



Treating ADHD in Schools

Introduction

Part 1 of this series (*School Nurse News*, March, 2001) described the processes of assessing and diagnosing school-aged youngsters with Attention Deficit Hyperactivity Disorder (ADHD). The diagnostic process culminates, and the treatment process begins, with a family-based feedback session which informs the child and parents about ADHD: its causes, different subtypes, manifestations, and developmental courses, and the variety of treatment options available. Effective treatments for ADHD take place in the home, school, and community settings in which these youngsters live, recognizing that traditional office-based psychotherapeutic interventions have shown a woefully low rate of success in generalizing from the therapist's office to where the core impairing ADHD symptoms (inattention, hyperactivity, and impulsivity) of concern actually occur. The school portion of this psychoeducation session focuses on explaining to the child and parents exactly how that child's ADHD interferes with learning. This may include difficulty

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initially paying attention, blocking out common distractions, being able to make transitions as easily as others, being able to stay organized with time and materials, holding back urges to talk or get one's way, waiting for turns, or difficulty making and keeping friends because, like parents and teachers, sometimes other children get really frustrated with youngsters with ADHD. We also must take into account each child's specific comorbidities and how they impair the child's functioning. Comorbidities of ADHD occur at a very high rate, with estimates as follows: oppositional defiant disorder nearly 40%, anxiety and mood disorders in 30% of cases, and learning disabilities in more than 30% of cases. Analogies, such as an otherwise great car having faulty brakes, are often employed to help people comprehend the way in which ADHD interferes with important life functions such as learning and peer relations. ADHD is not, in and of itself, a learning disability, but it certainly can impair one's ability to learn and to apply what one has learned.

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Treatment options are openly discussed with the parents and child, and typically lead to discussions about the controversies associated with combined medical and behavioral treatments. The NYU Child Study Center is clear in its recommendation to parents in most cases that the current scientific evidence best supports a combined behavioral and pharmacologic approach. The subtleties of how to time the introduction of each treatment component, i.e., which behavioral techniques to introduce or which particular medicines to use, are best decided with input and collaboration from all the members of "the team," which actively should include the parents and the child. One should take into account the preferences of those involved and the resources available and balance that with known, efficacious interventions.

School nurses have the opportunity to play a critical role in correcting many of the misconceptions associated with medications for children with ADHD and can inform their "constituents," the child, parents, and other school personnel, that overall, we expect a good medication response in 70-80% of these children. The school nurse also can facilitate the treatment process by educating the various parties that treatment is an ongoing process in ADHD, i.e., a series of experiments to see which specific interventions work with a specific child. For example, a child may have a negative response to one stimulant but a profound, positive response to another. School nurses effectively decrease parental and child anxiety by describing in concrete terms how they help monitor side effects and how they help minimize anticipated embarrassment about coming to the office mid-day to take medicines. In our experience, the school nurse is as well poised as any professional in the school to serve as a liaison between the home, treating doctor, and school in monitoring treatment effects. Our preference in medication trials is to tell the teachers that, indeed, different doses and medications may be tried

and that we rely very heavily on their feedback on standardized, brief rating scales to help determine the best dose of a particular agent. We prefer not to inform the teachers completing the ratings exactly when and how much of a particular medicine is being used, so as not to subjectively bias their reporting of behavioral changes. There are several new agents for the treatment of ADHD that meet the criteria of being safe and effective for young people that can last throughout the school day, and research is proceeding feverishly on new stimulant and non-stimulant medicines for treating ADHD. The NYU Child Study Center is one of a number of sites, called RUPPs, that are specially funded by the NIMH to investigate safety and effectiveness of psychiatric medicines in children and adolescents.

School nurses also are ideally poised to participate in developing the positive behavior support plans, otherwise known as BIPs, or Behavior Intervention Plans, which are required under law when children with ADHD exhibit behaviors that interfere with their learning or the learning of others. Functional behavioral assessment (FBA) is a methodology that schools are now using to determine exactly what behavioral interventions need to be used with a given child.

Treating Attention-Deficit/Hyperactivity Disorder (ADHD) in School Settings

Children with ADHD do not, by definition, need to be, nor are they typically, classified as having an educationally handicapping condition, and therefore are not typically receiving formal special educational services. They are, however, eligible for classroom and school accommodations under what is commonly referred to as Section 504, an important part of the Americans with Disabilities Act, if their ADHD interferes with learning and behavior in school. School personnel can play a critical role in helping to identify which specific accommodations are indicated for a given child. For example, having

SAMPLE LIST OF APPROPRIATE TARGET BEHAVIORS

- Contribute appropriately to class discussion
- Write down homework assignments completely
- Complete writing assignment in specified time
- Follow directions with up to two reminders
- Attempt half of all math problems
- Check work over before asking for help
- Remain seated during independent seat work unless asking teacher first by raising hand
- Ignore teasing during Circle Time
- Use inside voice level during snack time
- Put homework in Mr. Jones's Inbox before attendance is taken in the morning
- Complete "Do Now" without a fuss
- No loose papers in binder before going home
- Start seatwork with only one reminder

20 SUGGESTED SCHOOL-BASED REWARDS

- Homework reduction
- Extra computer time
- Free time in class
- Grab bag/treasure chest toys
- Meal with a teacher and a friend
- Listening to music on tape/CD
- Leading in a game
- First on line
- Bringing something special to class (Show and Tell)
- Clean erasers/wash chalkboard
- Teacher's helper/errand person
- Choose book to read to class
- Care for class animal
- Earn class party
- Choose stickers
- Good note home/call parents
- Lottery tickets toward a prize
- Play card game
- Award certificate
- Visit principal

someone check the child's backpack at the end of the day is a simple accommodation that can successfully "level the playing field" when it comes to doing homework and having the necessary materials.

School nurses need to remember some key evidence-based characteristics about youngsters with ADHD, in order to help themselves and others deal with these children, as these students often leave even very caring adults quite frustrated with them. As Dr. Russell Barkley states, "Children with ADHD forget to remember" — they have the rules of behavior stored in memory but fail to access those rules at the time they need to apply them. They are, as a rule, more bound by immediate consequences and less governed by longer-term consequences than their peers. Simply put, the pleasing distraction in front of them, maybe a tapping pencil, a toy or hand-held video game, has pleasing effects that are more compelling to them than the seemingly faint and far-off consequence of not finishing an assignment on time; non-ADHD youngsters are significantly more likely to inhibit these behaviors as needed. Consider how this might lead to protracted off-task behavior, forgetting to start or finish a required task, or even peer rejection as a result of not sharing well. This inability to inhibit responding is considered by experts a core deficit that accounts for much ADHD-related behavior. Consequently, school nurses can help teachers and others to establish behavior modification programs, which can be done on an individual, or even a classroom, basis.

work independently. Again, we emphasize that these are strategies that research supports as effective in a variety of ADHD-related educational settings.

Antecedent interventions alone are not considered sufficient in ADHD situations, and are best paired with consequence-based strategies, such as token economy, time-out, and punishment. The controversies surrounding time-out and punishment are considerable and beyond the scope of this discussion; much care should be taken in their implementation, and only after active participation with the parents. When you help to design behavior contracts, also called Daily Report Cards or DRCs, remember that as a rule ADHD children need more frequent and more immediate feedback on their behavior than their non-ADHD peers. Where a weekly note might suffice to help a non-ADHD child improve homework completion, the ADHD child is more likely to need daily feedback and daily consequences, both positive and negative.

The DRC begins with identifying the desired or *target* behaviors. The school nurse can identify with the parent, teacher, and child the one, two, or three most important behaviors. A well-defined target behavior is stated in positive terms, e.g., "completing in-class math sheets" and is observable, measurable, and specific. By contrast, a target behavior such as "not getting off-task" is not so clearly stated, is more difficult to measure, and doesn't necessarily lead to greater productivity (see Sample List of

ADHD children need more frequent and more immediate feedback on their behavior than their non-ADHD peers

Many schools find classwide techniques a practical way to alleviate concerns about stigmatizing individual children.

Optimal interventions to help youngsters with ADHD are of two types: **antecedent** interventions, i.e., those things we do *before* the target behavior occurs, and **consequence**-based interventions, those things we do *after* the behavior happens. Both are designed to change the rate at which some behavior occurs. Antecedent interventions prevent problem behaviors before they occur usually by prompting some alternative or replacement behavior in its place. Decreasing "down time," such as the time to pass out papers, increasing the pacing of tasks, more frequently announcing and reiterating class rules and their consequences, doing more difficult academic, problem-solving tasks in the morning (as opposed to the afternoon) are all evidence-based antecedent changes that have been shown to help ADHD youth in classroom comportment. *Individualized checklists* to prompt specific desired target behaviors also are antecedent interventions. The school nurse can facilitate antecedent interventions by thinking of the task as the need to design the environment to be ADHD-friendly, such as encouraging teachers to use closed spaces, decreased visual and auditory intrusions, minimizing materials to play with that can get a child into "trouble," modifying the length of tasks, or using more frequent "checking in" with the child during the times they are expected to

Appropriate Target Behaviors). The format of DRCs can vary. One might target "quiet listening in seat" during the child's high-risk times of writing, math, and spelling/grammar or completing work and working without disturbing others during different times of the day (see Two-Behavior DRC). The school nurse can help others determine appropriate school-based rewards (see 20 Suggested School-based Rewards), such as extra computer time, first on line to gym, or taking care of the class animal for the day, bearing in mind some characteristics of ADHD children: their rewards must be carefully picked to be salient to them; they tend to require more frequent rewards, and they satiate more quickly on the same rewards — thus variety is important. When the student fails to meet the criteria for a reward, or breaks an important class rule, the research informs us that "prudent reprimands" are most effective, and public reprimands, or reprimands stated with a negative emotional tone are both less effective and potentially damaging, as they may lead to diminished self-esteem. "Prudent" reprimands are brief, clear statements to start, or stop, a specific behavior, delivered immediately after the behavior, not delayed, and said in an unemotional, neutral tone of voice, as opposed to an angry tone. They work best when consistently backed up with a predetermined time-out or loss of privilege. School nurses can be helpful in reminding teachers and other school staff of the generally accepted goal of having a minimum ratio of 4 positive comments to 1 negative comment in working with students.

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It is worth reiterating that the goal of all of these behavioral and pharmacologic interventions is to facilitate children with ADHD being more available for learning and decreasing the impulsive and intrusive behaviors that quickly mark them as “socially toxic.” Research shows that their negative social behaviors are very quickly identified in peer situations, and that their labeling by peers as troubled children to be avoided is quite stable; i.e., even after positive behavior changes, the “re-assessment” of their behavior lags considerably.

Social skills groups are often recommended and sometimes available in educational settings or in clinic situations. Ironically, while these are widely recommended, there is a paucity of evidence that they are effective in changing behavior over time and in generalizing to the classroom or the playground. There is some promising data to suggest certain types of social skills interventions that may be more effective in this regard, but further research is needed before we can make a general recommendation. The critical characteristics to look for in recommending a social skills group to a family may be the teaching of specific, identifiable skills, and the planned prompting and reinforcement in the class and playground situation of the specific social skill learned in the group. Likewise, while the recommendation for treatment of organizational skills deficits is ubiquitously made for children with ADHD, there is no known validated treatment protocol for

this. We are currently piloting treatments in this area in the hopes of identifying such a protocol. We encourage school nurses to be aware of which of the recommendations they make truly have support in research and which do not. Websites such as www.AboutOurKids.org and periodicals such as *The ADHD Report* are readily available and are particularly good sources of current evidence-based information for school nurses, families, and all other concerned parties.

School-based treatment for youngsters with ADHD is sometimes best supplemented by specialty programs. School nurses can play a pivotal advocacy role by informing their Committees on Special Education (CSE) and parents that such programs exist. For children whose behavior or learning can be expected to regress over the summer months, the CSE is required to provide such 12-month programming.

Summary

The school nurse has a tremendous opportunity to be a part of the home, school, and community team in promoting state-of-the-art care for youngsters with ADHD. The **multi-modal strategic approach**, combining carefully titrated pharmacotherapy with these specific behavioral interventions in the child’s school and other settings, currently provides the greatest likelihood of a positive treatment outcome for youth with ADHD. 🌟

TWO-BEHAVIOR DAILY REPORT CARD

Daily Report Card

Child’s Name: *Sample Child*

Date:

Teacher’s Name: *(each teacher completes separately)*

Day: M T W Th F

Grade:

Target Behaviors

completing work	Yes No N/A	Yes No N/A	Yes No N/A	Yes No N/A	Yes No N/A	Yes No N/A	Yes No N/A
working without disturbing	Yes No N/A	Yes No N/A	Yes No N/A	Yes No N/A	Yes No N/A	Yes No N/A	Yes No N/A

Daily Percentage = $\frac{\# \text{ Yes}}{\# (\text{Yes} + \text{No})} = \underline{\hspace{2cm}} = \boxed{\hspace{2cm}}$

Teacher’s Initials _____

Comments: 80% or better earns choice of reward from Prize List

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WEBSITE RESOURCES

For information regarding Section 504 and classroom accommodations
<http://specialed.about.com/cs/accommodations/>

For information regarding Functional Behavioral Assessment (FBA)
<http://pbis.org/english/index/html>

For information regarding ethical considerations in medicating youth with ADHD
<http://www.nami.org/youth/bkgu-winter2001.pdf>

For information regarding advocacy and education
<http://www.chadd.org>

For information on learning disabilities
<http://www.ldonline.org>

AboutOurKids Related Articles

About Attention-Deficit/Hyperactivity Disorder
http://www.aboutourkids.org/articles/about_adhd.html

Attention-Deficit/Hyperactivity (ADHD) and Anxiety Disorders
<http://www.aboutourkids.org/articles/adhdanxiety.html>

Guide to Psychiatric Medications for Children and Adolescents
<http://www.aboutourkids.org/articles/guidetopsychmeds.html>

Kids on Medication: Beyond the Controversy
<http://www.aboutourkids.org/articles/kidsonmeds.html>

Summer Plans for Kids With Attention-Deficit/Hyperactivity Disorder
<http://www.aboutourkids.org/articles/summeradhd.html>

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