ADHD Overview

Previously distinguished as "Attention Deficit Disorder (ADD)" or "Attention Deficit Hyperactivity Disorder (ADHD)" under the current DSM-5 there is just one diagnostic heading of "Attention Deficit Hyperactivity Disorder (ADHD)" with the following presentations:

- Combined Presentation
- Predominantly Inattentive Presentation
- Predominantly Hyperactive-Impulsive Presentation

Considerations in children and youth:

- ADHD is estimated to affect around 5% of school-aged children. As it is a chronic condition that can manifest at a young age, there are different guidelines for treatment based on the patient's age range.
- ADHD is more frequent in males than in females in the general population (2:1 in children). Females are more likely than males to present primarily with inattentive features, which often leads to missed diagnoses.
- There is substantial increase in the incidence of ADHD in first-degree biological relatives of individuals with ADHD. Additionally, family interactions in early childhood may not cause ADHD but may influence or contribute to secondary development of conduct problems. Consider recommending parents of pre-school aged children complete a parent-training program and/or placement in a qualified pre-school program first before confirming an ADHD diagnosis.

American Academy of Pediatrics Recommendations:

- The treatment algorithm on the following pages is based on the American Academy of Pediatrics Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents*, which is based on a collaborative review of relevant articles on the diagnosis and treatment of ADHD. Recommendations are ordered based on the quality of evidence backing the strength of the proposed recommendation.
- ADHD should be recognized as a chronic condition, and therefore, consider children and adolescents with ADHD as children and youth with special healthcare needs. For these cases, the medical home model has been the preferred standard of care. Encourage strong family-school partnerships as well as bidirectional communication with teachers, parents and patient.

Resource:
American Academy of Pediatrics, Subcommittee on Attention-Deficit/Hyperactivity Disorder, Steering Committee on Quality Improvement and Management. ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents. *Pediatrics*. 2011;128;1007.

DSM 5 Criteria for ADHD Disorders

The diagnostic criteria includes a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning/development, as characterized by (1) and/or (2), with symptoms inconsistent with developmental level that negatively impact directly on social and academic/occupational activities:

1. Inattention: 6 or more (5+ in adolescents) of the following symptoms for at least 6 months
    a. Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during 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
    e. Often has difficulty organizing tasks and activities
    f. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort
    g. Often loses things necessary for tasks or activities
    h. Is often easily distracted by extraneous stimuli (for older adolescents and adults, may include unrelated thoughts)
    i. Is often forgetful in daily activities (ex: doing chores, running errands, keeping appointments)
2. Hyperactivity and Impulsivity: 6 or more of the following symptoms for at least 6 months
    a. Often fidgets with or taps hands or feet or squirms in seat
    b. Often leaves seat in situations when remaining seated is expected
    c. Often runs about or climbs in situations where it is inappropriate (Note: In adolescents or adults, may be limited to feeling restless)
    d. Often unable to play or engage in leisure activities quietly
    e. Is often "on the go", acting as if "driven by a motor"
    f. Often talks excessively
    g. Often blurts out an answer before a question has been completed
    h. Often has difficulty waiting his or her turn
    i. Often interrupts or intrudes on others (ex: conversations, games, activities)

Combined Presentation - ICD-10: F90.2

If both (1) and (2) are met for the past 6 months

Predominantly Inattentive Presentation - ICD-10: F90.0

If only (1) is met for the past 6 months

Predominantly Hyperactive/Impulsive Presentation - ICD-10: F90.1

If only (2) is met for the past 6 months

Other Specified Attention-Deficit/Hyperactivity Disorder - ICD-10: F90.8

Symptoms characteristic of attention-deficit/hyperactivity disorder that cause significant distress or impairment in social, occupational or other important areas of functioning predominate but do not meet the full criteria for attention-deficit/hyperactivity disorder or any of the disorders in the neurodevelopmental disorders diagnostic class.

Resource:
American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA: American Psychiatric Association, 2013.

Algorithm for Evaluation and Diagnosis

Routine screening and/or appointment with concern for inattention/hyperactivity

1. Rule out any underlying medical causes which may also be contributing (e.g. hyperthyroidism, seizures, drug or medication side effect)
2. Rule out any other psychiatric conditions (e.g. Anxiety, depression, pervasive developmental disorders such as Autism/Asperger's, learning disabilities, or psychotic disorders) with similar or related symptoms (ex: Anxiety may lead to avoidance of difficult tasks or restlessness, psychotic disorders may result in inattention due to focus on internal stimuli). Oppositional Defiant Disorder and Intermittent Explosive Disorder may also be present with or without ADHD.
3. With "sudden onset" change in functioning, also consider screening for psychosocial factors such as bullying (including cyberbullying), trauma or substance use (especially in adolescents)

Once other factors are ruled out, establish if patient meets diagnostic criteria through screening questionnaires. It is important to establish symptoms in more than one setting through objective reporting (ex: Vanderbilt Assessment Scale – Teacher Informant).

- If symptoms are only present in one setting, consider other environmental or behavioral factors contributing to symptoms.
- Pre-school aged children who are not in a school setting may only have parent reports – if there are concerns about the parent observation consider recommending parents to a parent-training program or place child in a qualified preschool program.
- In adolescents try to obtain information from at least 2 teachers as well as other sources such as coaches, school guidance counselors, or leaders of community activities where they participate.
- In situations where there is diagnostic uncertainty, neuropsychological testing may be helpful to provide further diagnostic clarification

SCREENING MEASURES

Diagnostic tools can be a helpful way to screen for ADHD. They can also be used to follow up on symptoms once treatment is initiated. An important thing to note is that the symptoms must be present in more than one setting (ex: home and school), and also a positive screening measure does not necessarily equal a diagnosis, as other differential diagnoses still have to be ruled in/out. One helpful tool is the Vanderbilt questionnaire, which has both parent and teacher versions (example below)

CHOC Children's

Vanderbilt Assessment Scale
Parent Informant

Today's Date: _____ **Child's Name:** _____ **Date of Birth:** _____

Parent's Name: _____ **Parent's Phone Number:** _____

Directions: **Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.**

Is this evaluation based on a time when the child was ☐on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework.	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie,"cons" others)	0	1	2	3

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD, Revised – 1102

Algorithm for Treatment

Patient diagnosed with Attention Deficit Hyperactivity Disorder (based on DSM criteria)

Ages 4-5 (preschool):
Start with behavioral therapy or parent training program
+
If ongoing moderate to severe symptoms consider adding on methylphenidate
(Although dextroamphetamine is the only medication FDA approved for children <6yrs old, methylphenidate has the most data for safety and efficacy in this patient population)

Ages 6-11 (school age):
Start with behavioral therapy and/or FDA approved medications for ADHD [stronger evidence for stimulants vs Strattera, Intuniv (Guanfacine ER), or Kapvay (Clonidine ER)]

Ages 12-18 (teenagers):
Start with FDA approved medications for ADHD (see chart on next page)
+
May prescribe behavior therapy, depending on circumstances

Until symptoms are stabilized, follow up at least every 3-4 weeks. Give parents follow-up parent and school Vanderbilt forms to complete before each follow up visit to help track the efficacy of treatments that have been initiated. At each follow up, assess treatment efficacy, side effects (ex: monitor height, weight, blood pressure, pulse, sleep, appetite, mood, tics), and presence of other comorbid conditions.

Considerations when using stimulant medications:

- Stimulants are the first-line treatment for ADHD
- In children 6yrs and older, start with methylphenidate and then if intolerable side effects or treatment failure (on at least 40mg total daily), switch to mixed salts of amphetamine options. If ineffective or serious side effects, consider 4-6wk trial of non-stimulant or referral to child/adolescent psychiatry.
- Use stimulants with caution in patients with drug/alcohol dependence or possible misuse/diversion. Consider starting with non-stimulant options in this population.
- The most common side effects are decrease in appetite and/or difficulty sleeping. Some patients may also have behavioral rebound when the medication wears off.
- For initial trial of medications, consider starting with short acting formulations and then when dose is stabilized and tolerated, switching to extended release for ease of administration
- Consider cardiac clearance first in any patients with family history of arrhythmias or sudden death or if patient is symptomatic (ex: chest pain, shortness of breath, palpitations, suspected hypertrophic obstructive cardiomyopathy)

Commonly Used Medications

Medication	Starting dose	Max daily dose	Dosing	Features
Methylphenidate - Ritalin - Methylin	5mg	60mg	Start with 5mg (2.5mg for Focalin) 1-2 times per day and increase by 5mg each week until good control is achieved	Type: Stimulant, immediate release (IR) Duration of effect: 3-4 hrs Has most evidence for safety/efficacy in preschool-aged children
Methylphenidate sustained/extended release - Concerta - Ritalin SR - Ritalin LA - Metadate CD (30% IR/70% ER) - Metadate ER	Concerta – 18mg	Concerta – 72mg	Concerta – Start with 18mg each morning and increase by 18mg each week until good control is achieved	Type: Stimulant, sustained/ extended release Duration of effect: 4-8 hrs Ritalin LA capsules can be sprinkled onto food for patients that cannot swallow pills
	Ritalin SR and LA – 20mg	Ritalin SR and LA – 60mg	Ritalin SR and LA – Start with 20mg daily and increase by 20mg each week until good control is achieved (may need second dose or methylphenidate IR dose in the afternoon)	
	Metadate CD – 20mg Metadate ER – 10mg	Metadate CD – 60mg Metadate ER – 60mg	Metadate CD/ER – Can increase by 10mg increments weekly until good control is achieved	
Dexmethylphenidate - **Focalin**	2.5mg	20mg	Start with 2.5mg 1-2 times per day and increase by 2.5mg-5mg each week until good control is achieved	Type: Stimulant, immediate release (IR) Duration of effect: 3-5 hrs
Dexmethylphenidate extended release - **Focalin XR**	5mg	30mg	Start with 5mg each morning and increase 5mg each week until good control is achieved	Type: Stimulant, extended release (XR) Duration of effect: 9-12 hrs

Mixed salts of amphetamine - **Adderall**	5mg	40mg	Start with 5mg 1-2 times per day and increase by 5mg each week until good control is achieved	Type: Stimulant, immediate release (IR) Duration of effect: 4-6 hrs Do not use in patients with Cardiac disease
Mixed salts of amphetamine extended release - **Adderall XR**	10mg	40mg	Start with 10mg each morning and increase by 10mg each week until good control is achieved	Type: Stimulant, extended release Duration of effect: 8-12 hrs Do not use in patients with Cardiac disease
Dextroamphetamine - **Dexedrine**	5mg	40mg	Start with 5mg 1-2 times per day and increase by 5mg each week until good control is achieved	Type: Stimulant, immediate release (IR) Duration of effect: 4-5 hrs
Dextroamphetamine extended release - **Dexedrine Spansule**	5mg	45mg	Start with 5mg each morning and increase by 5mg each week until good control is achieved	Type: Stimulant, extended release Duration of effect: 8-10 hrs
Lisdexamfetamine - **Vyvanse**	20mg	70mg	Start with 20mg I the morning and increase in 10-20mg intervals every 3-7 days until good control is achieved	Type: Stimulant, extended release Duration of effect: Prodrug of dextroamphetamine and so it's only active if ingested (pts cannot misuse medication by injecting it for a "high") Also effective for binge eating disorder Available in chewable tablets
Atomoxetine - **Strattera**	0.5mg/kg/day	1.4mg/kg/day	Start as a single daily dose, 0.5mg/kg/day for the first week then increase to single daily dose of 1.4mg/kg/day (Capsule forms: 10mg, 18mg, 25mg, 40mg, 60mg, 80mg, 100mg)	Type: Selective norepinephrine reuptake inhibitor Plasma concentrations may be increased by drugs that inhibit CYP450 2D6 (ex: Paroxetine, Fluoxetine) so doses should be reduced by half in coadministration

Guanfacine - **Tenex (IR)** – not FDA approved for ADHD - **Intuniv (ER)**	IR: 0.5mg QHS (if pt ≤45kg) or 1mg QHS (if pt >45kg)	IR: 2mg/day (if 27-40.5kg), 3mg/day (if 40.5-45kg), 4mg/day (if >45kg)	IR: Titrate up every 3 to 4 days in 0.5mg/day increments, can dose up to four times a day	Type: Alpha 2A agonist Can be used either monotherapy or as adjunct therapy with stimulant for partial responders
	ER: 1mg QHS	ER: 4mg (ages 6-12) or 7mg (ages 13-17)	ER: Start with 1mg once per day and increase by 1mg per week until adequate clinical response or max dose is achieved	Can cause dose related hypotension For ADHD can take a few weeks to see maximum benefits
Clonidine - **Catapres (IR) –** not FDA approved for ADHD - **Kapvay (ER)**	IR: 0.05mg QHS (if pt ≤45kg) or 0.1mg QHS (if pt >45kg)	IR: 0.2mg/day (if 27-40.5kg), 0.3mg/day (if 40.5-45kg), 0.4mg/day (if >45kg)	IR: Can increase in 0.05-0.1mg increments (depending on weight) every 3-7 days, up to four times a day	Type: Alpha 2A agonist Can be used either monotherapy or as adjunct therapy with stimulant for partial responders
	ER: 0.1mg QHS	ER: 0.4mg	ER: Start with 0.1mg QHS and increase by 0.1mg per week with doses divided and larger dose at bedtime	Can cause dose related hypotension

Possible strategies for common side effects:

- Decreased appetite/weight loss – Decrease dose, dose after meals, offer frequent snacks, take drug holidays on weekends/breaks, try another stimulant medication, try a non-stimulant medication
- Insomnia (most common with stimulants) – Dose earlier in the day, reduce dose, reduce or hold afternoon booster dose, restrict or eliminate other sources of caffeine/sugar
- Somnolence (most common with non-stimulants) – Dose earlier or later (depending on if somnolence is in the evening or morning), reduce dose, try another non-stimulant medication or if using Tenex, switch to Intuniv, which is less sedating
- Wearing off too soon – Increase dose, move AM dose to later in the day, add afternoon dose, try sustained release stimulant

Consider referral to psychiatry if:

- Considering meds in child <6yrs old
- Medically complicated or multiple co- morbid psychiatric conditions
- Medication or comorbid condition contraindicating stimulant (ex: substance abuse, eating disorder)
- Previous failed medication trials
- Any time you're considering medication or treatment outside of your comfort zone

OTHER RESOURCES/CONSIDERATIONS

For additional resources, check out the following:

- American Academy of Pediatrics (AAP) – Caring for Children with ADHD: A Resource Toolkit for Clinicians

- ADHD MedCalc – Easy to use online tool to help providers calculate equivalent doses between different stimulant medications
    - http://www.adhdmedcalc.com

- CHOC Children's Individualized Education Program (IEP) Tips for Parents of Children with ADHD*

- CHOC Children's Tips for Parents of Children with ADHD*

- CHOC Children's ADHD Assessment Toolkit*

- Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD)
    - http://www.chadd.org

*Documents found at the end of this ADHD Toolkit document for your reference.

Additional References

C.A. Childress, Psy.D.

Goldblatt E.S. (2007) 18 Tips for Getting Quality Special Education for Your Child. Disability Rights California www.disabilityrightsca.org/pubs.513001.htm

Wayne RESA Parent Advisory Committee (2003) Parent Handbook

Individualized Education Program (IEP)/504 Plan

What is an IEP (Individualized Education Program)?

An IEP is a program that addresses a child's special education experience at school. Special education services must be provided even for undocumented children who need these supports. The school district is required to provide these accommodations/services at no cost to parents.

Who is eligible for an IEP?

In order to qualify for an IEP, your child generally must be between the ages of 3 and 18, and have one of 13 specific disabilities listed in a federal special education law (IDEA). The identified disability must also be affecting their school performance and/or their ability to learn in a general education setting.

Eligible conditions can include specific learning disabilities, emotional disabilities, cognitive delays, intellectual disability, and certain medical/health conditions (including ADHD).

If they are found not to be eligible for an IEP, they may still qualify for a 504 Plan. A 504 Plan is another way for a child to receive accommodations, support, or services to support their learning.

How do I start the process?

A written request should be sent to your child's school principal or director of special education services. It should ask the school district to evaluate whether your child is eligible for special education services (see example on next page).

What types of services or placements are available?

There are many options, and your school will be able to tell you what is offered there. Some examples include:

- Modifications to general education classroom (e.g. sitting at the front of the classroom, being given written notes/handouts to follow along with during classes, etc.)
- Resource Specialist Program (RSP) – your child will be pulled out of the general education classroom for a particular subject(s) to receive more individualized help
- Special Day Class (SDC) – a special education classroom environment for those with more extensive educational needs
- Additional services/therapies (e.g., speech therapy (ST), occupational therapy (OT), physical therapy (PT), nursing assistance, psychological counseling, etc.)

Who attends the IEP meeting?

- All individuals who help develop the IEP: parents, child (if older), school administrator, general education and/or special education teachers, nurse, and/or school psychologist
- Other people who sometimes attend are those who provide special services like ST, OT or PT
- An interpreter, provided by the district, if parents do not speak English
- Parents can also bring a representative to the meeting, such as a relative, family friend, the child's therapist/counselor, an educational advocate, or someone who has independently evaluated their child, such as a neuropsychologist. Parents can also bring an attorney, however, the school district must be notified of this 5 days prior to the meeting.

Tips for Parents

- Assessments should be completed and an IEP developed within 60 calendar days of receipt of parents' written consent for an evaluation
- Discuss any concerns your child's current teachers have prior to IEP meetings
- Bring any copies of any prior assessments and/or medical/psychiatric diagnoses
- Actively participate in the meeting (e.g. bring a list of questions, discuss status of goals)
- An IEP is a legal document. If you are uncertain about anything or disagree with the findings or recommendations, you **do not** have to sign the IEP
    - The parts of the IEP that you DO agree to can be started while other aspects can be rewritten or appealed
    - Parents can take a copy of the written IEP home before signing to review it first
    - The school district must offer to translate the written IEP into the language of the child's parents, by request, if parents do not speak English
- Parents can request an IEP meeting any time it is appropriate to review or change the plan
- It is generally NOT recommended to bring an attorney to an IEP meeting unless an issue is already in dispute

Sample Letter – Request for Assessment (fill in bold portions)

(Your Name)
(Your Address)
(Your Telephone Number)

(Date)

(Name of Principal, Special Education Director and/or Program Specialist)

(Address)

Re: **(Your Child's Name/Date of Birth)**

Dear **(X),**

I am writing to refer my child, **(Name)**, for a full assessment to determine if **s/he** is eligible for special education services and support. **S/He** is **(age)** years old and attends **(name of school)**. I am requesting my child be evaluated for an IEP in the areas of **(speech, academics, behavior, etc.)** for the following reasons: **(e.g. s/he is not clear when speaking, s/he is failing several classes, s/he has a medical/psychiatric condition that is impacting learning)**.

I also request that my child be evaluated under Section 504 of the Rehabilitation Act of 1973 if applicable.

I would like an assessment plan authorizing this evaluation within 15 days after receipt of this request. I am also requesting that the IEP meeting be set within the time required by law so that we may discuss the results and programing my child required. Please ensure that I get copies of the assessment reports one week before the IEP meeting.

Sincerely,

(Signature)

(Your Name)

WHAT IS ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)?

- ADHD is medical condition that makes it hard for children and adolescents to pay attention, stay focused and control their behaviors
- ADHD influences your child's ability to organize and remember things
- Often children and adolescents with ADHD feel restless, lost, overloaded with information, impatient (it's hard to wait), feel more picked on by parents and teachers, and unpopular
- These behaviors make it challenging for children and adolescents to function at school and home as well as make it hard to get along with other kids

Symptoms of ADHD

- Trouble paying attention
- Trouble focusing on one thing at a time
- Trouble keeping still
- Trouble thinking before acting
- Trouble keeping track of things
- Trouble learning in school

WHO EXPERIENCES ADHD?

- Approximately 11% of U.S. children ages 4-17 are diagnosed with ADHD
- Boys are diagnosed with ADHD more than twice the rate of girls
- As your child becomes a teen and an adult, trouble thinking before acting, keeping track of things, and focusing on one thing at a time often continues, while his/her/their ability to keep still typically improves

RESOURCES & RECOMMEDED RESOURCES

Learning to Slow Down and Pay Attention by Nadeau and Ellen Dixon
National Institute of Mental Health (NIMH): https://www.nimh.nih.gov/health/statistics/attention-deficit-hyperactivity-disorder-adhd.shtml
National Institute of Mental Health (NIMH): https://www.nimh.nih.gov/health/publications/attention-deficit-hyperactivity-disorder-adhd-the-basics/index.shtml
Defiant Children by Russell Barkley
Parenting Hyperactive Preschoolers by Elizabeth Harvey, Sharonne Herbert, & Rebecca Stowe
Putting on the Breaks: Understand and Taking Control of Your ADD or ADHD by Patricia Quinn and Judith Stern
Taking Charge of ADHD by Russell Barkley
Your Defiant Child by Russell Barkley and Christine Benton

TIPS FOR PARENTS

- **Catching your child being good.** Notice the things you like about your child's behavior and express your appreciation of the good behavior.
- **Reward your child's good behavior and ignore negative behavior.** If your child is behaving, give positive attention to it, while you ignore misbehavior. Note: Do not ignore dangerous behavior.
- **Use clear commands.** Be clear, specific, and tell your child what to do (for example, "turn off the video games now," "walk please" (instead of saying don't run). Use one command at a time, multiple steps can be difficult for the child to follow.
- **Use consequences and rewards.** Make sure consequences and rewards are used immediately, are things your child cares about, and are things your child can follow through on each time. To decrease or increase a behavior, you want to connect the consequence or reward with the behavior as soon as possible. Rewards can be simple, like choosing dessert at dinner. Consequences should be short, like removing video games for 1 hour or 1 day.
- **Identifying and labeling emotions.** Children are born with the ability to express emotion, but not the ability to know how to appropriately express them. Teach your child about emotion and ways to express emotion by commenting on your child's, yours, and others' emotions (for example, "I am very sad today," "you are mad, and it is not ok to hit others").
- **Developing routines.** Help your child develop strategies to organize himself/herself/themselves. These might include a written daily schedule, a homework notebook, etc.
- **Give frequent breaks.** When your child is doing a difficult task, such as homework, build in frequent, short (5 minutes) breaks to help concentration.
- **Find treatment for your child.** Your child may benefit from parent training, therapy/counseling and/or medications. Talk with your child's doctor to decide what will work best for your family.

CHOC Children's

Vanderbilt Assessment Scale
Parent Informant

Today's Date: _____ **Child's Name:** _____ **Date of Birth:** _____

Parent's Name: _____ **Parent's Phone Number:** _____

Directions: **Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.**

Is this evaluation based on a time when the child was ☐on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework.	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie,"cons" others)	0	1	2	3

Adapted from the Vanderbilt Rating Scales developed by Mark L.Wolraich, MD. Revised - 1102

Symptoms (Continued)	Never	Occasionally	Often	Very Often
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance

	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: _____ Total number of questions scored 2 or 3 in questions 10–18:_____ Total Symptom Score for questions 1–18: _____ Total number of questions scored 2 or 3 in questions 19–26:_____

Total number of questions scored 2 or 3 in questions 27–40: _____

Total number of questions scored 2 or 3 in questions 41–47: _____

Total number of questions scored 4 or 5 in questions 48–55: _____

Average Performance Score: _____

Adapted from the Vanderbilt Rating Scales developed by Mark L.Wolraich, MD. Revised - 1102

CHOC Children's

Vanderbilt Assessment Scale
Teacher Informant

Teacher's Name: _____ **Class Time:** _____ **Class Name/Period:** _____

Today's Date: _____ **Child's Name:** _____ **Grade Level:** _____

Directions: **Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the beginning of the school year. Please indicate the number of weeks or months you have been able to evaluate the behaviors: _____.**

Is this evaluation based on a time when the child was ☐on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Fails to give attention to details or makes careless mistakes in schoolwork	0	1	2	3
2. Has difficulty sustaining attention to tasks or activities	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (school assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by extraneous stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat in classroom or in other situations in which remaining seated is expected	0	1	2	3
12. Runs about or climbs excessively in situations in which remaining seated is expected	0	1	2	3
13. Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks excessively	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting in line	0	1	2	3
18. Interrupts or intrudes on others (eg, butts into conversations/games)	0	1	2	3
19. Loses temper	0	1	2	3
20. Actively defies or refuses to comply with adult's requests or rules	0	1	2	3
21. Is angry or resentful	0	1	2	3
22. Is spiteful and vindictive	0	1	2	3
23. Bullies, threatens, or intimidates others	0	1	2	3
24. Initiates physical fights	0	1	2	3
25. Lies to obtain goods for favors or to avoid obligations (eg, "cons" others)	0	1	2	3
26. Is physically cruel to people	0	1	2	3

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circum-stances, may be appropriate.

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD. Revised - 0303

Symptoms (continued)	Never	Occasionally	Often	Very Often
27. Has stolen items of nontrivial value	0	1	2	3
28. Deliberately destroys others' property	0	1	2	3
29. Is fearful, anxious, or worried	0	1	2	3
30. Is self-conscious or easily embarrassed	0	1	2	3
31. Is afraid to try new things for fear of making mistakes	0	1	2	3
32. Feels worthless or inferior	0	1	2	3
33. Blames self for problems; feels guilty	0	1	2	3
34. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
35. Is sad, unhappy, or depressed	0	1	2	3

Performance

Academic Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
36. Reading	1	2	3	4	5
37. Mathematics	1	2	3	4	5
38. Written expression	1	2	3	4	5

Classroom Behavioral Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
39. Relationship with peers	1	2	3	4	5
40. Following directions	1	2	3	4	5
41. Disrupting class	1	2	3	4	5
42. Assignment completion	1	2	3	4	5
43. Organizational skills	1	2	3	4	5

Please return this form to: _____

Mailing Address: _____

Fax Number: _____

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–28: _____

Total number of questions scored 2 or 3 in questions 29–35: _____

Total number of questions scored 4 or 5 in questions 36–43: _____

Average Performance Score: _____

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circum-stances, may be appropriate.

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD. Revised - 0303

CHOC Children's

Vanderbilt Assessment Scale
Parent Informant – **FOLLOW UP**

Today's Date: _____ **Child's Name:** _____ **Date of Birth:** _____

Parent's Name: _____ **Parent's Phone Number**_____

Directions: **Each rating should be considered in the context of what is appropriate for the age of your child. Please think about your child's behaviors since the last assessment scale was filled out when rating his/her behaviors.**

Is this evaluation based on a time when the child was…

- ☐ **on medication**
- ☐ **was not on medication**
- ☐ **not sure?**

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD. Revised – 0303
Adapted from the Pittsburgh side effects scale, developed by William E. Pelham, Jr, PhD.

Performance	Excellent	Above Averag	Average	Somewhat of a Problem	Problematic
19. Overall school performance	1	2	3	4	5
20. Reading	1	2	3	4	5
21. Writing	1	2	3	4	5
22. Mathematics	1	2	3	4	5
23. Relationship with parents	1	2	3	4	5
24. Relationship with siblings	1	2	3	4	5
25. Relationship with peers	1	2	3	4	5
26. Participation in organized activities (eg, teams)	1	2	3	4	5

Side Effects: Has your child experienced any of the following side effects or problems in the past week?	Are these side effects currently a problem?			
	None	Mild	Moderate	Severe
Headache				
Stomachache				
Change of appetite—explain below				
Trouble sleeping				
Irritability in the late morning, late afternoon, or evening—explain below				
Socially withdrawn—decreased interaction with others				
Extreme sadness or unusual crying				
Dull, tired, listless behavior				
Tremors/feeling shaky				
Repetitive movements, tics, jerking, twitching, eye blinking—explain below				
Picking at skin or fingers, nail biting, lip or cheek chewing—explain below				
Sees or hears things that aren't there				

Explain/Comments:

For Office Use Only

Total Symptom Score for questions 1–18: _____

Average Performance Score for questions 19–26: _____

CHOC Children's

Vanderbilt Assessment Scale
Teacher Informant – **FOLLOW UP**

Today's Date: _____ **Child's Name:** _____ **Grade Level:**_____

Teacher's Name: _____**Class Time:** _____ **Class Name/ Period:**_____

Directions: **Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the last assessment scale was filled out. Please indicate the number of weeks or months you have been able to evaluate the behaviors: _____.**

Is this evaluation based on a time when the child was ☐ on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
19. Reading	1	2	3	4	5
20. Mathematics	1	2	3	4	5
21. Written expression	1	2	3	4	5
22. Relationship with peers	1	2	3	4	5
23. Following direction	1	2	3	4	5
24. Disrupting class	1	2	3	4	5
25. Assignment completion	1	2	3	4	5
26. Organizational skills	1	2	3	4	5

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD. Revised – 0303

Adapted from the Pittsburgh side effects scale, developed by William E. Pelham, Jr. PhD.

Side Effects: Has the child experienced any of the following side effects or problems in the past week?	**Are these side effects currently a problem?**			
	None	**Mild**	**Moderate**	**Severe**
Headache				
Stomachache				
Change of appetite—explain below				
Trouble sleeping				
Irritability in the late morning, late afternoon, or evening—explain below				
Socially withdrawn—decreased interaction with others				
Extreme sadness or unusual crying				
Dull, tired, listless behavior				
Tremors/feeling shaky				
Repetitive movements, tics, jerking, twitching, eye blinking—explain below				
Picking at skin or fingers, nail biting, lip or cheek chewing—explain below				
Sees or hears things that aren't there				

Explain/Comments:

For Office Use Only

Total Symptom Score for questions 1–18: _____

Average Performance Score: _____

Please return this form to: _____

Mailing address: _____

_____

Fax number: _____

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD. Revised – 0303

Adapted from the Pittsburgh side effects scale, developed by William E. Pelham, Jr. PhD.

Baseline Assessment

These scales should NOT be used alone to make any diagnosis. You must take into consideration information from multiple sources. Scores of 2 or 3 on a single Symptom question reflect often-occurring behaviors. Scores of 4 or 5 on Performance questions reflect problems in performance.

The initial assessment scales, parent and teacher, have 2 components: symptom assessment and impairment in performance. On both the parent and teacher initial scales, the symptom assessment screens for symptoms that meet criteria for both inattentive (items 1–9) and hyperactive ADHD (items 10–18).

To meet *DSM-IV** criteria for the diagnosis, one must have at least 6 positive responses to either the inattentive 9 or hyperactive 9 core symptoms, or both. A positive response is a 2 or 3 (often, very often) (you could draw a line straight down the page and count the positive answers in each subsegment). There is a place to record the number of positives in each subsegment, and a place for total score for the first 18 symptoms (just add them up).

The initial scales also have symptom screens for 3 other co- morbidities—oppositional-defiant, conduct, and anxiety/depression. These are screened by the number of positive respon-ses in each of the segments separated by the "squares." The specific item sets and numbers of positives required for each co-morbid symptom screen set are detailed below.

The second section of the scale has a set of performance measures, scored 1 to 5, with 4 and 5 being somewhat of a problem/problematic. To meet criteria for ADHD there must be at least one item of the Performance set in which the child scores a 4 or 5; ie, there must be impairment, not just symptoms to meet diagnostic criteria. The sheet has a place to record the number of positives (4s, 5s) and an Average Performance Score—add them up and divide by number of Performance criteria answered.

*Please Note, *DSM-V* contains the most updated criteria for diagnostic assessment. Please see "Attention Deficit Hyperactivity Disorder (ADHD) and the DSM 5" Handout for the differences between *DSM-IV* and *DSM-V.*

Parent Assessment Scale	Teacher Assessment Scale
Predominantly Inattentive subtype • Must score a 2 or 3 on 6 out of 9 items on questions 1-9 **AND** • Score a 4 or 5 on any of the Performance questions 48-55.	**Predominantly Inattentive subtype** • Must score a 2 or 3 on 6 out of 9 items on questions 1-9 **AND** • Score a 4 or 5 on any of the Performance questions 36-43.
Predominantly Hyperactive/Impulsive subtype • Must score a 2 or 3 on 6 out of 9 items on questions 10-18 **AND** • Score a 4 or 5 on any of the Performance questions 48-55.	**Predominantly Hyperactive/Impulsive subtype** • Must score a 2 or 3 on 6 out of 9 items on questions 10-18 **AND** • Score a 4 or 5 on any of the Performance questions 36-43.
ADHD Combined Inattention/Hyperactivity • Requires the above criteria on both Inattentive **AND** Hyperactive/Impulsive Subtypes.	**ADHD Combined Inattention/Hyperactivity** • Requires the above criteria on both Inattentive **AND** Hyperactive/Impulsive Subtypes.
Oppositional-Defiant Disorder • Must score a 2 or 3 on 4 out of 8 behaviors on questions 19-26 **AND** • Score a 4 or 5 on any of the Performance questions 48-55.	**Oppositional-Defiant/ Conduct Disorder** • Must score a 2 or 3 on 3 out of 10 items on questions 19-28 **AND** • Score a 4 or 5 on any of the Performance questions 36-43.
Conduct Disorder • Must score a 2 or 3 on 3 out of 14 behaviors on questions 27-40 **AND** • Score a 4 or 5 on any of the Performance questions 48-55.	
Anxiety/Depression • Must score a 2 or 3 on 3 out of 7 behaviors on questions 41-47 **AND** • Score a 4 or 5 on any of the Performance questions 48-55.	**Anxiety/Depression** • Must score a 2 or 3 on 3 out of 7 items on questions 29-35 **AND** • Score a 4 or 5 on any of the Performance questions 36-43.

Follow-up Assessment

The parent and teacher follow-up scales have the first 18 core ADHD symptoms, not the co-morbid symptoms. The section segment has the same Performance items and impairment assessment as the initial scales, and then has a side-effect reporting scale that can be used to both assess and monitor the presence of adverse reactions to medications prescribed, if any.

Scoring the follow-up scales involves only calculating a total symptom score for items 1–18 that can be tracked over time, and the average of the Performance items answered as measures of improvement over time with treatment.

Parent Assessment Follow-up	Teacher Assessment Scale
• Calculate Total Symptom Score for questions 1-18. • Calculate Average Performance Score for questions 19-26.	• Calculate Total Symptom Score for questions 1-18. • Calculate Average Performance Score for questions 19-26.

What is ADHD?

ADHD is a neurodevelopmental disorder affecting both children and adults. It is described as a "persistent" or on-going pattern of inattention and/or hyperactivity-impulsivity that gets in the way of daily life or typical development. Individuals with ADHD may also have difficulties with maintaining attention, executive function (or the brain's ability to begin an activity, organize itself and manage tasks) and working memory.

There are three presentations of ADHD:

- Inattentive
- Hyperactive-impulsive
- Combined inattentive & hyperactive-impulsive

What is the DSM-5?

The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition,* (DSM-5), published by the American, Psychiatric Association is the guide that lays out the criteria to be used by doctors, mental health professionals, and other qualified clinicians when making a diagnosis of ADHD. The DSM-5 was updated in 2013 and made changes to the definition of ADHD that will affect how the disorder is diagnosed in children and adults.

What about ADHD has changed with the DSM-5?

- Adult ADHD: For many years, the diagnostic criteria for ADHD stated that it was children who were diagnosed with the disorder. That meant that teens and adults with symptoms of the disorder, and who may have been struggling for many years but didn't know why, couldn't officially be diagnosed with ADHD. The DSM-5 has changed this; adults and teens can now be officially diagnosed with the disorder. The diagnostic criteria mentions and gives examples of how the disorder appears in adults and teens.
- In diagnosing ADHD in adults, clinicians now look back to middle childhood (age 12) and the teen years when making a diagnosis for the beginning of symptoms, not all the way back to childhood (age 7).
- In the previous edition, DSM-IV TR, the three types of ADHD were referring to as "subtypes." This has changed; subtypes are now referred to as "presentations." Furthermore, a person can change "presentations" during their lifetime. This change better describes how the disorder affects an individual at different points of life.
- A person with ADHD can have now have mild, moderate or severe ADHD. This is based on how many symptoms a person has and how difficult those symptoms make daily life.

What is a significant change between DSM-IV TR and DSM-5?

- A person can now be diagnosed with ADHD and Autism Spectrum Disorder.

Adapted from the National Resource Center on ADHD: A Program of CHADD (NRC). The NRC is supported through Cooperative Agreement Number CDC-RFA-DD13-1302 from the Centers for Disease Control and Prevention (CDC). The contents are solely the responsibility of the authors and do not necessarily represent the official views of CDC.

Reference: American Psychiatric Association (2013). Diagnostic and statistical manual of mental disorders (DSM-5), Washington, D.C.: American Psychiatric Association

What symptoms must a person have for a diagnosis of ADHD?

- In making the diagnosis, children still should have six or more symptoms of the disorder. In older teens and adults, the DSM-5 states they should have at least five symptoms.

Inattentive Presentation	• Fails to give close attention to details or makes careless mistakes. • Has difficulty sustaining attention. • Does not appear to listen. • Struggles to follow through on instructions. • Has difficulty with organization. • Avoids or dislikes tasks requiring a lot of thinking. • Loses things. • Is easily distracted. • Is forgetful in daily activities
Hyperactive-impulsive Presentation	• Fidgets with hands or feet or squirms in chair. • Has difficulty remaining seated. • Runs about or climbs excessively in children; extreme restlessness in adults. • Difficulty engaging in activities quietly. • Acts as if driven by a motor; adults will often feel inside like they were driven by a motor. • Talks excessively. • Blurts out answers before questions have been completed. • Difficulty waiting or taking turns. • Interrupts or intrudes upon others.
Combined Inattentive & Hyperactive-Impulsive Presentation	• Has symptoms from both of the above presentations.

Adapted from the National Resource Center on ADHD: A Program of CHADD (NRC). The NRC is supported through Cooperative Agreement Number CDC-RFA-DD13-1302 from the Centers for Disease Control and Prevention (CDC). The contents are solely the responsibility of the authors and do not necessarily represent the official views of CDC.

Reference: American Psychiatric Association (2013). Diagnostic and statistical manual of mental disorders (DSM-5), Washington, D.C.: American Psychiatric Association

Dear Teacher:

The parents of one of your students are seeking to have their child evaluated by our office for a health concern. As part of our evaluation process, we ask that both the child's parents and teacher complete a set of behavioral rating scales. This information is important for the diagnosis and treatment of your student.

Your time and cooperation in this matter is greatly appreciated. Attached please find a Release of Information Form that the parents have completed and a set of teacher rating scales and questionnaires. These forms include:

1. NICHQ Vanderbilt Teacher Assessment Scale
2. _____
3. _____
4. _____

Generally, the teacher who spends the most time with the child should complete the teacher rating scales. However, if the child has more than one primary teacher, or has a special education teacher, it would be useful for us to obtain a separate set of rating scales from each teacher. If more than one set of rating scales is required, please have the parent contact us directly at_____and we will forward additional rating scales as needed. Please note that the same teacher should complete each entire set of forms.

Please fill out the forms as completely as possible. If you do not know the answer to a question, please write, "Don't know," so that we can be sure the item was not simply overlooked. Some of the questions in the rating scales may seem redundant. This is necessary to ensure that we obtain accurate diagnostic information.

We ask that you complete these forms as soon as possible, as we are unable to begin a child's evaluation without the teacher rating scales. The forms should be mailed to us directly in the envelope provided.

Thank you for your assistance and cooperation in the completion of these forms. If you have any questions regarding the enclosed materials, or if you would like additional information regarding services provided, please do not hesitate to contact us.

Sincerely,

John Doe, MD
Clinical Director
Pediatric Clinic
Pediatric Clinic Address
Pediatric Clinic Phone Number
Pediatric Clinic Fax Number

CHOC Children's

ADHD Management Plan
Sample A

Date:_____

To the family of_____, please refer to this plan between visits if you have questions about care.

If you are still unsure, call us at_____for assistance.

Patient_____'s doctor is_____Pager #_____

Parent/Guardian_____Relationship_____

Contact Number(s)_____

School Name_____School Phone No. ___ _____Fax No._____

Key Teacher Contact Name_____Grade_____Teacher's E-mail Address_____

Goals: What improvements would you most like to see? Specific behavior you would like to see improve:

At Home:_____

At School:_____

Plans to reach these goals:

1._____

2._____

3._____

Medication

1. _____	Time _____am/pm Dose 1_____mg	Time_____am/pm Dose 2_____mg	Time_____am/pm Dose 3_____mg
2. _____	Time_____am/pm Dose 1_____mg	Time_____am/pm Dose 2_____mg	Time_____am/pm Dose 3_____mg

Circle/Highlight all that apply:

- Medication to be given on non-school days
- School authorization signed by parent and MD
- Side effects explained/information given
- Medication given for_____number of days
- School authorization signed by parent and MD
- Rx written for duplicate bottle for administration at school

Common Side Effects: decreased appetite, sleep problems, transient stomachache, transient headache, behavioral rebound

Call your doctor immediately if any infrequent side effects occur: weight loss, increased heart rate and/or blood pressure, dizziness, growth suppression, hallucinations/mania, exacerbation of tics and Tourette syndrome (rare).

Further Evaluation

- School Testing Scheduled Date_____
- Parent and Teacher Vanderbilt Assessments Completed_____

Additional Resources and Treatment Strategies

- F/U Parent Vanderbilt given Completed_____
- F/U Teacher Vanderbilt given to parent | F/U Teacher Vanderbilt to be faxed to school Date_____
- Behavioral Modification Counseling Referral to_____
- Community Resources/ Referrals: _____

Patient_____'s doctor is _____Pager #_____

Parent/Guardian_____Relationship_____

Contact Number(s)_____

School Name_____School Phone No._____Fax No._____

Key Teacher Contact Name_____Grade_____Teacher's E-mail Address_____

Goals: What improvements would you most like to see?

_____

_____

_____

Medication

1._____	Time_____am/pm	Time_____am/pm	Time_____am/pm
	Dose 1_____mg	Dose 2_____mg	Dose 3_____mg
2._____	Time_____am/pm	Time_____am/pm	Time_____am/pm
	Dose 1_____mg	Dose 2_____mg	Dose 3_____mg

Further Evaluation:

- Parent Assessment received and follow-up appointment scheduled for__/____/____
- Teacher Assessment will be done by Ms./Mr. _____
- School testing scheduled on this date__/____/____

Additional Resources and Treatment Strategies

- Behavioral Modification Counseling Referral to _____
- Parenting Tips Sheet given
- Parent Follow-up form completed___/____/____
- Teacher Follow-up form completed__/_____/___
- CHADD phone number given: 800/233-4050

Common Side Effects	If Any Infrequent Side Effects Occur, Call Your Doctor Immediately!
Decreased appetite	Weight loss
Sleep problems	Increased heart rate and/or blood pressure
Transient headache	Dizziness
Transient stomachache	Growth suppression
Behavioral rebound	Hallucinations/mania
	Exacerbation of tics and Tourette syndrome (rare)

General Tips

1. Rules should be clear and brief. Your child should know exactly what you expect from him or her.
2. Give your child chores. This will give him or her a sense of responsibility and boost self-esteem.
3. Short lists of tasks are excellent to help a child remember.
4. Routines are extremely important for children with ADHD. Set up regular times for meals, homework, TV, getting up, and going to bed. Follow through on the schedule!
5. Identify what your child is good at doing (like art, math, computer skills) and build on it.
6. Tell your child that you love and support him or her unconditionally.
7. Catch your child being good and give immediate positive feedback.

Common Daily Problems | "It is very hard to get my child ready for school in the morning."

- Set up a routine so that your child can predict the order of events. Put this routine in writing or in pictures on a poster for your child. Schedule example:

Alarm goes off ➔ Brush teeth ➔ Wash face ➔ Get dressed ➔ Eat breakfast ➔ Take medication ➔ Get on school bus

- Reward & praise your child. This will motivate your child to succeed. Even if your child does not succeed in all parts of the "morning routine," use praise to reward your child when he or she is successful. Progress is often made in a series of small steps!
- If your child is on medication, try waking your child up 30 to 45 minutes before the usual wake time and give him or her the medication immediately. Then allow your child to "rest" in bed for the next 30 minutes. This rest period will allow the medication to begin working and your child will be better able to participate in the morning routine.

Common Daily Problems | "My child is very irritable in the late afternoon/ early evening."

This is a common side effect of stimulant medications. If your child is on medication, your child may also be experiencing "rebound" – the time when your child's medication is wearing off and ADHD symptoms may reappear.

- Adjust your child's dosing schedule so that the medication is not wearing off during a time of "high demand" (for example, when homework or chores are usually being done).
- Create a period of "downtime" when your child can do calm activities like listen to music, take a bath, read, etc.
- Physical Exercise, can alternatively, let your child "blow off extra energy and tension."
- Talk to your child's doctor about giving your child a smaller dose of medication in the late afternoon. This is called a "stepped down" dose and helps a child transition off medication in the evening.

Common Daily Problems | "My child is losing weight or not eating enough."

- Encourage breakfast with calorie-dense foods.
- Plan the timing of the medication by giving the morning dose of medication after your child has already eaten breakfast. Afternoon doses should also be given after lunch.
- Provide your child with nutritious snacks that are high in protein and in complex carbohydrates. Examples: Nutrition/protein bars, shakes/drinks made with protein powder, liquid meals.
- Plan the timing of your meals by considering shifting dinner to a time later in the evening when your child's medication has worn off. Alternatively, allow your child to "graze" in the evening on healthy snacks, as he or she may be hungriest right before bed.
- Follow your child's height and weight with careful measurements at your child's doctor's office.

Common Daily Problems | Homework Tips

- Establish a routine and schedule for homework (a specific time and place.) Don't allow your child to wait until the evening to get started.
- Limit distractions in the home during homework hours by reducing unnecessary noise, activity, and phone calls, and turning off the TV.
- Praise and compliment your child when he or she puts forth good effort and completes tasks. In a supportive, noncritical manner, it is appropriate and helpful to assist in pointing out and making some corrections of errors on the homework. It is not your responsibility to correct all your child's errors on homework or make him or her complete and turn in a perfect paper.
- Remind your child to do homework and offer incentives: "When you finish your homework, you can watch TV or play a game.
- Help set scheduled breaks by working a certain amount of time and then stop working on homework.
- Consider a Tutor. Many parents find it very difficult to help their own child with schoolwork. Find someone who can. Consider hiring a tutor! Often a junior or senior high school student is ideal, depending on the need and age of your child.

Common Daily Problems | Taking Care of Yourself

- Come to terms with your child's challenges and strengths.
- Seek support from family and friends or professional help such as counseling or support groups.
- Help other family members recognize and understand ADHD.

"Common Daily Problems" adapted from material developed by Laurel K. Leslie, MD, San Diego ADHD Project. The information contained in this publication should not be used as a substitute for the medical care and advice of your pediatrician. The information contained in this publication should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances.

When Your Child has Difficulty Sleeping

Tips for Parents of Children with ADHD

Many children with ADHD have difficulty sleeping at night, whether or not they are on medication. This is partially related to the ADHD; parents often describe their children as being "on the go" and collapsing late at night. It may also be because stimulant medication has worn off, making it more difficult for them to manage their behavior. Lastly, some children have difficulty falling asleep because the stimulants affect them the same way caffeine affects adults.

Develop bedtime rituals/routines.

- A bedtime ritual is a powerful sign that it is time to sleep. It needs to be simple so the child can "re-create" the ritual even if the parent is not present.
- Try writing out the bedtime ritual to make it consistent.

Pay attention to the sleep environment.

- Background noises, location, sleep partners, bedding, favorite toys, and lighting can all affect a child's ability to fall asleep.
- A cool, dark, quiet room is best.

Letting children cry themselves to sleep is not recommended.

- Teach them to soothe themselves, such as giving the child a special blanket, a picture of the parent(s), or a stuffed animal to hold while falling asleep.
- Avoid activities that depend on a parent's presence, including rocking or holding the child until he or she falls asleep.

Make the bedroom a sleep-only zone.

- Remove most toys, games, televisions, computers, and radios from your child's bedroom if your child is having trouble falling asleep or is often up at night.
- One or two stuffed animals are acceptable.

Limit time in bed.

- Hours spent awake in bed interfere with good sleep patterns; the goal is to make the child's bed a place for sleeping only.
- Be aware of how much sleep children need at different ages.
- Even though adults need about 8 hours of sleep, infants and toddlers often sleep more than 12 hours and children usually sleep 10 hours. Teenagers also need lots of sleep, sometimes requiring 9 hours or more.

Adapted from material developed by Laurel K. Leslie, MD, San Diego ADHD Project, and from material developed by Henry L. Shapiro, MD, FAAP, for the Pediatric Development and Behavior Web site (www.dbpeds.org).

Establish consistent waking times.

- Bedtimes and waking times should be the same 7 days a week.
- It is easier to enforce a waking time than a bedtime.

Avoid drinks with caffeine.

- Caffeine is present in a wide range of beverages, such as tea, soda, cocoa, and coffee. Drinking these beverages past the afternoon may make it more difficult for your child to settle down to sleep.

Establish daytime routines.

- Regular mealtimes and activity times, including playtime with parents, also help set sleep times.

Chart your child's progress.

- Praise your child for successful quiet nights.
- Consider marking successful nights on a star chart and providing rewards at the end of the week.

Waking up at night is a habit.

- Social contact with parents, feeding, and availability of interesting toys encourage the child to be up late, so set limits on attention-getting behaviors at night.

Consider medical problems.

- Allergy, asthma, or conditions that cause pain can disrupt sleep. If your child snores loudly and/or pauses in breathing, talk to your doctor.
- Try medications to help your child sleep only under the care of your child's doctor.
    - Medications need to be used very carefully in young children. Many medications can have complications and make sleep worse.
    - Some children with ADHD may actually be helped by a small dose of a stimulant medication at bedtime. Paradoxically, this dose may help a child to get organized for sleep.
    - Some children may ultimately need other bedtime medications—at least for a little while—to help improve sleep. Talk with your doctor before starting any over-the- counter or prescription medications.

Adapted from material developed by Laurel K. Leslie, MD, San Diego ADHD Project, and from material developed by Henry L. Shapiro, MD, FAAP, for the Pediatric Development and Behavior Web site (www.dbpeds.org).

What is an IEP (Individualized Education Program)?

An IEP is an Individualized Education Program that develops the educational program for the student.

Special education programs in California are governed by a combination of State and Federal laws that require school districts to provide every child with a disability between the ages of 3 and 22 years old with a free and appropriate public education.

This education must be provided in the least restrictive environment possible for the child. This means that, to the extent possible, children with disabilities must be educated with children who do not have disabilities. In addition, the school district must provide whatever additional services (such as speech therapy or occupational therapy) the child needs in order to benefit from his or her education.

Who is eligible for an IEP?

Children between the ages of 3 and 18 years old who have a handicapping condition and who need special education in order to benefit from their education qualify for an IEP. Some young adults older than 18 may also qualify.

Special education services must be provided without regard to the child's immigration status. This means that **children who are undocumented must be provided with special education services** by the school district if such services are needed by the child in order to benefit from his or her education.

Typical problems that might be addressed by an IEP include the following:

- Disabling health impairments. These involve any medical condition that requires changes in the school or classroom environments in order for the child to benefit from his or her education.
- Specific learning disabilities. For some children, learning is more difficult because of the natural ways their brains organize and process information. This is called a learning disability. For a child's learning problems to be eligible for special education services as a learning disability, the problems must meet certain criteria:
    - There must be a significant difference between the child's intellectual potential (intelligence) and academic achievement.
    - The learning problems must be determined to be the result of "cognitive processing deficits," meaning that the problems result from how the child's brain is naturally processing information.
        - These cognitive processing deficits can include problems with visual organization (how the brain organizes what it sees), auditory processing (how the brain handles information it hears), memory storage and retrieval, and sometimes attention and concentration.

- Emotional disabilities. Some children may qualify for special education services because of significant emotional problems that limit their ability to benefit from their education. These emotional problems often present as: Intense anxiety, intense sadness, depression, and social withdrawal, behavioral problems, such as defiance fighting, or oppositional behavior, or hyperactivity and extreme difficulty attending to instruction.
- Cognitive delays and mental retardation. These involve significant mental deficiency as defined by professionally administered tests of intellectual ability and adaptive behavior. School psychologists and qualified psychologists in the community can identify these delays.

How do parents request an IEP for their child?

A **written** request should be made to the school district where the child lives. Any person can make a request for an IEP, although this usually comes from the child's parents or teacher.

- The request for an IEP evaluation should always be made in writing.
- The written request should contain a specific statement that you are asking for an evaluation for the purposes of qualifying the child for special education services.
- The written request for evaluation should be sent to the principal of the public school the child attends or to the director of special education for the school district.

What types of services or placements are available?

Many types of service and placement options exist. Some examples include:

- Modifications to the general education classroom. These modifications are developed individually for each child based on the special needs of the child. For example, classroom modifications might include having the child sit closer to the front of the class and to the teacher or giving the child written handouts to follow during lectures.

- Resource Specialist Program (RSP). Resource Specialist teachers provide additional help to the child outside the general education classroom. They also provide consultation to parents and to the child's general education teacher. When not receiving Resource help, the child participates in the general education classroom.

- Additional Support Services. These include whatever additional services are needed by the child to benefit from his or her education. Examples include services such as speech and language therapy, occupational or physical therapy, nursing assistance, or psychological counseling.

- Special Day Class (SDC). A special day class provides instruction for children with more extensive educational needs that cannot be met in the general education classroom. Children in a special day class may be "mainstreamed" in a general education classroom for portions of their instruction and daily schedule.

- Non-public School. A non-public school is a special school designed to help children with special needs.

Who attends the IEP meeting?

The IEP is developed by a team of people that must include:

- The parent
- A school administrator
- A general education teacher (if the child attends a general education classroom)
- A special education teacher
- The school psychologist

Other people who sometimes attend an IEP might include:

- A speech and language specialist
- An occupational or physical therapist
- An adaptive physical education teacher
- Other service providers or professionals involved with the child

Parents may also bring a representative to the IEP meeting, such as:

- A trusted relative
- A family friend
- The child's counselor or therapist
- An attorney
    - If parents bring an attorney to the IEP meeting they must notify the school district 5 days prior to the meeting. Also, bringing an attorney to an IEP meeting is generally NOT recommended unless an issue is in dispute.

If the child's parents do not speak English, the school district must provide an interpreter at the IEP meeting. The school district must also offer to have the written IEP translated into the language of the child's parents upon request.

IEP Timetable

The school district must follow certain time guidelines in response to a written request for an IEP evaluation:

Day 1	Official Special Education Referral
By **Day 15**	Parents receive a written assessment plan

- After the parents sign and return the assessment plan, the school has 50 days to assess the student and hold an IEP meeting.
- Parental consent is necessary for the IEP assessment.
- Parental consent is also necessary before the IEP can be put into effect.

The IEP is a legal document.

- If parents are uncertain about anything, or if they do not agree with the IEP findings and recommendations, they can choose not to sign the IEP.
- Those parts of the IEP that are agreed to by the parents can be started while other parts can be rewritten or appealed.
- Parents can take a copy of the written IEP home before they sign it in order to review it and think about it.
- Parents can request an IEP meeting anytime it is appropriate to change the plan.

Sample Letter

Request for Special Education Assessment and I.E.P. Meeting

(Date)

(Person in District Responsible for Special Education)

(District Street Address)

(District City, State, and Zip Code)

Re: **(Student's name and Date of Birth)**

Dear **(Name of Person in District Responsible for Special Education):**

I am requesting a full assessment of my child in all areas of the child's suspected disabilities for the purposes of determining whether or not **(name of child)** qualifies for special education services. I understand that I am to be given an assessment plan authorizing this assessment within fifteen days of your receipt of this request.

I am also requesting that an I.E.P. meeting be set within the time required by law so that we may discuss the results of the assessment and the type of educational program my child requires.

My child attends the **(insert name of school)**. You may call me at **(insert telephone number where you can be reached during the day)** during the day or at **(insert evening telephone number)** in the evening if you have any questions regarding this request.

Sincerely,

(Signature)

(Type or print your name)

cc: **(Principal of local school)**