observe the child in different settings, such as the cafeteria, classroom and/or playground. They will interview or gather reports from teachers, peers and other people that interact on a regular basis with the child. The team will review the child's records, including any private assessments the parents share with the school. With information from the FBA, parents and teachers will be able to develop a hypothesis or educated guess about why problem behavior(s) happen and develop a positive behavior intervention plan to modify, replace or eliminate inappropriate behavior (s). (ALLIANCE ACTion Sheet ALL-12, p. 1)

Adults usually have two philosophies about behavior—the child is a problem or the child has a problem. The former often results in punishing the child and/or blaming the child, neither will improve behavior long-term. Positive behavior intervention plans focus on the latter. Typically the plan will include:

- Description of the behavior(s) that the plan is targeting, the function of the undesirable behavior(s), and a description of the behavior(s) that will replace the inappropriate behavior
- Description of any previous interventions and how well they did or did not work
- Skills training to increase appropriate behavior
- Changes that will be made in classrooms or other environments to reduce or eliminate problem behaviors
- Description of how behavioral changes will be measured
- When and how the plan will be reviewed
- Supports for the child to use the appropriate behaviors
- A list of the student's strengths and abilities
- Description of when and how information will be shared between home and school
- Coordination with the home to monitor appropriate behaviors in other settings

Parenting a Child with AD/HD

As a parent of a child with AD/HD, it is important to remember that your child with AD/HD can succeed. Do not waste your time and energy on self-blame. AD/HD is a dysfunction in certain areas of the brain. Currently there is no cure for AD/HD but you can take positive steps to decrease its impact on the life of your child and your family's. Therefore, learn all you can about AD/HD.

Many AD/HD children are socially immature compared with their peers. For example, your 12 year old may function more like a 9 year old. Do not compare your child with a child or sibling who does not have AD/HD. Their development may be superior in some areas and delayed in others. Consistency, patience and repetition are keys to behavior change for children with AD/HD.

Pay attention to good behavior. By only paying attention to inappropriate or poor behavior and ignoring the good behaviors, the child has no motivation to learn appropriate behavior skills and will continue to misbehave to get your attention. This is called negative reinforcement. Punishment also does not teach new skills. Find positive ways to teach and reinforce new skills that will result in positive behavior changes. For educators, remember that a child would rather appear bad than stupid. Class disruptions may be a defensive mechanism to save self esteem with their peers. Pay attention and recognize when they are "being good." Do not reward them with attention for "being bad."

Always be specific when complementing the AD/HD child. Say exactly what you like or do not like. Children with AD/HD often are not aware of how their behaviors affect others. Repetition and reinforcement are necessary to make positive behavior a habit. Positive feedback and rewards also will increase the likelihood of acceptable behavior. For those families who have "house rules," post rules where the child can see them and in words that they can read and understand. If there is no TV until homework is completed, the child with AD/HD still will need to be reminded of what is expected. Any rules must be enforced with consistency for the entire family.

Sleep is an absolute must for students with AD/HD. The information received during the day is stored in the short-term memory. During the sleep stage called REM (Rapid Eye Movement), this information transfers over to long-term memory. Unfortunately, children with AD/HD often have trouble sleeping. Try to schedule "downtime" before bedtime by turning off computers, electronic games and cell phones. If your child has a difficult time waking up, it may be due to lack of restful sleep. Oftentimes, anxiety, hormonal changes, night terrors, depression, bullying, etc. may interfere with restful sleep. Discuss any suspicions with the child's doctor.

Executive Function Deficits

School often is very difficult for students with AD/HD. When executive function deficits are present, academic problems may become overwhelming to the student and his/her family. Research has shown that executive functions develop slower in many children with AD/HD. These functions operate as the "brain's CEO," helping to manage and regulate behavior. Tasks influenced by executive functions include:

- Organizing materials
- Getting started on and finishing schoolwork
- Remembering homework
- Memorizing facts
- Writing essays or reports
- Solving complex math problems
- Completing long-term projects
- Being on time
- Controlling emotions
- Planning for the future (Zeigler Dendy, 2008)

Prior to understanding the role executive functions play in the life of a child with AD/HD, parents and teachers often thought that academic failure was a simple matter of laziness or lack of motivation. The child chose not to do the assignment.

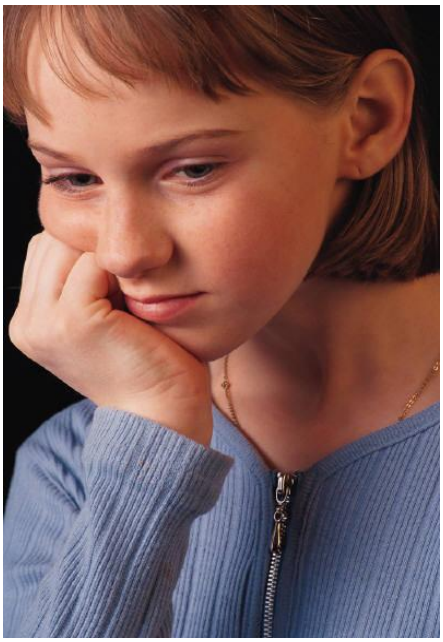
According to Russell Barkley, PhD, a leading researcher on the topic, students with AD/HD experience roughly a 30 percent developmental delay in organizational and social skills. For example, a 12-year-old adolescent may have executive skills more like those of a 9-year-old. Barkley describes executive functions as "those actions that help accomplish self-control, goal-directed behavior, and the maximization of future outcomes." (Zeigler Dendy, 2008)

Executive Functions that impact school performance:

- Working memory and recall (holding facts in mind while manipulating information; accessing facts stored in long-term memory)
- Activation, arousal, and effort (getting started, paying attention, finishing work)
- Controlling emotions (tolerating frustration, thinking before acting or speaking)
- Internalizing language (using "self-talk" to control one's behavior and direct future actions)
- Complex problem solving (taking an issue apart, analyzing the pieces, reconstituting and organizing it into new ideas) (Zeigler Dendy, 2008)

School Performance affected by poor working memory:

- Remembering and following instructions
- Memorizing math facts, spelling words, and dates
- Performing mental computations in one's head
- Completing complex math problems (algebra)
- Remembering one part of an assignment while working on another segment
- Paraphrasing or summarizing
- Organizing and writing essays
- Learning from past behavior
- Judging the passage of time accurately, and may not allow enough time to complete academic work
- Examining or changing their own behavior
- Preparing for the future.



Often it is in middle schools that the student with AD/HD hits the proverbial "brick wall." Middle school students are expected to work independently, organize themselves, get started on assignments and remember multiple assignments. Understanding the role of executive functions will help parents and teachers realize that school is very difficult for children with executive function deficits.

Teachers, please avoid telling parents that their child is very bright and that he could make better grades if he would just try harder. In truth, they often are trying harder, but without proper treatment and academic supports they will not make better grades. Think for a minute what it would be like if you told the parent of a child with vision problems that if they just tried harder they would be able to read books.

In addition to impaired working memory, many students with AD/HD have slow-processing speed which affects their ability to respond quickly and their ability to write essays or work on math problems. Research has identified written expression as a learning disability among 65 percent of children with AD/HD. In order to write an essay, the AD/HD student needs to hold many ideas in their mind, retrieve grammar, spelling and punctuation rules from long term memory, manipulate all this information, all while trying to remember to write down ideas, organize the material in a logical sequence, and then review and correct errors. Same holds true for math calculations where the student has to hold facts in their head, apply the rules; and shift information between working and short-term memory to solve the problem and determine the answer.

Suggested Strategies for Success in School

Make the learning process as concrete and visual as possible.

Written Expression

- Allow the child to dictate information to a "scribe" or parent
- Provide graphic organizers to serve as visual prompts
- Teach child to use "post-it" notes to brainstorm essay ideas
- Use a computer for written assignments
- Have a note taker or teacher-provided notes
- Limit recopying
- Use a scribe for long written assignments

Math

- Match the child with a peer tutor
- Use paired learning: teachers explains problem, then students make up their own examples, swap problems, and discuss answers

Memory

- Teach child to use mnemonics (memory tricks), such as acronyms or acrostics; for example, HOMES to remember the names of the Great Lakes
- Use "visual posting" of key information on strips of poster board

Modify Teaching Methods

- Use an overhead projector, white board, or computer to demonstrate how to write an essay.
- Use color to highlight important information (Orange highlighters may work better than yellow.)
- Use graphic organizers to help students organize their thoughts

Modify assignments—reduce written work

- Shorten assignments
- Check time spent on homework, and reduce it if homework takes longer than roughly 10 minutes per grade, as recommend by PTA/NEA policy. For example, a 7th grader should spend no longer than 70 minutes on homework.
- Write answers only, not the questions (photocopy questions)
- Hand out spelling words on Friday instead of Monday

Modify testing and grading

- Give extended time on tests.
- Divide long-term projects into segments with separate due dates and grades.
- Average two grades on essays—one for content and one for grammar
- Use reader/scribe to read questions and to record answers, particularly if the child has a reading disability or Dysgraphia*
- Give tests orally

Modify level of support and supervision

- Appoint "row captains" to check to see that homework assignments are written down and later turned in to the teacher
- Increase the amount of supervision and monitoring, if they are struggling (Zeigler, 2008)

*Dysgraphia

Most AD/HD students struggle in the area of penmanship or writing with a pen or pencil. If this is extremely difficult for your child or student, request an occupational therapist to evaluate for dysgraphia. This evaluation also may be requested as part of the initial evaluation. If you want the child evaluated in this area, you will have to request it specifically.

Medication and Treatment of AD/HD

Following a diagnosis of AD/HD, your child's doctor will discuss treatment options. You may become overwhelmed with information about the safest, most effective treatment plan.

In Ohio, a school district **cannot make a parent place their child on medications. The school district cannot refuse to serve the child until the parent puts the child on medication. Rule 3301-51-09 (L) (1) and (2)** (Operating Standards for Ohio Educational Agencies serving Children with Disabilities, 2008)

Keep in mind that medication will not cure your child. The same drug may affect your child differently than another child, even siblings with AD/HD. Ask your doctor if there are any side effects with the use of a specific medication.

AD/HD medications affect the area of the brain chemicals called neurotransmitters that run the nervous system where attention and impulses are regulated. These medications, called stimulants, are helpful for about 70% to 80% of children who use them. When medications work, children have more control over impulsiveness and aggressive behaviors. Their attention span in school is increased and they show improvement in the quality and quantity of school work. Peer and family relations also improve.

Most common stimulants:

Methylphenidate (Ritalin, Concerta, Metadate, Focalin, Daytrana): This is the most widely used medication for AD/HD.

Dextroamphetamine (Dexedrine, Dexedrine Spansule): Usually prescribed when methylphenidate does not work on symptoms or causes unwanted side effects.

Mixed Amphetamine (Adderall): Similar to dextroamphetamine but may work better on certain brain neurons than dextroamphetamine does.

Lisdexamfetamine Dimesylate (Vyvanse): This newer medications has been on the market since 2007. It is known as a "prodrug", meaning that it is chemically inert until in interacts with an amino acid in the gastrointestinal tracts. Comparable to Adderall XR.

Stimulants are the best tested and most widely used medications; however, some children and adolescents respond just as well to treatments with other medications that are not stimulants.

Nonstimulant medications may be used when contraindications to stimulant medications exist, stimulants have been ineffective or have unacceptable side effects, or parents prefer a nonstimulant for personal reasons. Antidepressants are nonstimulant medications that have been used to treat AD/HD but are used less frequently.

Most common nonstimulants:

Atomoxetine (Stattera): Approved by FDA in 2002 for treatment of AD/HD

Antidepressants may include: Bupropion (Wellbutrin), Imipramine (Tofranil), Flueoxetine (Prozac), Sertraline (Zoloft), Citalopram (Celexa), Clonidine (Catapres) and Guanfacine (Tenex) (CHADD, What We Know Info Fact Sheet #3, May 2011)

In addition to medication, research reports that the best results in behavior modification result when medication is combined with behavioral counseling. Family counseling also may be helpful.

Although cardiovascular complications are rare, the FDA now is requiring a label warning that stimulant medications may cause heart problems. If you or your child has an irregular heartbeat or heart palpitations, or if there is a family history of heart disease, you should have your child tested before starting stimulant medications.

Some researchers have found that some children taking stimulants lagged behind peers on their growth curve by ¾ of an inch in height and by six pounds in weight. Other researchers have good research data to show that the lag in height is unrelated to taking medication. However, it is a good idea for the child's doctor to monitor height and weight.

Alternative AD/HD Treatments

In the age of herbal supplements, cult diets, and As Seen on TV miracle cures, it is very important for parents of children with AD/HD to separate legitimate therapies from dangerous scams.

Research has found that the best AD/HD treatment may involve a combination of stimulants, behavioral modification training, and non-drug alternatives, such as, fish oil and exercise. Since the effectiveness of any treatment for AD/HD varies by individual, do not begin any alternative treatment plan before discussing it with your child's doctor.

Disclaimer: This publication is not designed to replace the advice of a trained physician or educator.

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- #5 AD/HD and Co-Existing Disorders
- #5D AD/HD, Sleep, and Sleep Disorders
- #6 Complementary and Alternative Treatments for AD/HD
- #7 Psychosocial Treatment for Children and Teenagers with AD/HD

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- #5A AD/HD and Coexisting Conditions: Tics and Tourette Syndrome
- #5B AD/HD and Coexisting Conditions: Disruptive Behavior Disorders
- #5C AD/HD and Coexisting Conditions: Depression
- #5D AD/HD, Sleep, and Sleep Disorders
- #6 Complementary and Alternative Treatments for AD/HD
- #6A Complementary and Alternative Treatments: Neurofeedback (EEG Biofeedback) and AD/HD
- #7 Psychosocial Treatment for Children and Teenagers with AD/HD
- #8 AD/HD Predominantly Inattentive Type
- #9 Diagnosis of AD/HD in Adults
- #10 Managing Medications for Adults with AD/HD
- #11 Time Management: Learning to Use a Day Planner
- #12 A Guide to Organizing the Home and Office
- #13 Succeeding in College
- #14 Legal Rights: Higher Education and the Workplace
- #15 Social Skills in Adults with AD/HD
- #16 Succeeding in the Workplace
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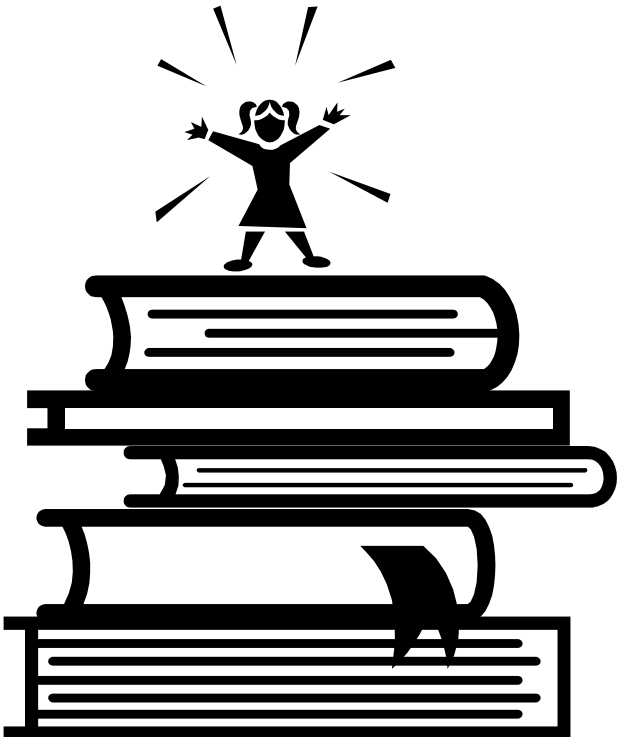

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