Parenting and Advocating for Children with ADHD

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Overview

- Overview of ADHD and associated problems
- How stress effects parenting
- Evidence based practices for helping kids at home and school

A Variety of Names—Same Disorder—Same Children

- Brain Damage (BD)
- Minimal Brain Damage (MBD)
- Minimal Brain Dysfunction (MBD)
- Hyperkinetic-Impulse Disorder
- Hyperkinetic Reaction of Childhood/Hyperkinesis/Hyperactivity—DSM II
- Attention Deficit Disorder (with and without hyperactivity)—DSM III
- Attention Deficit-Hyperactivity Disorder—DSM III-R, DSM-IV

Core Symptoms--Same Over Past 50 Years

- Inattention
- Impulsivity
- Hyperactivity
- But are symptoms what we should focus on in diagnosis and treatment?

DSM-IV Definition for Attention-Deficit/Hyperactivity Disorder

- A. Six Symptoms of either Inatt. or Hyp/Impuls.
- (1) Inattention:
  - often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities
  - often has difficulty sustaining attention in tasks or play activities
  - often does not seem to listen to what is being said to him or her
  - often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace
  - often has difficulties organizing tasks and activities
  - often avoids or has difficulties engaging in tasks that require standard mental effort
  - often loses things necessary for tasks or activities
  - is often easily distracted by extraneous stimuli
  - often forgetful in daily activities

DSM-IV Definition for Attention-Deficit/Hyperactivity Disorder

- **(2) Hyperactivity-Impulsivity**:
  - often has difficulty playing or engaging in leisure activities quietly
  - is always "on the go" or acts as if "driven by a motor"
  - often talks excessively
  - often blurts out answers to questions before the questions have been completed
  - often has difficulty waiting in lines or awaiting turn in games or group situations
  - often interrupts or intrudes on others (e.g. butts into other's conversations or games)
  - often runs about or climbs inappropriately
  - often fidgets with hands or feet or squirms in seat
  - leaves seat in classroom or in other situations in which remaining seated is expected

DSM-IV Definition for Attention-Deficit/Hyperactivity Disorder-Subtypes

- Predominantly Inattentive Type: Criterion (1) is met but not criterion (2) for the past six months
- Predominantly Hyperactive-Impulsive Type: Criterion (2) is met but no criterion (1) for the past six months
- Combined Type: Both criteria (1) and (2) are met for the past six months
- Not Otherwise Specified: This category is for disorders with prominent symptoms of attention-deficit or hyperactivity-impulsivity that do not meet criteria for Attention Deficit/Hyperactivity Disorder.

DSM-IV Definition for Attention-Deficit/Hyperactivity Disorder

- B. Some symptoms that caused impairment were present before age seven.
- C. Some symptoms that cause impairment are present in two or more settings (e.g. at school, work, and at home).
- D. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.
- E. Does not occur exclusively during the course of Pervasive Developmental Disorder, Schizophrenia or other Psychotic Disorder, and is not better accounted for by a Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder.

Domains of Impairment in ADHD Children

- Relationships with parents, teachers, and other adults
- Relationships with peers and siblings
- Academic achievement
- Behavioral functioning at school
- Family functioning at home
- Leisure activities

Central Role of Impairment in Treatment

- Impairment--that is, problems in daily life functioning that result from symptoms and deficits in adaptive skills--rather than symptoms themselves is
  - (1) why children are referred,
  - (2) what mediates long-term outcome, and therefore
  - (3) what should be targeted in treatment.
- Key domains are peer relationships, parenting/family, and academic achievement
- Assessment of impairment in daily life functioning and adaptive skills is the most fundamental aspect of
  - initial evaluation to determine targets of treatment
  - Ongoing assessment to evaluate treatment response.
- Normalization or minimization of impairment in daily life functioning and maximization of adaptive skills is the goal of treatment--not elimination of symptoms

Why Is it Important to Treat ADHD in Childhood?

- Causes substantial problems in daily life functioning for children, families, schools, and peers
- Very poor long-term outcomes
- Major costs to multiple sectors of society
- Serious public health problem

Economic Impact of ADHD on Society--the Cost of Illness?

Pelham, Robb & Foster

Ambulatory Pediatrics, Spec. Supp. Jan. 2007

Total Annual Incremental Costs Per Child Across Sectors

Health and Mental Health	$ 2,636
Education	$ 4,900
Crime and Delinquency	$ 7,040
Family costs	No data available
Other costs	No data available
Total	$14,576
Range (lowest to highest ests.)	$12,500--$17,458

Annual Costs of Childhood/Adolescent ADHD

- Health and Mental Health $7.9 billion
- Education $13.6 billion
- Crime and Delinquency $21.1 billion
- Family cost ?
- Parental work loss, personal loss ?

- Total (very low estimate based on incomplete data) $42.5 billion

- Range (lower to upper bounds based on
- currently available data) $36--$52.4

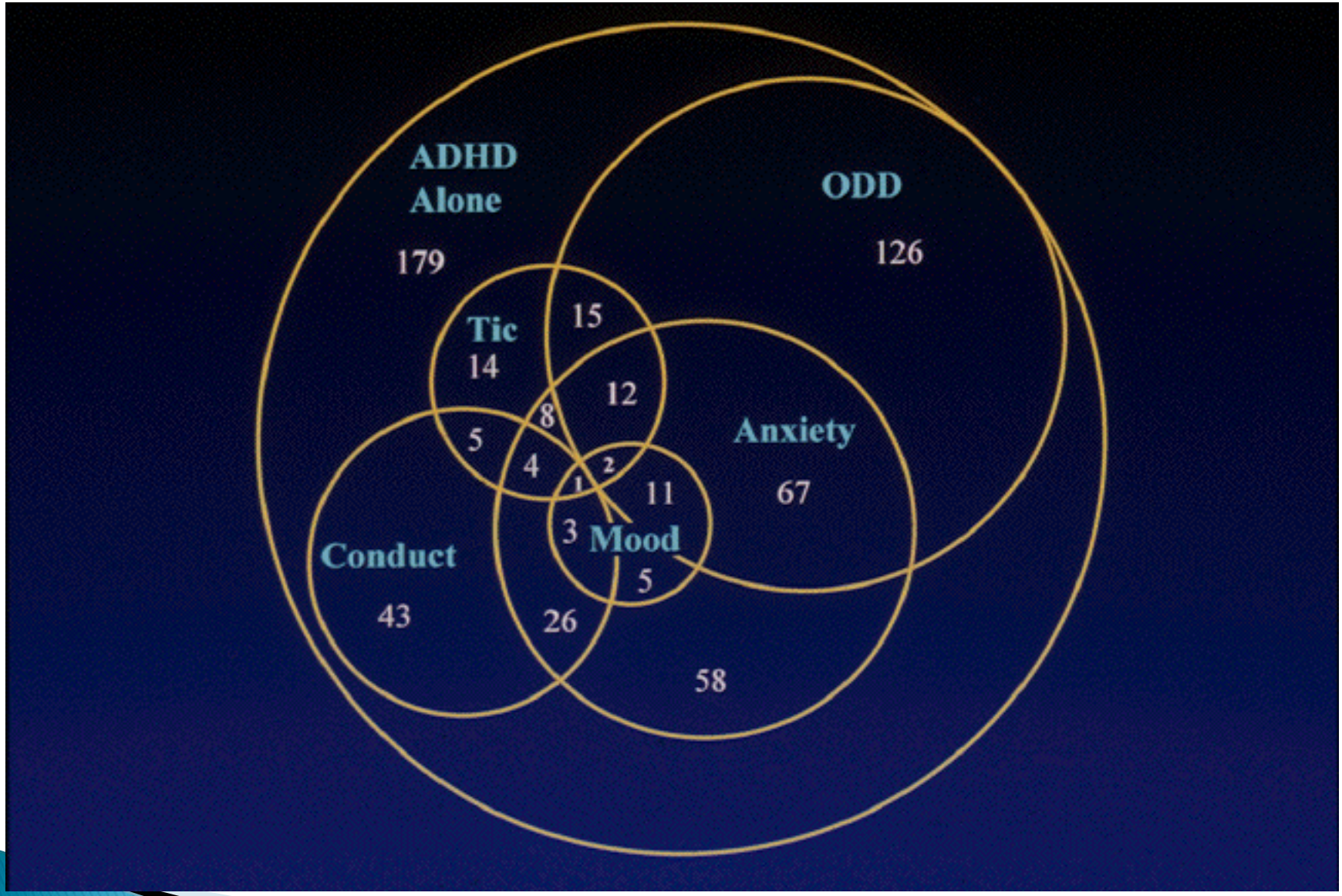
Annual Cost of Other Disorders in U.S.

- Depression: $44 billion
- Stroke: $53.6 billion
- ADHD (child, adolescent, adult) $80 billion
- Alzheimer's $100 billion
- Alcohol abuse/dep $180
- Drug abuse/dep $180

Comorbidity with ADHD

- Learning disorders
- Language and communication disorders
- Conduct disorder
- Oppositional defiant disorder
- Anxiety disorder
- Mood disorders
- Tourette's syndrome; chronic tics

- Is it Important in Treatment? No, but differences in functional impairments means treatment targets may be different


ADHD
Alone
179
ODD
126
Tic
14
15
12
8
5
4
1
2
11
Anxiety
67
3
Mood
5
Conduct
43
26
58

Associated Problems

1. Learning and Achievement Problems
   - LD in 25% to 50% of ADHD children
   - Achievement problems in 50% to 75% of ADHD children
   - Failure, retention, school dropout
2. Self esteem?
   - Inflated or low?
   - Accurate or inaccurate?
   - Childhood vs. adolescence

Prognosis for ADHD Children

- Chronic disorder extending into adolescence and adulthood
  - One-third: **Tolerable outcome**; appear to have mild problems but must constantly work to adapt to their difficulties
  - One-third: **Moderately poor outcome**; continue to have a variety of moderate to serious problems, including school difficulties (adolescents) or vocational adjustment difficulties (adults), interpersonal problems, general underachievement, problems with alcohol, etc.
  - One-third: **Bad outcome**; severe dysfunction and/or psychopathology, including sociopathy, repeated criminal activity and resulting incarceration, alcoholism, drug use disorders

Academic Functioning

PALS (Robb et al, under review)

- 33% of ADHD have academic problems (special ed., academic probation, dropped out, or held back) every year, vs. 2% of controls
- 48% of ADHD children have at least one year of special education placement vs. 3% of controls (bulk of cost)
- Far more likely than comparisons to be placed in remedial classes even in regular ed. and less likely to be in advanced
- 12% of ADHD vs. 5% of controls have been held back a grade
- 9% of ADHD adolescents drop out of school vs. 1% of controls
- ADHD adolescents a full letter grade lower than controls, with twice the rate of absences
- Concurrent learning disabilities occur in 25% to 75% of ADHD children

School Discipline Problems

(lifetime--PALS (Robb et al, under review))

- Discipline Problems (sent to principal, serious warnings, detention, suspension, expulsion) per Year:

	ADHD	Control
None	20%	41%
< Quarterly	34%	51%
Quarterly	17%	7%
Monthly	19%	1%
Weekly	10%	0%

What does an Adolescent with ADHD look like in High School?

(PALS; Kent et al, in preparation)

- Academic GPA ~ 75.3
- Each school year, they are absent ~17 days and tardy ~11 days
- They complete and turn in only ~65% of their school work
- Likely to have lower class placement and more likely to fail their courses
- Over 2 times more likely to drop out of school than non-ADHD peers

Overall & Academic GPA

(PALS; Kent et al, in preparation)

Estimated Marginal Means				
	Overall GPA		Academic GPA	
	ADHD (n=77)	Control (n=62)	ADHD (n=77)	Control (n=62)
9th grade	74.5	81.7	73.0	80.0
10th grade	76.7	81.8	75.9	80.4
11th grade	77.9	80.9	76.0	79.0
12th grade	78.5	80.6	76.2	79.0
Overall HS	76.9	81.3	75.3	79.6
	df	*F*	*p*	*d*
Overall GPA	(1, 444)	28.4	< .01	.92
Academic GPA	(1, 445)	23.6	< .01	.83

Associated Problems

3. Peer problems
   - Seriously disturbed in many ADHD children (50% - 75%)
   - Less well-liked and much more rejected than other children
   - Deficits predict long-term negative outcomes
   - Peer relationships mediate long-term outcome
   - Must be changed to improve long-term outcome of ADHD children
4. Defiance/Noncompliance/Oppositional behavior and Aggression/Conduct Disorder

Why are Peer Relationships Important in ADHD?

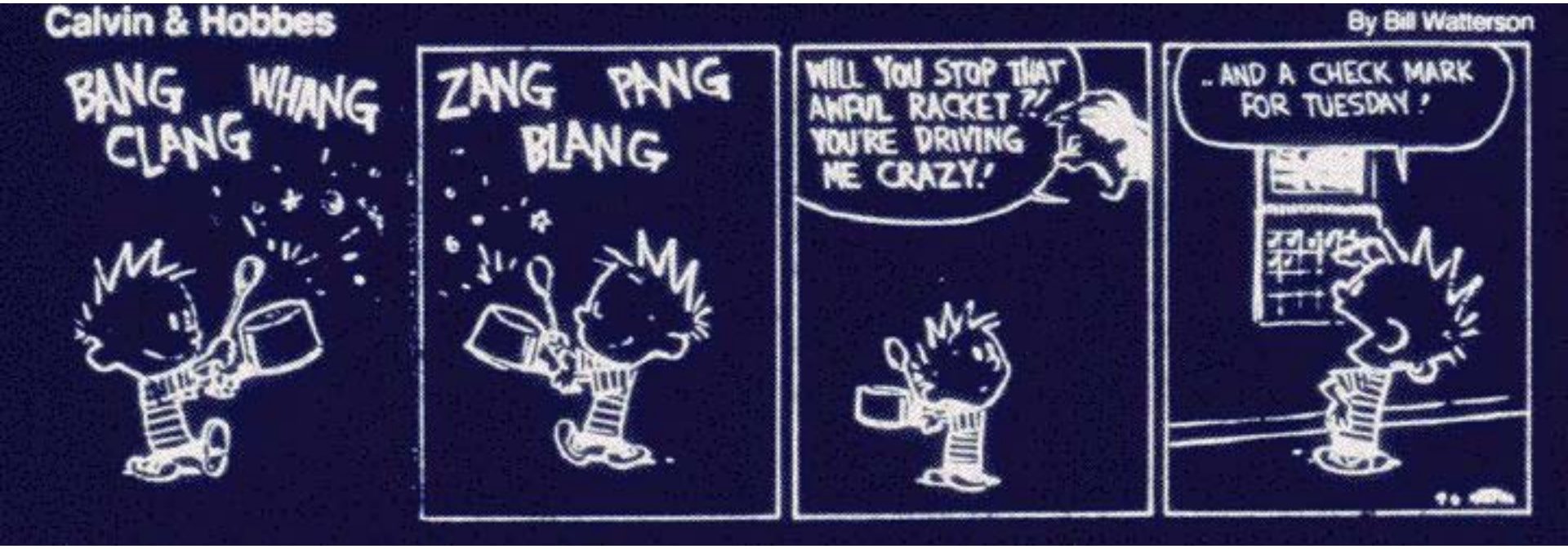
- We have long known that impaired peer relationships in children are the best predictors of negative adult outcomes
- ADHD children have seriously impaired peer relationships and also the adult outcomes that they predict
- Peer relationships arguably mediate ADHD children's adult outcomes

Associated Problems

- 5. Family problems/Parental psychopathology
  - alcohol problems
  - maternal stress and depression
  - antisocial personality
  - divorce/single parent status
  - parental and sibling ADHD

Consider the Family Context--Parental Functioning and Parent-Child Relationships

Do Your Children Cause You Stress?


Calvin & Hobbes
By Bill Watterson
BANG WHANG CLANG
ZANG PANG BLANG
WILL YOU STOP THAT AWFUL RACKET?! YOU'RE DRIVING ME CRAZY!
.. AND A CHECK MARK FOR TUESDAY!

Caregiver Strain Questionnaire

Assesses the impact on parents of having a child member with ADHD (Branna, Heflinger, & Bickman, 1997).

3 subscales:

Objective caregiver strain (e.g., loss of personal time, trouble in neighborhood, disruption of family relationships)

Internalized subjective caregiver strain (feelings internalized by caregiver; e.g., worry, guilt, tired)

Externalized subjective caregiver strain (negative feelings directed at the child; e.g., anger, embarrassment, resentful toward child)

Caregiver Strain Questionnaire

(mother report lifetime–PALS; Robb et al, in preparation)

	ADHD	Control
Objective caregiver strain	28.1 (10.5)	4.1 (5.6)
Internalized subjective strain	19.7 (5.4)	10.4 (5.5)
Externalized subjective strain	10.3 (2.7)	8.4 (2.3)

- Significant group differences ($p < .01$) on all scales

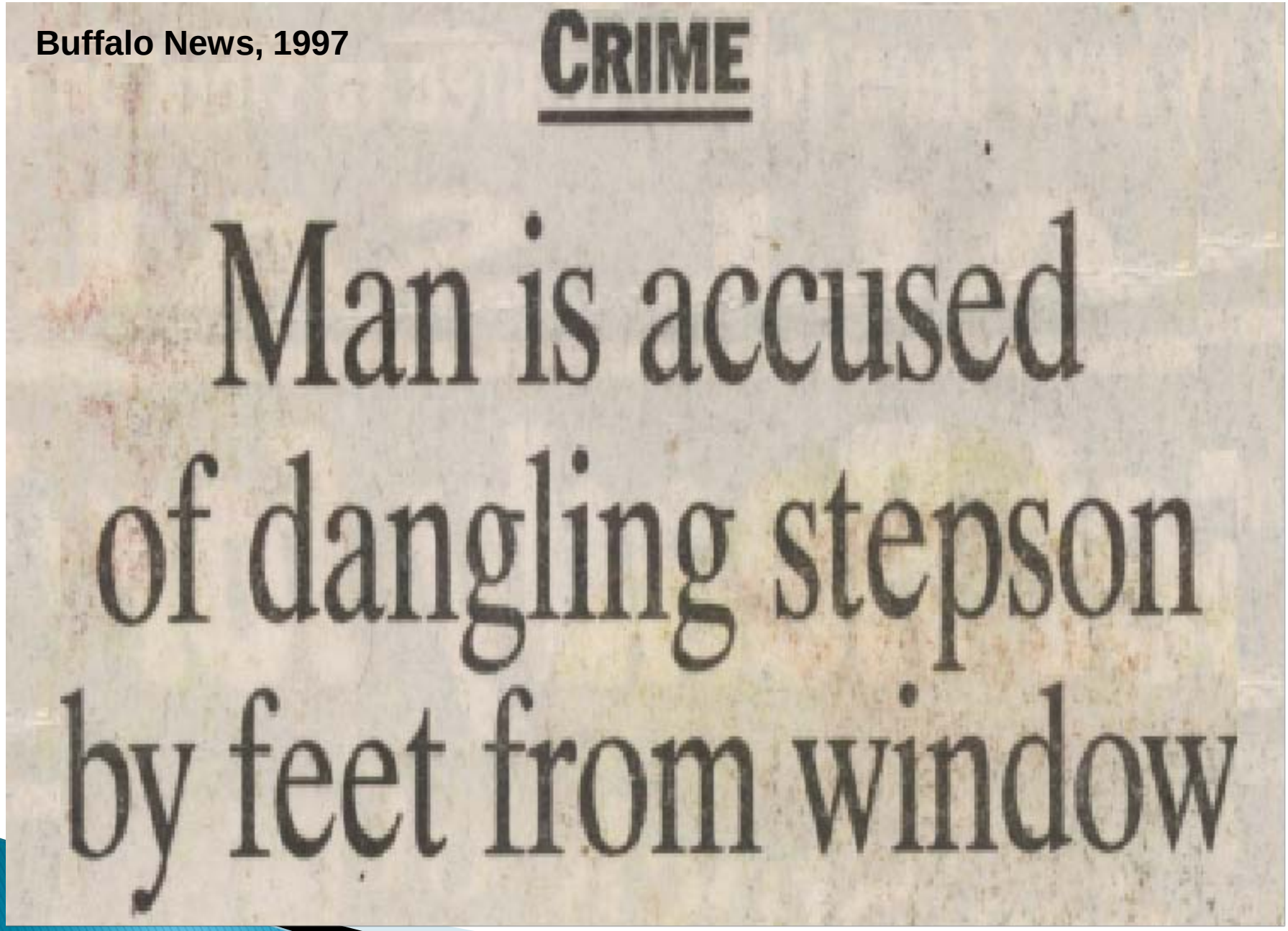
Health States from CSQ

(from PALS mothers; Robb et al, in preparation)

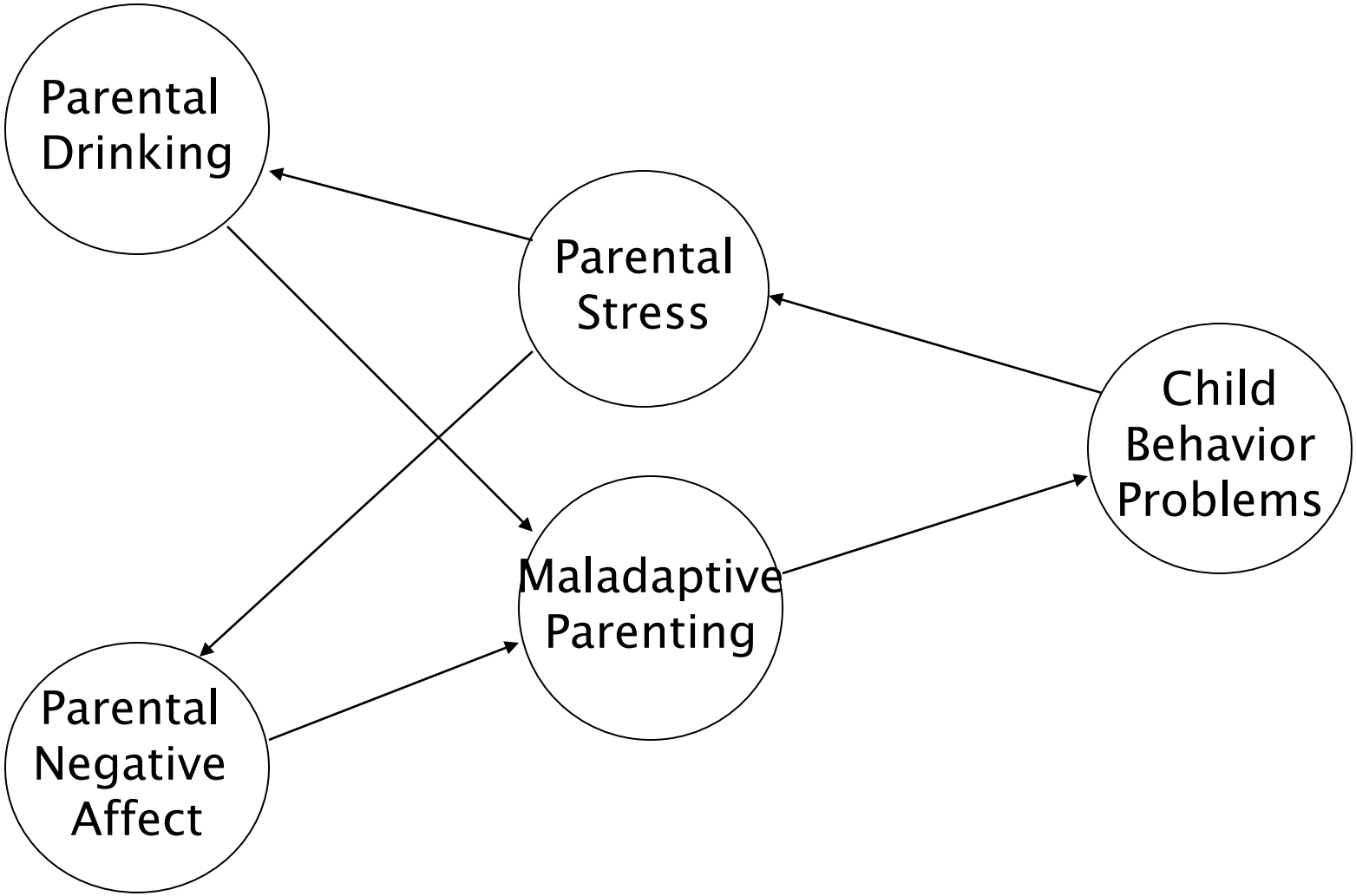
- Computed health states using the CSQ analogous to those from HRQoL (EQ-5D Group)

- 29% of mothers of ADHD kids had lifetime health state scores (QALY)= .67
- 31% had QALY= .72
- Only 8.6% of control mothers had QALYs this low
- These scores are equivalent to scores for major depression, colitis, diabetes, asthma, migraine, ulcers, and stroke
- Only 2% said ADHD child did not interfere with daily life activities (vs. 50% of control mothers)

Buffalo News, 1997

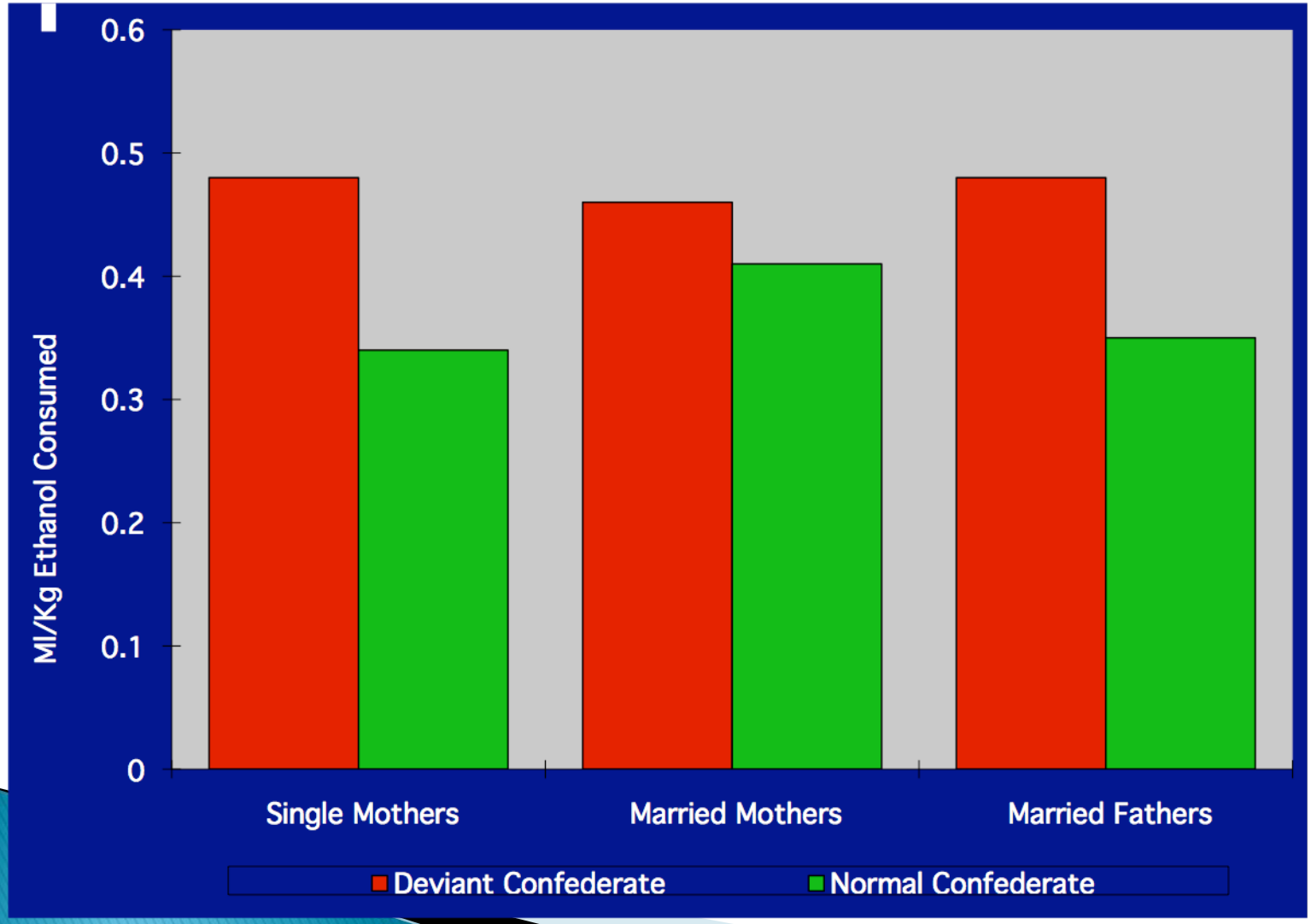

CRIME

Man is accused of dangling stepson by feet from window


Parental Drinking
Parental Stress
Child Behavior Problems
Maladaptive Parenting
Parental Negative Affect

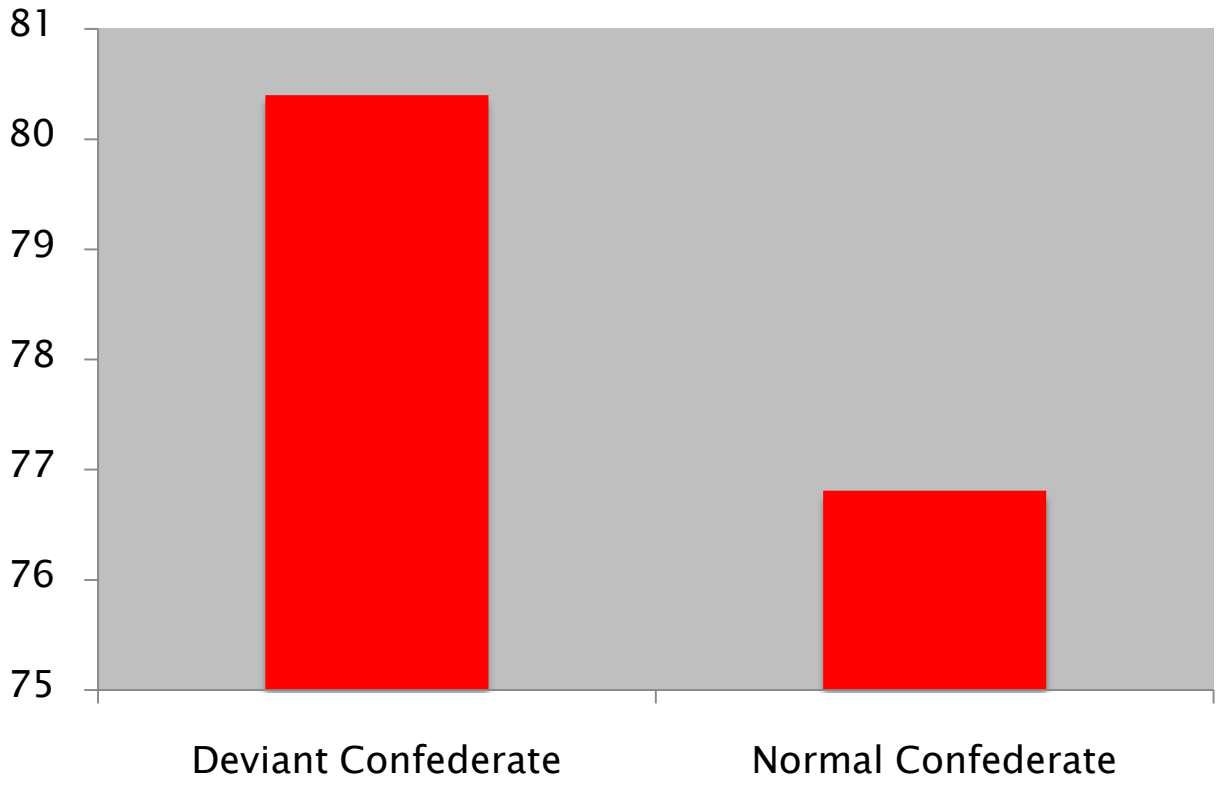
Ml/kg Ethanol Consumed as a Function of Confederate Type and Parent Type for Parents of Normal Children

(Pelham et al, 1998)



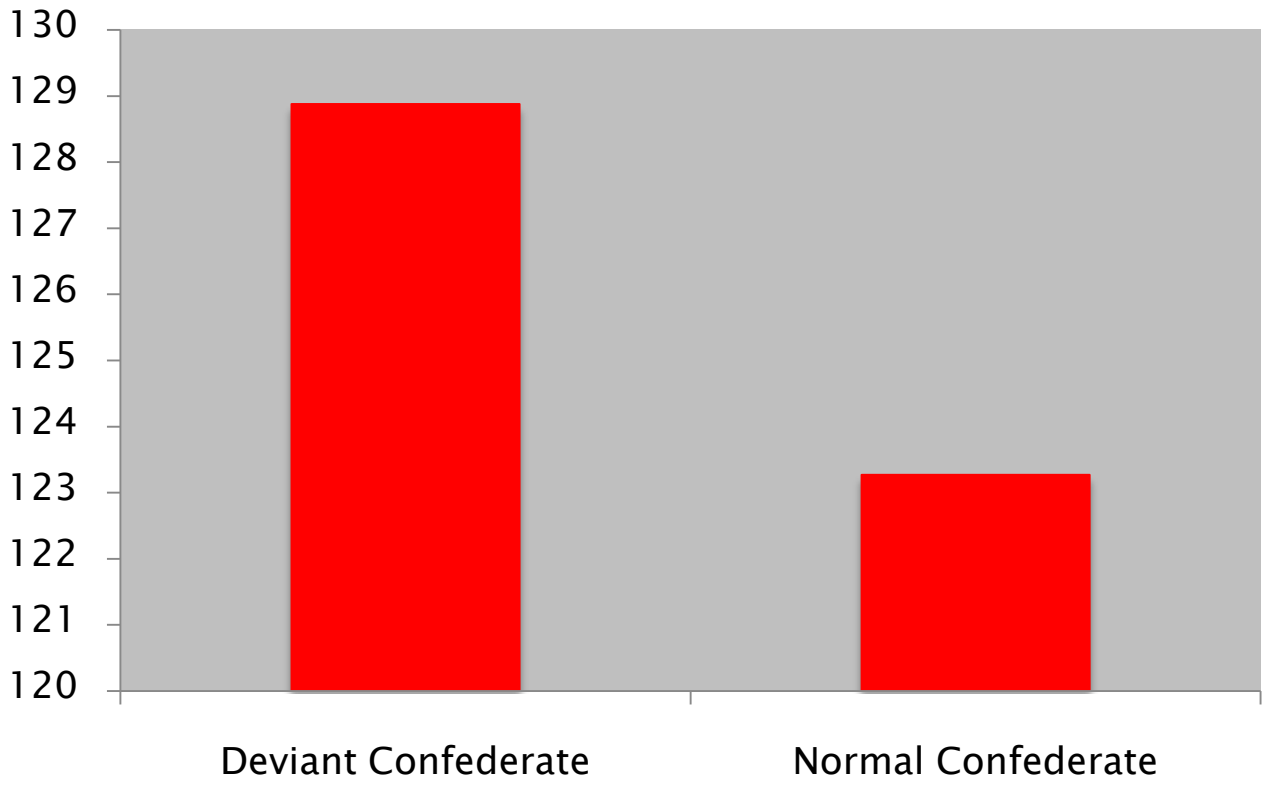
Heart Rate as a Function of Confederate Type in 60 Mothers of Deviant Children

(Pelham & Lang, NIAAA)



Systolic Blood Pressure as a Function of Confederate Type in 60 Mothers of Deviant Children

(Pelham & Lang, NIAAA)



Bratty kids like Bart Simpson may send frazzled parents running for the bottle

WHEN mom or dad shouts "Kids, cut it out! You're driving me to drink!" they may not be exaggerating. A new study shows that children who behave like Bart Simpson can cause parents to hit the bottle more.

"I'm not suggesting we blame children for the alcoholism of their parents," stresses Alan Lang, an associate professor of psychology at Florida State University. "Nonetheless, difficult children can cause serious distress for parents and, in some cases, this may contribute to increased alcohol use."

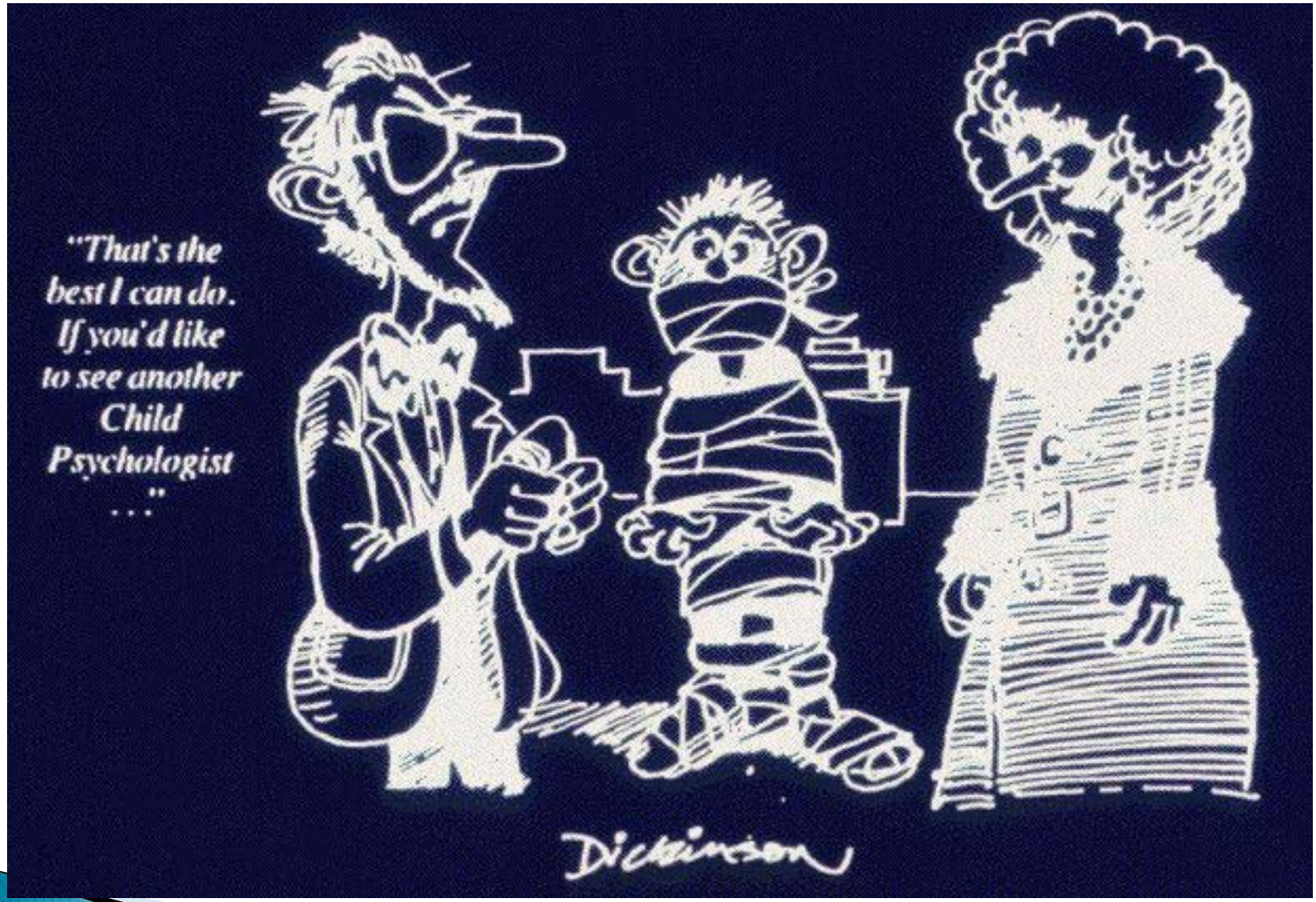
Lang, with Dr. William Pelham of the University of Pittsburgh, studied 120 parents with sons ages 5 to 12.

Moms and dads were allowed to drink freely as the kids played, and parents of the unruly tykes were found to guzzle more.

What is Effective, Evidence-based Treatment for ADHD in Children?

Treatments That Are Commonly Used but Are Not Evidence-Based (i.e., are Not Effective)

(1) Traditional one-to-one therapy
(2) Cognitive therapy
(3) Office based "Play therapy”
(4) Elimination diets
(5) Biofeedback/neural therapy/attention (EEG) training
(6) Allergy treatments
(7) Chiropractics
(8) Perceptual or motor training/sensory integration training
(9) Treatment for balance problems
(10) Pet therapy (including horse therapy)
(11) Dietary supplements (megavitamins, blue-green algae)

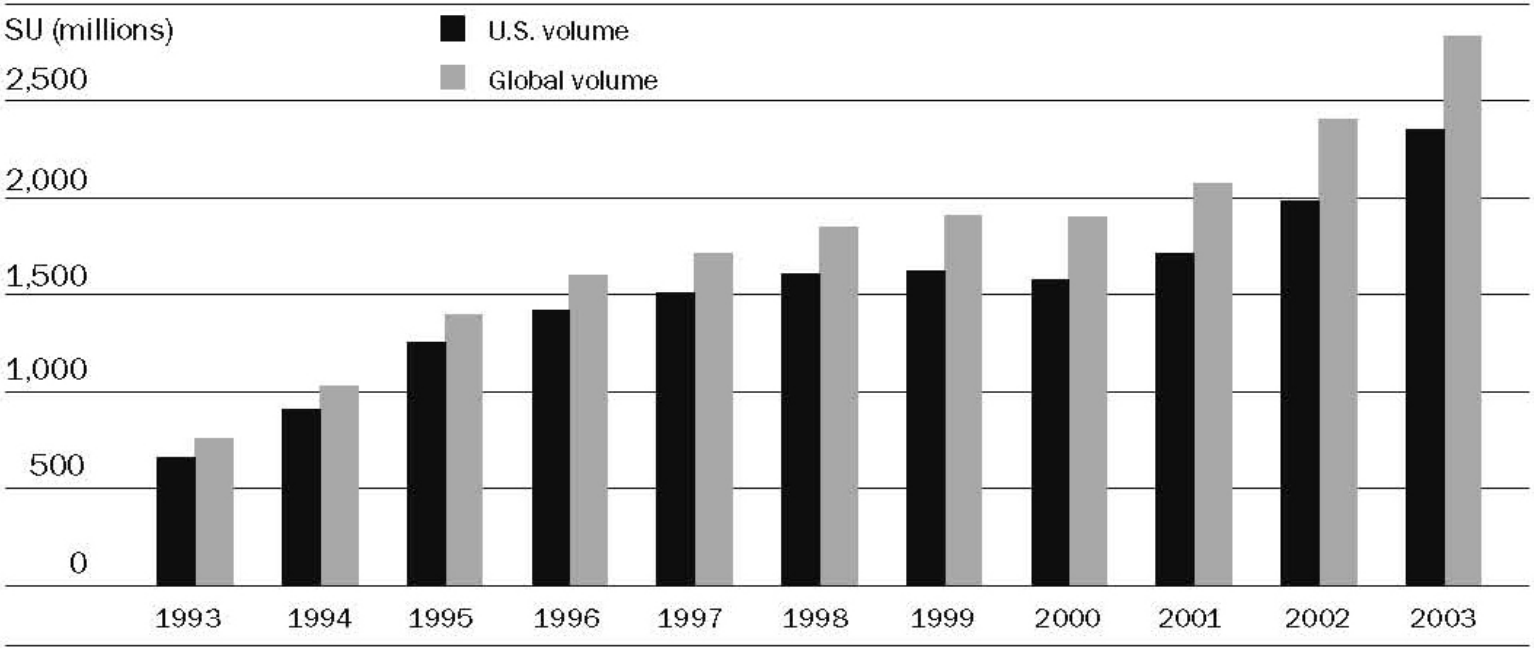

"That's the best I can do. If you'd like to see another Child Psychologist . . ."
Dickinson

Evidence-Based Short-term Treatments for ADHD

- (1) Behavior modification
- -175 studies
- (2) CNS stimulant medication
- >300 studies
- (3) The combination of (1) and (2).
- >25 studies
- Moderate to large effect sizes across treatments

- (Pelham & Fabiano, 2008; Greenhill & Ford, 2002; Hinshaw et al, 2002; Fabiano et al, 2009)

U.S. And Global Volume Of Attention Deficit Hyperactivity Disorder (ADHD) Medications, 1993–2003



SOURCE: MIDAS database, IMS Health, 1993–2003.
NOTES: Volume adjusted to generate dosage equivalence between short- and long-acting medications. Long-acting medications are weighted twofold over short-acting medications. SU is standard units.

Scheffler, R.M., Hinshaw, S.P., Modrek, S., & Levine, P. (2007). Trends: The global market for ADHD Medications. *Health Affairs, 26(2)*, 450–457.

Limitations of Pharmacological Interventions When Used Alone

1) Rarely sufficient to bring a child to the normal range of functioning
2) Works only as long as medication taken
3) Not effective for all children
4) Does not affect several important variables (e.g., academic achievement, concurrent family problems, peer relationships)
6) Poor Compliance in long-term use
7) Parents are not satisfied with medication alone
8) Removes incentive for parents and teachers/schools to work on other treatments
9) Uniform lack of evidence for beneficial long-term effects
10) Potential serious adverse effects in growth and substance use (data controversial)

Components of Effective, Comprehensive Treatment for ADHD

Behavioral Parent Training--

Use always

Behavioral School Intervention--

Use always

Intensive Behavioral Child Intervention--

Use when needed

Medication--Use when needed

ABCs of Behavior

IDEAL INTERACTION

Parent Command

↓

Child Compliance

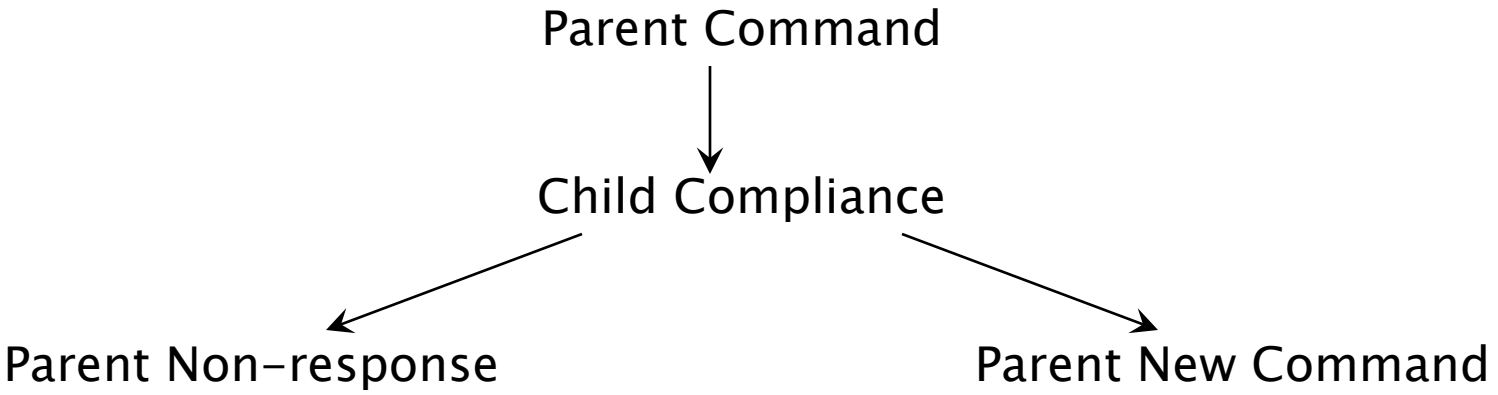
↓

Parent Praise / Reward

Child learns that good things come from doing what they're told to do

Parent learns that their child is enjoyable and compliant

ABCs of Behavior

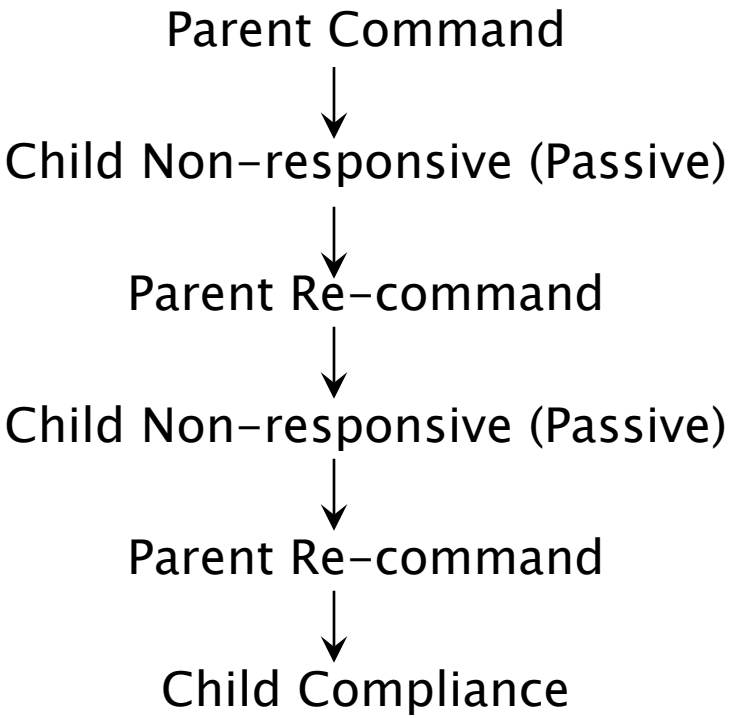


Child learns nothing good comes from compliance

Child learns compliance = get more work without reward

Parent learns to take compliance for granted

ABCs of Behavior



Child learns to wait before complying

Parent learns to nag child for compliance

ABCs of Behavior

Parent Command

↓

Child Non-responsive

↓

Parent Escalates Harsh tones, raised voice, physical discipline, etc.

↓

Child Compliance

Child learns that aggression is valid way to get what they want (modeling)

Parent learns that more aggressive, obtrusive methods are needed to enforce compliance

ABCs of Behavior

Parent Command

↓

Child Non-compliance

↓

Parent Re-command

↓

Child Escalates Scream, hits, break things, etc.

↓

Parent Withdraws

Child learns that increased aggression = get out of task (rewarding)

Parent learns to disengage / withdraw / ignore child

Ways to Change Behavior

Behavioral Interventions in the Home

1. House rules
   - –Posted chore lists
   - –Posted morning routine
   - –Posted evening routine
   - –Posted House Rules
2. Ignore mild inappropriate behaviors and praise appropriate behaviors (choose your battles)

   –Praises should outnumber reprimands and/or commands—at least 2 or 3 to 1 ratio

   –Use commands/reprimands to cue positive comments for children who are behaving appropriately—that is, find two children who can be praised each time a reprimand or command is given to a child who is misbehaving

   –Shape appropriate behavior by working within the child's ability/skill level.

   –Use praise and ignore consistently

Behavioral Interventions in the Home

3. Appropriate commands:
   - Obtain the child's attention: say the child's name
   - Use command not question language
   - Be specific
   - Command is brief and appropriate to the child's developmental level
   - State consequences and follow through

4. Premack contingencies/when…then (e.g., watch TV or phone time contingent upon homework completion)

4. Daily charts
   - Target behaviors and track daily
   - Home Daily Report Card (see target list and parent workbook)

Behavioral Interventions in the Home

- Procedures have been described in the behavioral literature for some time.
- In contrast to widespread belief, recent research suggests that the mildest procedures (e.g., praise and ignore) are usually not sufficient and that some type of prudent punishment program (time out, loss of privileges, response cost) is usually necessary.
- Procedures are arranged in order from mildest and least restrictive to intensive and most restrictive procedures.

COPE Parent Training Sessions: Content

Cunningham et al, 1998

1. Introduction to ADHD and Orientation
2. Attending and Rewards
3. Balanced attending
4. Planned Ignoring
5. Transitional Warnings and When Then
6. Planning ahead 1

7/8. Time out 1 and 2

9/10. Point systems 1 and 2

11. Planning ahead 2
12. School-home Daily Report Cards
13. Problem Solving

14/15. Selected problems 1 and 2

16. Closing session

COPE Parent Training Sessions

- Systems Levels
  - Parenting Skill
  - Problem Solving
  - Role Balance
  - Communication
  - Social Network

COPE Parent Training Sessions

- Attributional Questions (asked about all systems levels)
  - Social Effect (What difference make?)
  - Social Learning (What lesson taught?)
  - Communication (What message communicated?)
  - Long-term outcome (What long term effect?)
  - Effort (Is it worth the effort?)

Behavioral Interventions in the Home

- Social learning approach to train the ADHD child's parents to implement behavioral procedures in the home.
- Clinicians should use one of the parent training manuals that have been developed for use with children with externalizing disorders (Patterson/Oregon, Barkley, Forehand, Webster-Stratton, Cunningham-COPE, PCIT, Triple P).
- Most of these are written to fit with an 8- to 16-session series of individual or group therapist contacts.
- Typically the intervention that parents will conduct is individualized, consists of several of the components listed below, and is based on the child’s needs and the parents’ resources, skills, abilities, and preferences.

Intervening and advocating at school

- Parents must be the advocates for their children
- Parents of kiddos with ADHD must establish and maintain good communication with the school system
- Include multiple school personnel
  - Principal, assistant principal, guidance counselor, parent advocate
  - Face to face recommended
  - Teacher selection

Intervening and advocating at school

- When communication breaks down, remember:
  - Stay calm and neutral
  - Remember there are two sides to every story
  - View the teacher as a helping person
  - Reinforce teacher/school changes along the way

Interventions in detail

- **Class Lottery System**
- **Daily Report Card (DRC)**

Class Lottery Reward System

- A simple and efficient procedure for improving rule-following behavior in the classroom.

- Pros:
  - **Takes very little teacher time**
  - **Costs nothing**
  - **Popular with children/adolescents**
  - **Often quite effective**

- Can be used in both regular and special education classrooms

Establishing a Class Lottery Reward System

- Establish a brief list of class rules and post them
- Come up with a list of age appropriate incentives (e.g., class jobs, free time, permission to listen to CD for the last five minutes of class).
  - **Can encourage children/adolescents to nominate potential new jobs**
- Tell the class that you will be scanning the class at unannounced times 5 times in the period to see who is following the rules.
  - **Select scanning times in advance and write them in the planning book**
  - **Selected times should especially include times when the class is least likely to be following rules**

Establishing a Class Lottery Reward System

- After completing each scan (no more than 15 to 20 secs), announce to the class who was following rules and record those names
- At the end of the period, allow all children/adolescents who were following the rules at your designated criterion level (e.g., 3 out of 5 initially, progress to 4 out of 5, then to 5 out of 5) to put their names on paper in a hat
- Draw a pre-determined number of names from the hat (e.g., 10) and allow the child to choose the reward from the reward list
- Try to have between 5 to 10 rewards (e.g., class jobs)

Daily Report Card
ccf.fiu.edu

- An integral part of all of our school interventions with DBD children
- Serves as a means of identifying, monitoring, and changing the child's classroom problems
- Doubles as an avenue of regular communication between the parents and the teacher
- Costs little, takes little teacher time, and is highly motivating to the children if parents have selected the right rewards for home back-up
- Effectiveness documented in numerous studies

Establishing a DRC

- Select the goals to be achieved
- Determine how the goals will be defined (target behaviors)
- Gather a baseline to determine problem severity
- Decide on behaviors and criteria
- Explain the Daily Report Card to the child
- Establish a home-based reward system
- Monitor and modify the program
- Trouble-shoot the Daily Report Card

Select the Goals to be Achieved

- Involve all the staff who work with the child in a discussion of the child's behavior.
- Ask child specific goals they would like to work on (might incorporate these with your goals)
- Determine the child's greatest areas of impairment–areas that if, changed, would improve the child's major problems in daily life functioning and, if left unchanged, would have long-term negative consequences.

Determine How the Goals will be Defined (target behaviors)

- Must be meaningful behaviors
- Must be clearly defined in a way the child, teacher, and parents all understand
- Must be able to be observed and counted by the teacher and child
- The number of targets will depend on the child's developmental level (typically between 3 to 6)

Sample Targets

- Followed classroom rules
- Raised hand before talking
- Handwriting legible on assignment sheet, notes, or HW
- Brought homework completed
- Brought Friday report of progress toward term paper or other long-term project
- Followed cafeteria code of conduct
- Arrived to school on time
- Used eye contact with teacher at least once

Gather a Baseline to Determine Problem Severity

- Estimate how often the child/adolescent typically engages in the behavior
- If a good estimate can not be made, observe how frequently the child/adolescent engages in behavior

Decide on Behaviors and Criteria

- Select a few of the target behaviors
  - **Include a few of the more challenging behaviors**
  - **Include a few less challenging behaviors**
  - **May not be able to target all behaviors**
- Set a reasonable criterion for each target behavior
  - **Set criteria at a rate slightly better than what the child is doing now to encourage improvement (e.g., 20% improvement)**

Establish a Home/School-Based Reward System

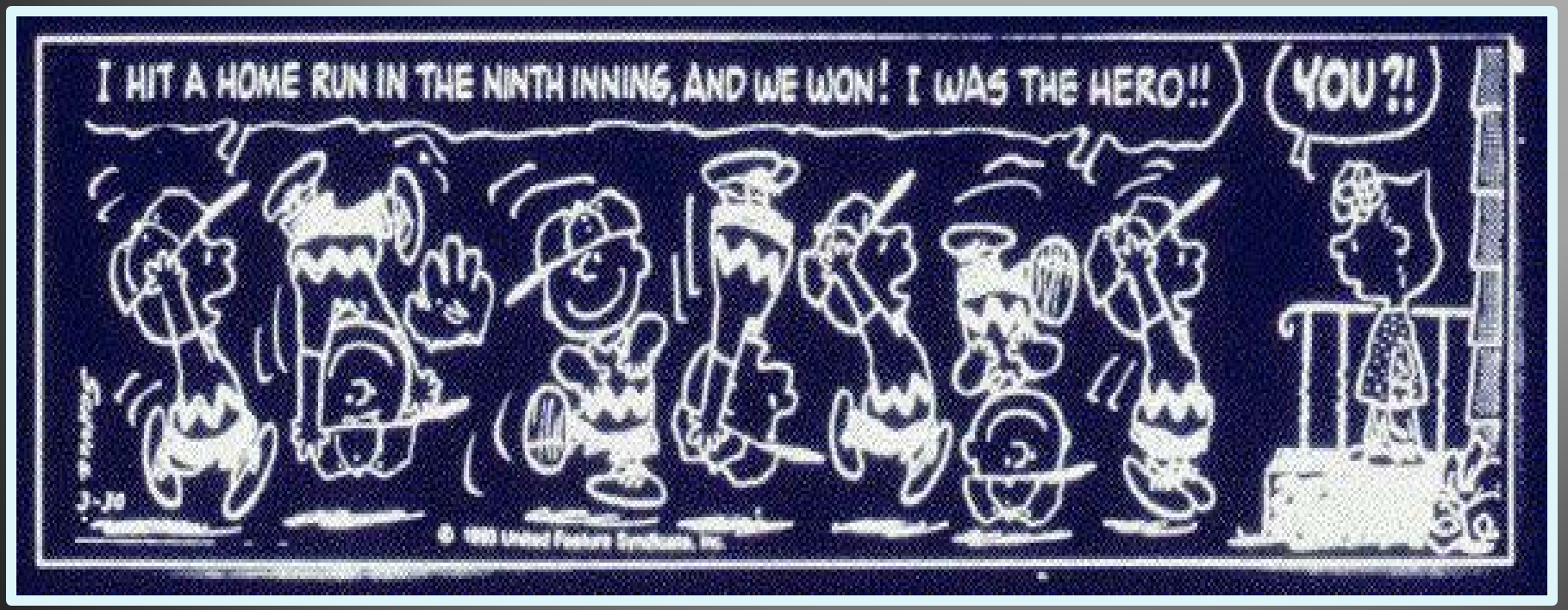
- Rewards provide the motivation for the child to work towards a good DRC, and they are a necessary component of the program
- Rewards can be provided at school or at home or both.
- If provided at school, can be provided either at the end of the class, mid-day, or at the end of day
- Rewards should be natural (e.g., computer time)

Possible Reinforcers

- EXAMPLES OF SCHOOL REWARDS
- Computer time
- Playing outside
- Educational games on computer
- Teacher's helper
- Class monitor
- Free time
- Listen to a CD player (with headphones)
- Read a book
- Help clean up classroom
- Be messenger for office
- Have treats
- Be a line leader
- Choose seat for specific time
- Playing card game
- Draw from "grab bag"
- Visit the principal

- EXAMPLES OF HOME REWARDS

- Choosing radio station in car (D)
- Selecting something special at the store (W)
- Making popcorn (W)
- Television time (D, W) (for sat/sun)
- Video game time D at home, w at mall
- Listening to radio/stereo (D, W) (for sat/sun)
- Playing outside (D, W) (for sat/su)
- Extra bathtub time (D)
- Educational games on computer (D)
- Talking on phone D (for friends), w (for long distance calls to relatives)
- Choosing family T.V. show (D)
- Choosing family movie (W)
- Renting movie video (W)


I HIT A HOME RUN IN THE NINTH INNING, AND WE WON! I WAS THE HERO!!
YOU?!

Other interventions at school

- Response to learning
  - Swifter intervention
  - Daily Report Card
- Individualized Education Plan (IEP)
  - Accommodation and Intervention
  - Plan
- Section 504 of ADA
  - Accommodation for disability
  - District defined (to an extent)

Behavioral Interventions in the Home

- Procedures have been described in the behavioral literature for some time.
- In contrast to widespread belief, recent research suggests that the mildest procedures (e.g., praise and ignore) are usually not sufficient and that some type of prudent punishment program (time out, loss of privileges, response cost) is usually necessary.
- Procedures are arranged in order from mildest and least restrictive to intensive and most restrictive procedures.

Important Clinical Guidelines/Issues-Home

1. Begin treatment by educating the parents about ADHD. Give parents the data regarding prognosis and convince them that medication alone will not solve their child's problem in the long run, although it may appear to in the short run. This information is critical to hook parents into parent training.

Important Clinical Guidelines/Issues-Home

2. Give the clear expectation that it won't be easy--treatment will mean lifestyle changes and long-term commitment to the intervention.
3. Although some parents can develop adequate programs with little direct help, most need explicit instructions and guidance. Simply giving parents one of the handbooks to read is generally completely ineffective.

Important Clinical Guidelines/Issues-Home

4. Constantly emphasize the importance of shaping and consistency. That is, ensure that parents set attainable initial goals for target behaviors and that they reward reasonable progress towards the goals, setting new criteria as child reaches the old ones.

5. Point or token system and time out will typically be absolutely essential. Punishment procedures (e.g., time out, response-cost) are almost invariably necessary, and often need to be taught early rather than late in the parent training session sequence.

Important Clinical Guidelines/Issues-Home

6. Involve collaterals in home (both adults and siblings), extended family (e.g., grandparents who care for the child), and neighborhood (e.g., neighbors who baby-sit, peers) if necessary.
7. Do at least some of the training with parents and children directly in the clinic to insure that parents are doing it right. Many parents can verbalize what they should do, but what they actually do with the child when faced with the problematic situation may differ.

Important Clinical Guidelines/Issues-Home

8. Provide support as well as training. Parent training in groups often serves this purpose (be sure groups are well comprised with regard to educational level).
9. Encourage parents of ADHD children to communicate with one another for help and advice (parent advocacy groups).
10. Don't stop training too soon. Use booster sessions for long period following initial training.
11. Be creative in developing and teaching programs and procedures.

Important Clinical Guidelines/Issues-Home

12. Be cognizant of family issues that may interact or interfere with parent training (e.g., paternal drinking, marital distress, maternal anxiety/depression, parental residual ADHD). Make appropriate referrals or institute appropriate treatment when problems are apparent.
13. For older children and adolescents, place greater emphasis on family sessions with the child/adolescent participating in contracting communication and negotiation.
14. Program for maintenance and relapse prevention.

http://www.effectivechildtherapy.com

Evidence-Based Mental Health Treatment for Children and Adolescents

ABCT ASSOCIATION FOR BEHAVIORAL AND COGNITIVE THERAPIES

SOCIETY OF CLINICAL CHILD AND ADOLESCENT PSYCHOLOGY SCCAP

Welcome | The Public | Professionals & Educators

The information on this website is offered as a completely free service to families and mental health professionals to help ensure that children and adolescents benefit from the most up-to-date information about mental health treatment. We request absolutely no information from visitors to this site, and hope this service will help all learn more about important differences in mental health treatments. Families want their children to get the best possible treatment, and this site maintains an updated list of treatments with strong scientific support.

The site was developed by the Association of Behavioral and Cognitive Therapies and the Society of Clinical Child and Adolescent Psychology, a division of the American Psychological Association. The site is maintained regularly to ensure that information reflects the current scientific literature. All psychological treatments are considered for inclusion on this website, and anyone may offer input on the information listed. To learn more about how to request a change to this site, click here.

SCCAP

ABCT

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Find the Best Treatments for You and Your Family

Information for parents, caregivers, and the general public

Practice the Best Treatments

Information for practitioners, educators, and other mental health professionals

Information on Evidence-based Mental Health Treatment for Children and Adolescents has been provided by a partnership between the Association for Behavioral and Cognitive Therapies and the Society of Clinical Child and Adolescent Psychology

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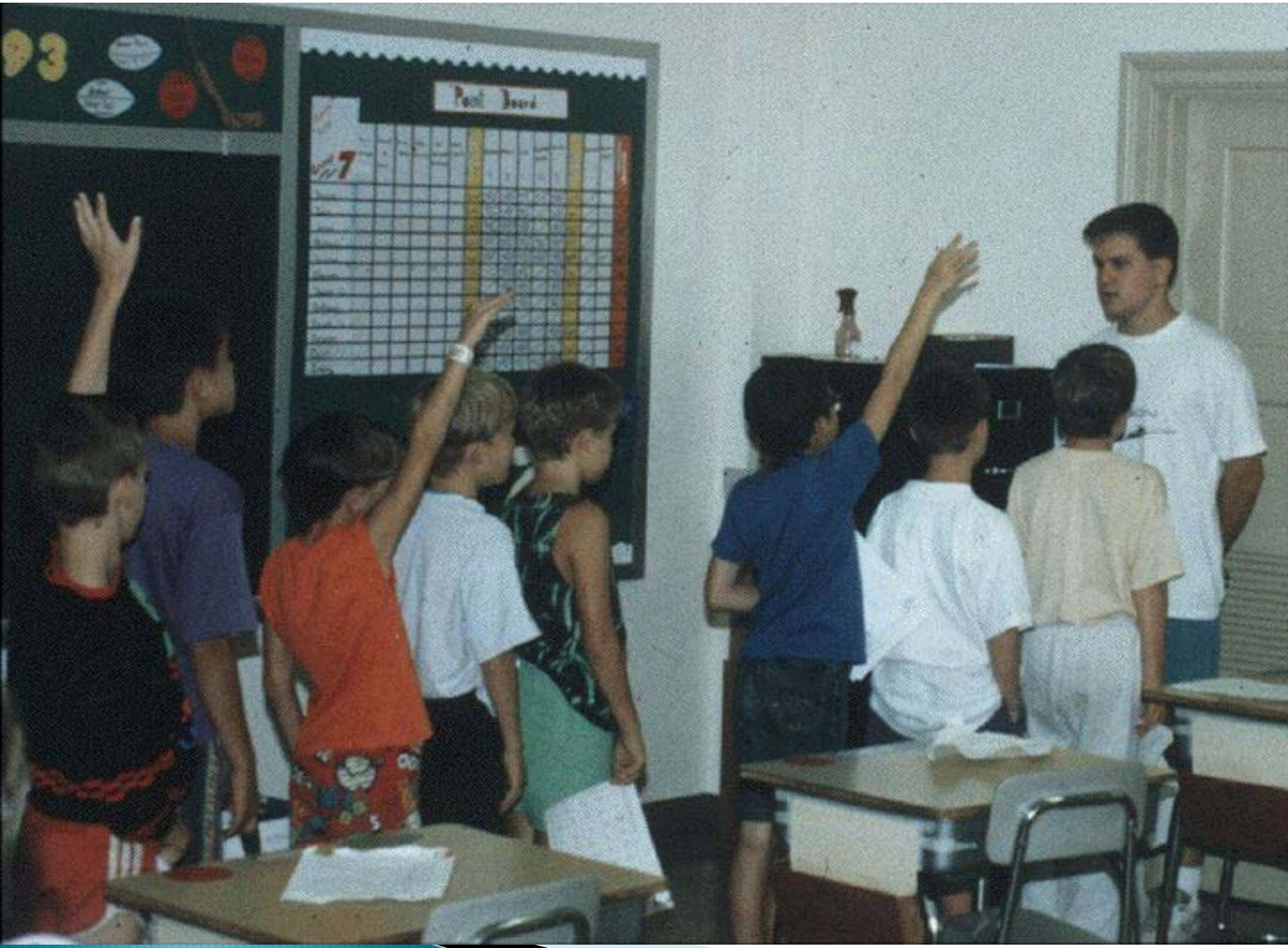
Comprehensive and Intensive Treatment for ADHD: Summer Treatment Program

- Named in 1993 as one of the country's model service delivery program for children and adolescents by the Section on Clinical Child Psychology of the American Psychological Association.
- Used successfully in clinical trials at NIMH, CMHS, and NIDA
- Innovative Program of the Year, 2003, CHADD
- SAMHSA list of Evidence Based Practices (NREPP), 2008

Summer Treatment Program Overview

- Children grouped by age into groups of 12-16
- Groups stay together throughout the day
- 4-5 paraprofessional counselors work with each group all day outside of the classroom
- One teacher and an aide staff the classroom for each group
- Treatment implemented in context of recreational and academic activities
- Focus on Impairment and teaching skills--not symptoms
- Parent training incorporated
- Medication is second line treatment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