Finding focus:

Equitable & evidence-based management of ADHD in schools

CASBHC 2025 Annual Conference – November 11, 2025

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Disclosures

- We have no financial relationships nor conflicts of interest to disclose.
- We will not be discussing any off label use of medication.

- The majority of images here today are free for use unless otherwise cited.
- RK is a Volunteer Board Member of the Connecticut Family Support Network (CTFSN)
- RK is a special education consultant for one (1) Connecticut School District

Getting to Know Me (More Disclosures):

- I'm a total geek (be prepared).
- You will see how I approach DBP work with a background in ecology and evolutionary biology as well as developmental psychology (#SystemsTheory).
- I identify as a non-disabled, white, (bicultural) second generation Cuban-American male.
- I use the pronouns (he/him).

Getting to Know Me (More Disclosures):

- I have a positive bias towards ethical behaviorism
- I have a positive bias towards evidence-based practices including CBT, MATCH-ADTC, & PCIT
- **Be prepared for me to geek out about ADHD!**
- **(I also have a positive bias towards capybaras)**

Moving from Safe/Brave to Accountable Spaces

- Ahenkorah, E. (2020, September 21). *Safe and brave spaces don't work (and what you can do instead)*. Medium. https://medium.com/@elise.k.ahen/safe-and-brave-spaces-dont-work-and-what-you-can-do-instead-f265aa339aff

Objectives

Objectives:

- Utilize core features of the MTA study when managing ADHD in school age children
- Describe the role of neurodiversity in providing equitable behavior management for children with ADHD
- Employ mindful medication management strategies for school age children with ADHD
- Discuss reasonable accommodations, modifications, and student disability rights related to ADHD

Level Setting and Shared Goals

- More focus on presentation? Or cases?
- Comfort with ADHD?

Level setting: ADHD Fundamentals & Updates

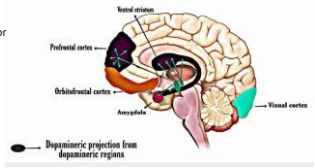
ADHD Updates: What We Know

Behavioral Theory:

- Disorder of inattention, hyperactivity, and/or impulsivity
- Disorder of *"Executive Function"*
  - Self-regulation
  - Behavioral inhibition

Medical Etiology:

- ***Dopamine*** pathways
- Frontal-striatal and other pathways
- Frontal lobe
- Genetic basis



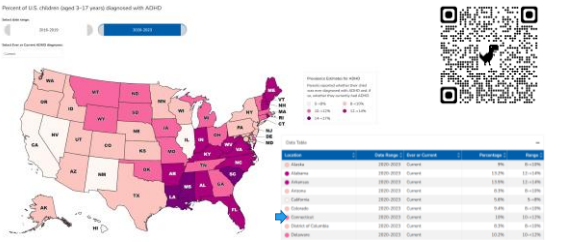
Valmiki, M., Fawzy, P., Valmiki, S., Aid, M. A., Chaitou, A. R., Zahid, M., ... & ZAHID, M. (2021). Reinforcement and Compensatory Mechanisms in Attention-Deficit Hyperactivity Disorder: A Systematic Review of Case-Control Studies. *Cureus*, *13*(3).

ADHD Updates: What We Know

CDC Data (November 19, 2024):

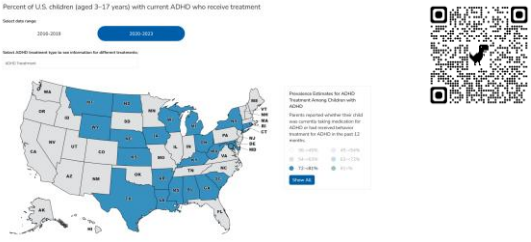
- Prevalence: 11.4% of children 3-17y ever diagnosed with ADHD
  - Parent report
  - National prevalence; does not represent micro-populations
- 62% taking medication (represent ~5% of all U.S. children)
- 47% received any behavioral treatment in past year
  - For children 2-5y increased to 60%
- 64% had comorbid disorder

ADHD & Connecticut



https://www.cdc.gov/adhd/data/state-based-prevalence-of-adhd-diagnosis-and-treatment-2016-2019.html (7/28/2025)

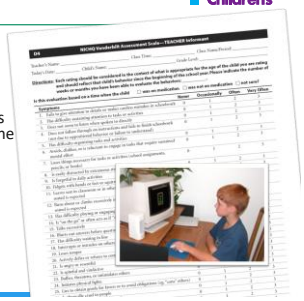
ADHD & Connecticut



https://www.cdc.gov/adhd/data/state-based-prevalence-of-adhd-diagnosis-and-treatment-2016-2019.html (7/28/2025)

ADHD Diagnosis

- Still a clinical diagnosis (the Vanderbilt is your best bet)
- While some clinical tests (i.e. Conners CPT) not sufficient evidence for routine diagnosis
- *When* complex developmental or emotional problems/disorders *then* referral* can be helpful for diagnosis
  (*DBP, CAP, Neuropsychology)



ADHD Differential &/or Comorbid Diagnosis:

- Problem Versus Disorder
- Anxiety
- Depression
- Complex Mood D/O (i.e. DMDD)
- Trauma (acute or toxic stress)
- Autism spectrum disorder
- Language/Cognitive Delays
- Learning Disorder
- Fetal Alcohol Spectrum Disorder
- Substance use
- Motor/Tic Disorder
- Sleep disorder
- Obstructive Sleep Apnea

Objective 1:

Utilize core features of the MTA study when managing ADHD in school age children.

ADHD Treatment: Evidence

The Multimodal Treatment of Attention Deficit Hyperactivity Disorder Study (**MTA**)

- N= 579 children, age 7-9y
- Randomly assigned to one of 4 treatments:
  - Intensive medication management alone
  - Intensive behavioral treatment alone
  - Combination of both
  - Routine community care (the control group)

ADHD Treatment: MTA Findings

- ≥70% of children responded to a stimulant medication at optimal dose
- *Combination treatment* and *medication management* alone were both significantly superior in reducing ADHD symptoms.
- Benefits last as long as 14mo (likely due to no longer observed as closely)

ADHD Treatment: MTA Findings

- For other areas of functioning (i.e. anxiety sx, academic performance, parent-child relations, and social skills), *combination treatment* was consistently superior.
- Children in the *combination treatment* also ended up taking lower doses of medication than the children in the medication-alone group.
- Findings consistent across all 6 research sites, despite substantial differences among sites in the children's sociodemographic characteristics.

ADHD Treatment: MTA Take Home

- Medication alone is superior for treating core ADHD symptoms (Inattention, hyperactivity, impulsivity)
- Combined Medication and Behavioral Therapy have a synergistic effect and are superior for treating function (academic performance, executive function, social interactions).
- Theory is that treating core symptoms allows better access to behavioral interventions.

ADHD Treatment: MTA Findings (long term)

- Swanson, J. M., Arnold, L. E., Molina, B. S., Sibley, M. H., Hechtman, L. T., Hinshaw, S. P., et al. Young adult outcomes in the follow-up of the multimodal treatment study of attention-deficit/hyperactivity disorder: Symptom persistence, source discrepancy, and height suppression. *Journal of Child Psychology and Psychiatry*, *58*(6), 663-678.

- **Long term findings**:
  - Those that received MTA treatment were 2.55+0.73 cm shorter
  - Treatment in childhood did not change symptom severity in adulthood (meaning ADHD is pervasive)

ADHD Treatment: MTA Findings (long term)

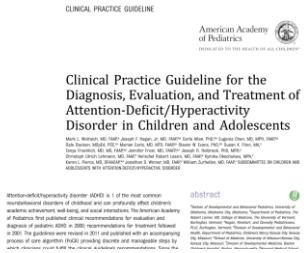
- Roy, A., Hechtman, L., Arnold, L. E., Swanson, J. M., Molina, B. S., Sibley, M. H., et al. (2017). Childhood predictors of adult functional outcomes in the multimodal treatment study of attention-deficit/hyperactivity disorder (MTA). *Journal of the American Academy of Child & Adolescent Psychiatry*, *56*(8), 687-695.

- **Predictors of adult functional outcomes in ADHD**
  - Clinical factors: baseline ADHD severity, IQ, and comorbidity
  - Demographic factors: family income, number of household members, and parental education
  - Family factors: parental monitoring, parental marital problems

ADHD Treatment: Long term data take home

- **Neither medication nor therapy "fix" ADHD. Instead they augment it and improve function and quality of life.**
- **Systemic and environmental factors play a huge role in outcomes!**

ADHD Practice Guidelines (AAP 2019*)



CLINICAL PRACTICE GUIDELINE

American Academy of Pediatrics

Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents

abstract

MTA & ADHD Practice Guidelines Tips

- Start with methylphenidate
- Use combined treatment (meds plus therapy)
- Set goals & monitor efficacy

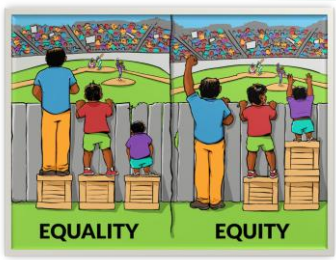
Objective 2:

Describe the role of neurodiversity in providing equitable behavior management for children with ADHD.

ADHD Treatment: Your Toolkit (Oversimplified)

1.) Pharmacotherapy
2.) Behavioral Modification
   - Accommodations
   - Behavioral Training

Viewing ADHD with an Equity Framework



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Different Models of Disability

Aspect	Medical Model	Social Model
Goal:	• Cure or treat disability.	• Empower and support access.
View of Disability:	• Problem within the patient.	• Problem in the environment.
Provider Role:	• Expert fixer.	• Partner and advocate.
i.e. Response to Autism:	• Normalize behavior.	• Accept and support diversity.
i.e. Response to Mobility Issue:	• Restore walking ability.	• Provide accessible tools and spaces.
Target for Success:	• Reduced symptoms.	• Increased participation and autonomy.
Target for Supporting ADHD:	• **Reduced symptoms.**	• **Increased academic, social and occupational participation, autonomy and self-efficacy.**

- Iezzoni, L. I. (2011). Eliminating health and health care disparities among the growing population of people with disabilities. *Health Affairs*, 30(10), 1947–1954. https://doi.org/10.1377/hlthaff.2011.0423
- Disability Rights Education and Defense Fund. (n.d.). *Healthcare access for people with disabilities*. DREDF. https://dredf.org
- National Center for Cultural Competence. (n.d.). *Cultural and linguistic competence in disability*. Georgetown University Center for Child and Human Development. https://nccc.georgetown.edu

Neurodiverity and Related Terms

- **Neurodiversity** – Diversity in the human mind. Infinite variation in neurocognitive function. Not all brains are the same.!
- **Neurodivergent (ND)** – Having a mind that functions in ways that are outliers when compared to dominant societal standards of "normal."
- **Neurotypical (NT)** - Having a mind that functions in the average/majority or dominant societal standards of "normal."
- **Neurodiverse** – Refers to groups when one or more members differ substantially from other members in terms of cognitive functioning.

Link: NEURODIVERSITY: SOME BASIC TERMS & DEFINITIONS by Nick Walker, PhD (she/her)

Disability Justice and Anti-ableism in Pediatric Care

- Lunsford, C. D., & Quirici, M. (2023). Disability Justice and Anti-ableism for the Pediatric Clinician. Pediatric clinics of North America, 70(3), 615–628. https://doi.org/10.1016/j.pcl.2023.01.015
- ***Ableism*** is a hidden health inequity. It shapes how clinicians talk, think, and make decisions about children with disabilities.
- ***Disability justice*** reframes disability as a form of human diversity, not a deficit to fix. It calls on us to center the voices, dignity, and lived experiences of disabled children and families.
- Language matters: Avoid euphemisms or deficit-based terms; ask families how they prefer to describe disability.
- Clinical impact: Ableist assumptions can lead to missed diagnoses, undertreatment, or unequal care.

Internalizing Messaging / Why Language Matters

- How do our implicit bias affect our expectations for children with ADHD?
- Why is it a MAJOR RED flag when young children hate school? Are we asking them to jump through invisible hoops?
- If a child with ADHD is by definition neurodivergent/disabled, how do we meet them where they are?
- What do you say to the parent who asks you how many reminders is too many reminders for their child to clean their room?

Disability Justice and Anti-ableism in Pediatric Care

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Action for clinicians:

1. Reflect on personal and systemic bias.
2. Design accessible, inclusive care environments.
3. Treat all children as experts in their own experience.

Take home: Look for the invisible strings, hoops, and demands.

https://muslimgirl.com/heres-care-equity-equality/ by Maryam Abdul-Kareem (1/5/2018)

Objective 3:

Employ mindful medication management strategies for school age children with ADHD.

Pharmacotherapy:

Three main classes of medications:

First Line:
- Stimulants (short and long acting forms)
  - **Methylphenidates (i.e. Ritalin, Focalin, Concerta, etc.)***
  - Amphetamines (i.e. Adderall, Vyvanse, etc.)
  - Effect size = 1.0

*Most well studied in children.

Second Line:
- Atomoxetine (Strattera)
  - Norepinephrine uptake inhibitor
  - Takes weeks for effect
  - Effect size = 0.7
  - Has Black Box Warning
- Alpha-2 adrenergic agonists
  - Guanfacine and Clonidine
  - Extended release cannot be stopped cold turkey
  - Effect size = 0.7

Upcoming?
- Viloxazine (Quelbree) (still new and being studied)

Pharmacotherapy:

- *Can improve*: hyperactivity, attention span, self-control, aggression, social interactions, and academic productivity
- *Cannot improve*: reading scores, social skills, academic achievement, or antisocial behavior

Pharmacotherapy:

- *Only stimulants* seem to have true efficacy treating inattention symptoms (alpha 2-agonists do not help)
- If no initial response to appropriate dose *or* adverse effect, can try switching class of stimulant methylphenidate ←→ amphetamine derivative*
  (depends on age an comorbidities)

Pharmacotherapy: General Considerations

- Age (AAP guidelines)
- Parent/Patient Compliance
- Patient capacity for pill swallowing
- Intended time for duration of effect

Pharmacotherapy: General Considerations

- No prior medication reactions
- Other medications
- General physical examination:
  - Normal heart rate
  - Normal blood pressure
  - Baseline height and weight

Pharmacotherapy: General Considerations

- Comorbid conditions (i.e. anxiety, autism, etc.)
  →Use stimulants cautiously
  →Use alpha-2 agents cautiously *if* needed to supplement
- Cardiac History
  →EKG if red flags (Hx: syncope, palpitations, arrhythmia; Sx: hypertension, tachycardia; FHx: sudden cardiac arrest, arrhythmia)
- Snoring?
  → rule out obstructive sleep apnea (OSA) first

Pharmacotherapy: Specific Considerations

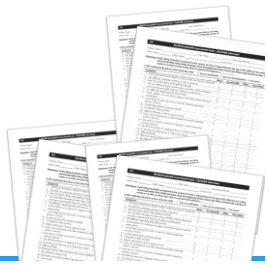
- History of tic disorder and/or trauma disorder
  →consider alpha-2 first
- Patient history of substance abuse
  →consider Atomoxetine
- Household medication diversion risk
  → Consider school administration only

Measuring Treatment Response Mindfully!

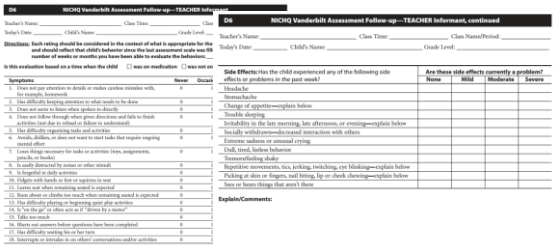
- **Define your treatment goal!!!**
  - (You already do this with all other interventions)
- Make SMART goals!

Measuring Treatment Response Mindfully!

- **Define your treatment goal!!!**
- Ideally: objective measurement of reduction in core symptoms such as:
  - 50% reduction in core symptoms from baseline
  - Decreased proportion of missed homework assignments
- Keep using teacher report as overall inconsistent correlation with parent report
- ***Keep using tracking/rating scales***
  - *(this is why I keep scores on file)*



Vanderbilt Follow Up Form



D6 NICHQ Vanderbilt Assessment Follow-up—TEACHER Informant

Teacher's Name: _____ Class Time: _____ Class: _____

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 student and should reflect that child's behavior since the last assessment scale was filled out (for example, 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

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

D6 NICHQ Vanderbilt Assessment Follow-up—TEACHER Informant, continued

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

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

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:

Celebrate but still be realistic!

- Target window of stimulant use is during the day (~7:30 AM to 4-6 PM).
- Stimulants are not an option to help 7 AM or 7 PM behavior.
- We still need to accommodate the child when they do not have access to their "wheelchair."
- If trouble getting to sleep, then might consider evening only dose of clonidine or guanfacine.

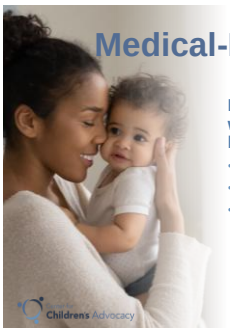
Objective 4:

Discuss reasonable accommodations, modifications, and student disability rights related to ADHD

Center for Children's Advocacy

Educational Access and ADHD

By Bonnie B. Roswig, J.D.
Director, Disability Rights Project, Medical-Legal Partnership Project
Center for Children's Advocacy



Medical-Legal Partnership

Medical and Legal Professionals working together to improve healthcare outcomes for children

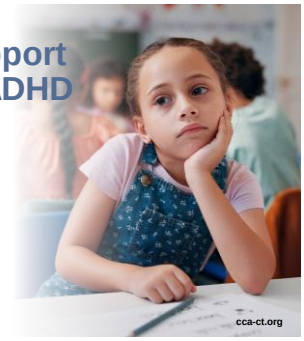
- **Direct representation**
- **Training**
- **Systemic Advocacy**

Disclosure

- **This presentation is the position of the Center for Children's Advocacy**
- **The Center for Children's Advocacy is not providing legal advice to your organization**
- **Legal questions should be referred to your attorney**

Laws that Support Children with ADHD

- **Americans with Disabilities Act**
- **Individuals with Disabilities Education Act**
- **Section 504 of the Rehabilitation Act**



Who are students with disabilities?

- **Students with disabilities often experience the following in school:**
  - Fall below grade-level standards
  - Are held back or promoted by exception
  - Have additional difficulty with transitions, especially back to school if out
  - Need support, consistency, and security from school
  - Experience disengagement or truancy
  - Receive disciplinary referrals
- **Many of these children may meet the criteria for**
  - 504 Accommodations
    OR
  - Special Education

Understanding Attention Deficit Hyperactivity Disorder "ADHD"

- **Neurodevelopmental disability that impacts attention, Impulse control and activity levels**
- **Difficulty staying focused, controlling behavior and/or paying attention**

Americans With Disabilities Act (ADA)

Title II

- **No qualified individual shall, on the basis of disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subject to discrimination by any public entity.**

ADA Requirements

Reasonable modification to policies, practices and procedures

Objective

- **Insure access to programs and services to children with disabilities**

Obligation

- **Integrate children, parents and guardians with disabilities**

Free and Appropriate Education "FAPE"

- **Requires schools to provide educational services to meet the needs of children with disabilities**
- **Accommodations to meet the specific needs of the child**
- **Access to the same school programming as non-disabled peers**

"CHILD FIND" – ADHD

OBLIGATION OF SCHOOL TO ASSESS CHILD WITH CONCERNING CHALLENGES

- **concerning behaviors/issues around access to education – following directions, concentrating, organizing tasks and activities, social skills deficits, recalling information, restlessness**
- **school should evaluate to determine eligibility for special education or 504 services**

Disability Laws

IDEA: Individuals with Disabilities Education Act

- academic accommodations for children with disabilities relating to accessing their education

504: Section 504 of the Rehabilitation Act

- accommodations for children with disabilities to ensure equal access to educational programming

Educational Supports: Children with ADHD

- **ADHD diagnosis qualifies the child for services under the disability laws**
- **School success does not negate accommodations obligations**
- **Mitigating impact of medication does not negate obligation of school to provide modifications, services and supports**

Special Education Accommodations Under IDEA

Individualized Assessment – Needs of Child Control Individualized Education Plan ("IEP")

1. **Accommodations options cannot be finite**
2. **Cost cannot influence access to requisite accommodation**
3. **Supports based on the individual needs of child**

IDEA and ADHD: Individuals with Disabilities in Education Act

Individual Education Plan ("IEP"): Memorialization of school plan/obligation to meet the academic needs of child

- **Includes:**
  - hours of academic support (reading, math, etc.)
  - special services (speech, PT, social work, behavioralist, access to assisted technology, etc).
  - goals and objectives

IDEA and ADHD: Individuals with Disabilities in Education Act

IEP: Delineates child's specific disability

- 13 Categories of disabilities
- ADHD is classified under the category of Other Health Impaired ("OHI")

504 Plans - ADHD

- **For child with a diagnosis of ADHD, 504 Plan:**
- **Addresses mental and behavioral health issue in school**
- **reasonable accommodations**
- **accommodations based on need, not finite list**
- **input from health care provider**
- **if Special Education eligible, ADHD accommodations included in IEP**
  - additional 504 Plan is not necessary

Supporting Success: Example Accommodations

- **Academic supports**
- **Behavioral Plans**
- **Extended time of tests**
- **Use of technology**
- **Breaks during academics**
- **Social skills group**
- **Preferential Seating**

Support of Child with ADHD is Responsibility of School District

- **IEP/504 cannot require parents to provide oversight**
  - Cannot insist that parent is part of behavior intervention plan
  - Cannot insist that parents physically stay at site
  - Cannot insist that parent pay for services

Supporting Children with ADHD: Role of SBHC Professionals

- Help identify early signs of ADHD
- Recommend appropriate interventions
- Medication management
- Work with school team to develop and implement appropriate accommodations in child's 504 Plan or IEP
- Supportive resource for student

Center for Children's Advocacy

Fighting for the legal rights of Connecticut's most vulnerable children

Center for Children's Advocacy

Questions & Information

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Center for Children's Advocacy

cca-ct.org

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CCA accepts/receives very little government funding and relies on grants and donations to fund its advocacy work.

Make a donation to support CCA's legal training and legal services so all Connecticut children have the opportunity to flourish.

Center for Children's Advocacy

cca-ct.org

Objective 4.1:
Recognize ecosystem/environmental factors affecting children with ADHD in schools.

CT and Social Drivers of Health

Connecticut Children's

- Increasing economic segregation in CT over the past 35+ years
- 169 municipalities = 169 loculated budgets
- 139 school districts in CT
- Affects allocation of federal and state resources
- Creates a concept called "***Double Jeopardy***"
  - Poverty in a low resource area
  - Affects on education, health, housing, transportation, etc.

The Greater Hartford Region

https://www.ctdatahaven.org/reports/greater-hartford-community-wellbeing-index

TABLE 5A

K–12 achievement

SELECTED ACADEMIC AND DISCIPLINARY OUTCOMES BY DISTRICT, WITH GREATER HARTFORD STUDENTS BY RACE/ETHNICITY, ELIGIBILITY FOR FREE/REDUCED PRICE MEALS (FRPM), SPECIAL EDUCATION (SPED), AND ENGLISH LANGUAGE LEARNER STATUS (ELL), 2020–21 AND 2021–22 SCHOOL YEARS

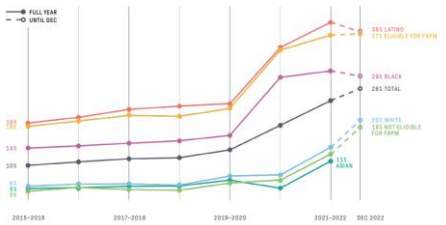
LOCATION	GRADE 3 SBAC ELA PASS RATE *	SUSPENSIONS PER 1K STUDENTS *	GRADUATION RATE *
Connecticut	48%	45	90%
Greater Hartford	42%	72	90%
BY DEMOGRAPHIC WITHIN GREATER HARTFORD			
White	63%	40	94%
Black	25%	138	83%
Latino	31%	108	90%
Asian	66%	35	96%
FRPM	31%	124	90%
Not FRPM	55%	36	96%
SPED	N/A	131	89%
Not SPED	N/A	69	93%
ELL	N/A	92	72%

https://www.ctdatahaven.org/reports/greater-hartford-community-wellbeing-index

FIGURE 5A

Since the start of the COVID pandemic, chronic absenteeism has skyrocketed

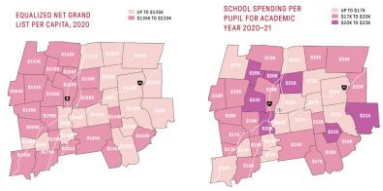
SHARE OF STUDENTS CHRONICALLY ABSENT BY RACE/ETHNICITY AND ELIGIBILITY FOR FREE/REDUCED PRICE MEALS, GREATER HARTFORD PUBLIC SCHOOLS, 2015–16 TO 2022–23 SCHOOL YEARS



https://www.ctdatahaven.org/reports/greater-hartford-community-wellbeing-index

FIGURE 8C

Wealthier towns net more income from property values and often spend more on libraries and education



https://www.ctdatahaven.org/reports/greater-hartford-community-wellbeing-index

Ecosystem Equity Questions

- Accommodations:
  - "How do you provide preferential seating when over a third of your class needs preferential seating?"
- Services:
  - How do you find services and supports that are affordable, accessible, and evidence based?
  - Through insurance?
  - Through schools?

School-Based Health Centers & Working with Families

You are the bridge

- The goal is to empower families to support the child
- Get consent. Are your records under HIPAA or FERPA? Do you bill Medicaid?
- Explain and encourage to teachers and psychologists why we want Vanderbilt rating scales, even when a Connors was completed.
- Disability rights are rights. Regardless of resources.
- Health equity issues are real. Partner and get creative together.

Systemic Support for Children with ADHD

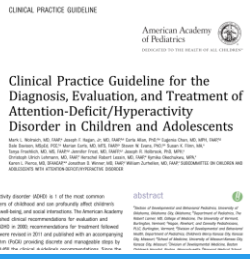
Fact: We are the voice for children in the realm of policy.

Sign up for policy briefs!!!

https://www.connecticutchildrens.org/support-us/advocacy/become-a-connecticut-childrens-champion/

Key ADHD Resources for your Clinical Toolkit

ADHD Practice Guidelines (AAP 2019)



CLINICAL PRACTICE GUIDELINE

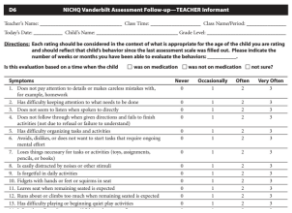
American Academy of Pediatrics

Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents

abstract

Vanderbilt ADHD Rating Scales:

- https://www.nichq.org/sites/default/files/resource-file/NICHQ-Vanderbilt-Assessment-Scales.pdf



DX NICHQ Vanderbilt Assessment Follow-up—TEACHER Informant

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

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

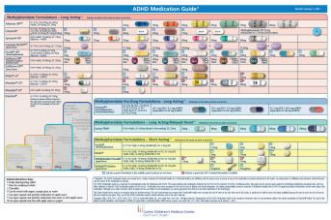
Directions: Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the last assessment scale was filled out. Please indicate the number of weeks or months you have been able to evaluate the behaviors: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

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

The ADHD Medication Guide©

- http://www.adhdmedicationguide.com/



ADHD Medication Calculator/Converter

https://www.adhdmedcalc.com/

Tools: Connecting with Community Mental/Behavioral Health Services

CHDI: Evidence-Based Practice Directory for CT

https://ebp.dcf.ct.gov/ebpsearch/

Tools: Child Adolescent Psychiatry Access

Access Mental Health CT

https://www.accessmhct.com/

Tools: Intensive Home-Based Services

CT: Intensive Home Based Services

https://portal.ct.gov/DCF/Behavioral-Health-Partnership/Intensive-Home-Based-Services

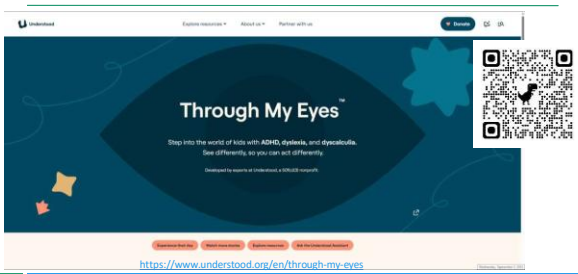
Intensive Home Based Services

Program Descriptions: Intensive Home-Based Services are clinical services provided in the child's home and community. Services are provided to children and youth who have returned or are returning home from out-of-home care or psychiatric hospitalization and require intensive community based services, or are at imminent risk of placement due to mental health issues, emotional disturbance, or substance abuse. The intent of this service is to provide the clinical intervention and support necessary to successfully maintain each child in his or her home or community. The goal is to provide a degree of clinical care and supervision in the home and community setting that is appropriate to children discharged from a more restrictive setting (e.g., residential, psychiatric hospitalization), or as an alternative to a more restrictive setting. All treatment, care and support services must be provided in a context that is child centered, family-focused, strength based, culturally competent and responsive to each child's psychosocial, developmental, and treatment care needs.

Intensive Home-Based Services currently include several distinct treatment models:

Functional Family Therapy (FFT)
Functional Family Therapy (at a Glance)
Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS)
Multidimensional Family Therapy (MDFT)
Multisystemic Therapy (MST)

Tools: Building Understanding of ADHD



https://www.understood.org/en/through-my-eyes

Other Helpful Readings:

- Southammakosane, C., & Schmitz, K. (2015). **Pediatric psychopharmacology for treatment of ADHD, depression, and anxiety.** Pediatrics, 136(2), 351-359.
- AAP, Subcommittee on ADHD (2019). **ADHD: clinical practice guideline for the diagnosis, evaluation, and treatment of attention-deficit/hyperactivity disorder in children and adolescents.** Pediatrics, peds-2019.
- Gleason, M. M., Goldson, E., Yogman, M. W., & COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH. (2016). **Addressing early childhood emotional and behavioral problems**. Pediatrics, e20163025.
- Wolraich, M., Brown, L., & Brown, R. T. (2011). **Implementing the key action statements: an algorithm and explanation for process of care for the evaluation, diagnosis, treatment, and monitoring of ADHD in children and adolescents**. Pediatrics, 128(5), 1007-1022.

Resources for Families:

- www.CHADD.org
- www.ADDitudemag.com
- https://www.aap.org/en-us/Documents/ttb_bring_out_best.pdf
- https://www.cdc.gov/ncbddd/adhd/materials-multimedia/factsheets.html

Cases?

Mateo. 4y/o boy in Pre-K.

- **Presenting Concern:** Mateo's teachers report he is "always on the go," has trouble sitting for circle time, frequently interrupts, and struggles to follow multi-step directions. Parents note that he rarely plays quietly at home and often shifts quickly between activities.
- **History:**
- **Birth/Medical:** Full-term, no complications. Up to date on vaccines.
- **Developmental:** Age-appropriate language and motor milestones. Toilet trained.
- **Family:** Lives with both parents and a younger sibling.
- **Social:** Family recently moved; limited peer interactions outside of preschool.
- **Classroom Feedback:** Teachers report difficulty maintaining classroom routines; requires frequent redirection. No significant aggression.
- **Assessment Focus:** NEXT STEPS?
- **Intervention Focus:** NEXT STEPS?

Aaliyah. 8yo. 3rd grade.

- **Presenting Concern:** Teacher reports frequent incomplete assignments, distractibility, fidgeting, and talking out of turn. Parents describe homework as a "battle every night."
- **History:**
- **Medical:** Healthy; normal hearing and vision screening.
- **Academic:** Reading at grade level; struggles with written expression.
- **Behavior:** Socially outgoing, sometimes impulsive with peers.
- **Home:** Lives with single parent; screen time 3–4 hours/day.
- **Assessment Focus:** NEXT STEPS?
- **Intervention Focus:** NEXT STEPS?

Jayden. 10yo. 5th grade.

- **Presenting Concern:** Ongoing difficulties with attention, organization, and reading comprehension despite medication for ADHD. Teacher notes frustration and avoidance of reading tasks.
- **History:**
- **Medical:** Diagnosed with combined-type ADHD at age 8; currently on methylphenidate with partial improvement.
- **Academic:** Struggles primarily with reading fluency and written expression; recent psychoeducational testing shows **specific learning disability in reading (dyslexia)**.
- **Behavior:** Occasionally shuts down or acts out when asked to read aloud.
- **Family:** Supportive; parents working closely with school for IEP supports.
- **Assessment Focus:** NEXT STEPS?
- **Intervention Focus:** NEXT STEPS?

Summary

How you might change your practice:

1. Not all kids who are busy have ADHD.
2. *Combined treatment* with methylphenidate and behavior support/interventions are first line of treatment for children with ADHD. → Know and map out what options for behavior support/interventions are in your local community.
3. Include children with ADHD in developing a role in their own management and care. Ask for and include their perspective.
4. Coach caregivers on meeting their child where they are and build skills up. Children can or can't yet! #GrowthMindset.
5. Work with schools and teachers where they are. IDEA, Section 504, and the ADA are laws. Health and systemic disparities are a reality. Use Vanderbilts whenever possible.

THANK YOU! Questions?