

AD/HD RESOURCE PACKAGE

This package was produced by the nurses working in the School Health Elementary program from Niagara Region Public Health in conjunction with the parents of the HOPE AD/HD parent support group from Smithville. There was a recognized need to provide pertinent information to individuals dealing with children, adolescents and adults experiencing AD/HD. Please contact Niagara Region Public Health for additional information at 905-688-8248 or 1-888-505-6074 Ext 7379. Information is also available on the website at www.regional.niagara.on.ca/health

Treatment

- A multi-model approach to treatment has proven most successful.
- Multi-model means the application of and networking between several areas of treatment including
 - **Home** – both parents well educated about AD/HD and it's implications to home, school & peers
 - **Health care provider(s)** – should be very experienced with this complicated disorder and able to oversee & administer effective medications if required.
 - **Counsellor(s)** – both individual & family counselling are often required to teach skills necessary to effectively cope with AD/HD.
 - **Support group(s)** – offer support and helpful strategies learned through shared experiences.
 - **School contact** – necessary to oversee child's progress and possible program modifications necessary to expedite child's learning, when dealing with co-morbid learning disabilities.

Contributed by:

Linda Elsegood – Parent and Founder of the HOPE support group for AD/HD families.

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25 GOOD THINGS ABOUT HAVING ADD

1. Lots of energy
2. Willing to try things – take risks
3. Ready to talk, can talk a lot
4. Gets along well with adults
5. Can do several things at one time
6. Smart
7. Need less sleep
8. Good sense of humour
9. Very good at taking care of younger kids
10. Spontaneous
11. See details that other people miss
12. Understand what it's like to be teased or to be in trouble so are understanding of other kids
13. Can think of different and new ways to do things
14. Volunteer to help others
15. Happy and enthusiastic
16. Imaginative - creative
17. Articulate - can say things well
18. Sensitive - compassionate
19. Eager to make new friends
20. Great memory
21. Courageous
22. More fun to be with than most kids
23. Charming
24. Warm and loving
25. Care a lot about families

List compiled at Learning Centre Summer Camp for Children with ADD, July 1992, by Staff and Parents.

FAMOUS PEOPLE WITH ADD/LD

Hans Christian Anderson	James Clark Maxwell
Beethoven	Steve McQueen
Harry Belafonte	Mozart
Alexander Graham Bell	David H. Murdock
Gregory Boyington	Jack Nicholson
Wright Brothers	Louis Pasteur
George Bush's children	Luci Baines Johnson Nugent
Prince Charles	Gen. George Patton
Agatha Christie	Edgar Allan Poe
Winston Churchill	Eddie Rickenbacker
John Corcoran	Nelson Rockefeller
Tom Cruise	Rodin
Leonardo da Vinci	Sergei Rachmoninoff
Walt Disney	Nolan Ryan
Thomas Edison	Charles Schwab
Albert Einstein	George C. Scott
Michael Faraday	Tom Smothers
Dwight D. Eisenhower	Suzanne Somers
F. Scott Fitzgerald	George Bernard Shaw
Henry Ford	Sylvester Stallone
Danny Glover	Jackie Stewart
Tracey Gold	Thomas Thoreau
Whoopi Goldberg	Alberto Tomba
Stephen Hawkings	Russell Varian
Mariel Hemingway	Jules Verne
Dustin Hoffman	Werner von Braun
Hubert H. Humphrey	Lindsay Wagner
Bruce Jenner	General Westmoreland
John. F. Kennedy	Weyerhauser family
Robert Kennedy	Russell White
Jason Kidd	Robin Williams
John Lennon	Woodrow Wilson
Carl Lewis	Henry Winkler
Greg Louganis	William Butler Yeats
Cher	Galileo

With Perseverance They Made It..... SO CAN YOU!

Source: C.H.A.D.D. of Beaver County

RESOURCE LIST FOR AD/HD FAMILIES

NIAGARA REGION SUPPORTS

Niagara Region Public Health

To obtain your free AD/HD Resource Package and Positive Parenting/Social Skills Fact Sheets

Go to www.regional.niagara.on.ca

(Click on "search" and enter AD/HD) or call 905-688-8248 or 1-888-505-6074 Ext. 7379 to request your package

HOPE - Family Support Group – For more information call

Sharon Knott at 905-688-8248, Ext 7539 (BMSV); Peggy Detlor 905-356-1538, Ext 226 (NF); Laurie McDowell 905-871-6513, Ext 31 (FE); Glenda Kerrigan 905-688-8248, Ext 7583 (STC).

Learning Disabilities Association of Niagara

Support and Resource Centre

366 St. Paul Street

St. Catharines, ON 905-641-1021

Contact Niagara

Is your child experiencing emotional and/or behavioural difficulty?

Contact Niagara offers a single point access to supports for children & youth – 905-684-3407

WEB SITES

Learning Disability Association of Canada

www.ldac-taac.ca

CHADD

Child and Adults with Attention Deficit Disorder

www.chadd.org

Attention Deficit Disorder in Adults

www.addag.ca

Ministry of Education Website

Copy of the Individual Education Plan

Or IEP Resource Guide

www.edu.gov.on.ca

Centre for Collective Problem Solving

Source of Parenting the Explosive Child Video

www.ccps.info

Russell A. Barkley, PHD

The Original Site

www.russellbarkley.org

Dr. Karen Gordon

www.drkaryn.com

www.regional.niagara.on.ca/health

AD/HD Magazine:

ADDitude Attention Deficit

www.additudemag.com

Robert Cooper

www.AD/HDfoundation.ca

Richard D. Lavoie, M.A., M.Ed.

www.ricklavoie.com

Debra Charlesworth & Associates

www.debracharlesworth.com

Sam Goldstein, Ph.D

www.samgoldstein.com

Offord Centre for Child Studies at McMaster University

www.knowledge.offordcentre.com

Bipolar Information

www.bpkids.org

BOOKS

A few suggested titles are included below. Many more are available at your local library.

When Something's Wrong	Canadian Psychiatric Research Foundation Order online for \$20.00 at www.cprf.ca
Driven From Distraction	Hallowell E.M., Ratey, John J. MP
A.D.D.ed Dimension You Mean I'm Not Lazy, Crazy or Stupid: For Adults	Kelly, Kate; Ramundo, Peggy Kelly, Kate; Ramundo, Peggy
A.D.D. and The College Student	Quinn, Patricia, M.D.
All About Attention Deficit Disorder Surviving Your Adolescents	Phelan, Thomas, Ph.D. Phelan, Thomas, Ph.D.
The Gift of AD/HD	Honos Webb, Laura Ph.D.
Solve Your Child's Sleep Problems	Ferber, Richard, M.D.
Why Johnny Can't Concentrate: Coping with Attention Deficit Problems	Moss, Robert A., M.D. with Huff-Dunlop, Helen
Lying and Deception in Everyday Life	Lewis, M; Saarni, C.
Teenagers with ADD, A Parent's Guide	Dendy, Chris A. Zeigler M.S.
The A.D.D. Book	Sears, W. M.D.; Thompson, L., PhD.
Stick Up For Yourself	Gershen, Kaufman, Ph.D.; Lev, Raphael
The Explosive Child	Greene, Ross, Ph.D.
With All Due Respect	Morrish, R. G.
Keys to Parenting Your Anxious Child	Manassis, K. M.D. FRCP (c)
The Myth of Laziness	Levine, Mel, M.D.
The Bipolar Child	Papoulos D., M.D. Papoulos J.

Books Recommended for Children and Youth

- child friendly
- can be used as a tool or workbook

Learning to Slow Down and Pay Attention

Kathleen G. Nadeau Ph.D.
Ellen B. Dixon Ph.D.

The Behavioural Survival Guide for Kids

Tom McIntyre Ph.D.

The Survival Guide for Kids with ADD or AD/HD

John F. Taylor Ph.D.

Putting on the Brakes

Quin. P., Stern, J.

HELPFUL VIDEOS

- | | |
|---|----------------------|
| 1) How Difficult Can This Be?
Beyond F.A.T. City | Richard Lavoie |
| 2) Learning Disabilities and Social Skills
Last One Picked...First One Picked On | Richard Lavoie |
| 3) When the Chips are Down | Richard Lavoie |
| 4) Misunderstood Minds
Understanding Kids Who Struggle to Learn | WGBH Boston Video |
| 5) 1-2-3 Magic | Thomas Phelan Ph.D. |
| 6) It's So Much Work To Be Your Friend | Lavoie, Richard |
| 7) Parenting the Explosive Child | Greene, Ross W. Ph.D |

Above videos available through the HOPE AD/HD Family Support Group and on the websites of the presenters.

WHAT IS AD/HD (ADD)?

The official definition of Attention Deficit Hyperactivity Disorder (AD/HD) as it appears in the Diagnostic and Statistical manual of the American Psychiatric Association is:

AD/HD is a disorder that can include a list of nine specific symptoms of inattention and nine symptoms of hyperactivity /impulsivity.

Individuals with AD/HD may know what to do but do not consistently do what they know because of their inability to efficiently stop and think prior to responding, regardless of the setting or task.

Characteristics of AD/HD have been demonstrated to arise in early childhood for most individuals. This disorder is marked by chronic behaviours lasting at least six months with an onset often before seven years of age. At this time, four subtypes of AD/HD have been defined. These include the following:

1. **AD/HD – Inattentive type** is defined by an individual experiencing at least six of the following characteristics:
 - a) Fails to give close attention to details or makes careless mistakes
 - b) Difficulty sustaining attention
 - c) Does not appear to listen
 - d) Struggles to follow through on instructions
 - e) Difficulty with organization
 - f) Avoids or dislikes tasks requiring sustained mental effort
 - g) Often loses things necessary for tasks
 - h) Easily distracted
 - i) Forgetful in daily activities
2. **AD/HD – hyperactive/impulsive type** is defined by an individual experiencing six of the following characteristics:
 - a) Fidgets with hands or feet or squirms in seat
 - b) Difficulty remaining seated
 - c) Runs about or climbs excessively (in adults may be limited to subjective feelings of restlessness)
 - d) Difficulty engaging in activities quietly
 - e) Acts as if driven by a motor
 - f) Talks excessively
 - g) Blurts out answers before questions have been completed
 - h) Difficulty waiting in turn taking situations
 - i) Interrupts or intrudes upon others

3. **AD/HD – combined type** is defined by an individual meeting both sets of attention and hyperactive/impulsive criteria.
4. **AD/HD – not otherwise specified** is defined by an individual who demonstrates some characteristics but an insufficient number of symptoms to reach a full diagnosis. These symptoms, however, disrupt every- day life.

The majority of adults with AD/HD have been described as experiencing symptoms very similar to the problems experienced by children. They are often restless, easily distracted, struggle to sustain attention, are impulsive and impatient. They have been described as experiencing problems with stress intolerance leading to greater expressed emotions. Within the workplace they may not achieve vocational positions or status commensurate with their co-workers or intellectual ability.

STATISTICS:

About 1% to 3% of the school-aged population has the full AD/HD syndrome, without symptoms of other disorders. Another 5% to 10% of the school-aged population have a partial AD/HD syndrome or one with other problems, such as anxiety and depression present.

CAUSES:

Experts have investigated genetic and environmental causes for AD/HD. Some children may inherit a biochemical condition, which influences the expression of AD/HD symptoms. Other children may acquire the condition due to abnormal fetal development, which has subtle effects on brain regions that control attention and movement.

HOW IS AD/HD DIAGNOSED?

While there is no biological or psychological test that makes a definitive diagnosis of AD/HD, a diagnosis can be made based on one's clinical history of abnormality and impairment.

An evaluation for AD/HD will often include assessment of intellectual, academic, social and emotional functioning. Medical examination is also important to rule out low occurring but possible causes of AD/HD like symptoms (e.g., adverse reaction to medications, thyroid problems, etc.). The diagnostic process must also include gathering data from teachers as well as other adults who may interact on a routine basis with the individual being evaluated.

It is even more important in the AD/HD adult diagnostic process to obtain a careful history of childhood, academic, behavioral and vocational problems. With the increased recognition that AD/HD is a disorder presenting throughout the life span, questionnaires and related diagnostic tools for the assessment of adult AD/HD have been standardized and are increasingly available.

AD/HD diagnoses are based on a person having three different symptoms. The full syndrome is diagnosed when at least nine symptoms from both sets of subtypes (above) are present. Partial syndromes, which are predominantly inattentive or hyperactivity/impulsivity subtypes, are diagnosed when six or more symptoms are present from just one set.

Treatment:

There are two modalities of treatment that specifically target symptoms of AD/HD. One uses medication and the other is a non-medical treatment with psychosocial interventions. The combination of these treatments is called multimodality treatment.

Treating AD/HD in children requires a coordinated effort between medical, mental health and education professionals in conjunction with parents. This combined set of treatments offered by a variety of individuals is referred to as multi-modal intervention. A multi-modal treatment program should include:

- Parent training concerning the nature of AD/HD as well as effective behaviour management strategies
- An appropriate educational program
- Individual and family counselling, when needed, to minimize the escalation of family problems.
- Medication when required.

Stimulant medications have been used to treat the cognitive and behavioral symptoms of AD/HD for more than 50 years. A study by Wilens and Biederman (1997) summarized the findings of controlled trials validating the use of these medications. Treatment with stimulants is beneficial in about 80% of children with AD/HD.

Behaviour modification techniques have been used to treat the behavioral symptoms of AD/HD for more than a quarter of a century. A summary of the literature on trials that have validated the efficacy of this approach shows that, in many cases, behaviour modification alone has not been sufficient to address severe symptoms of AD/HD.

Classroom success for children with AD/HD often requires a range of interventions. Most children with AD/HD can be taught in the regular classroom with either minor adjustments in the classroom setting, the addition of support personnel, and /or special education programs provided outside of the classroom. The most severely affected children with AD/HD often experience a number of occurring problems and require specialized classrooms.

Prognosis:

Children with AD/HD are at risk for school failure, emotional difficulties and significant, negative adult outcome in comparison to their peers. However, early identification and treatment has demonstrated that these children can overcome many of these hurdles and achieve success. The topic of AD/HD probably will continue to be one of the most widely researched and debated in mental health and child development.

The five-year multi-modal AD/HD treatment study underway by the NIMH will provide many answers to remaining questions regarding the diagnosis, treatment and outcome of individuals with AD/HD. Increasing awareness in the community of the nature and symptoms of AD/HD also offers encouraging signs of support and understanding for individuals with AD/HD and their families

Resources

Barkley, R.A. (1990)
Attention Deficit Hyperactivity Disorder: A Handbook for Diagnosis and Treatment.
New York, NY; Guilford Press

Barkley, R.A. (in press)
Attention Deficit Hyperactivity Disorder: A Handbook for Diagnosis and Treatment – 2nd edition.
New York, NY; Guilford Press

Barkley, R.A. (1997)
AD/HD and the Nature of Self-Control.
New York, NY; Guilford Press

DuPaul, G.J. & Stoner, G. (1994)
AD/HD in Schools: Assessment and Intervention Strategies.
New York, NY; Guilford Press

Adapted from the Learning Disabilities Association of Canada

AD/HD by Jake

Having AD/HD can be a real challenge. I know this because I have AD/HD. Everyday I face challenges that a lot of other kids do not, both at school and home. It sometimes feels like someone is always angry with you. One thing for sure, being a kid with AD/HD is not always EASY!

AD/HD stands for attention, deficit, hyperactive, disorder. Kids with AD/HD find it hard to stay still, pay attention and make good decisions. AD/HD affects everything in my life; it also affects the way I get along with adults and other kids. People do not always understand me, even when I don't think there is anything wrong.

The good thing is that you can try to control AD/HD. First you have to understand how it affects you, what I mean is how you do things and get along with others. I sometimes have trouble keeping my mouth and body still or to stop talking. Some people may say you are fidgeting or being hyper. It is hard for me to stay focused on things that are "boring". Noises around me can really bother me when I am trying to do my work. Any sound in class can bother me, like people talking in class or other classes having gym outside the portable. Kids with AD/HD also have a hard time stopping and thinking before they act. This always gets me in trouble; it is like there is an engine inside me that will not slow down.

Being a kid with AD/HD is not always easy; parents and teachers expect a lot from you. I feel that I have to work really, really hard to get things done and to do well. Sometimes people expect too much from me, making me feel angry and stressed. I then feel there is nothing that can make it better. So what I try to do is, everyday I try to make it a better day. AD/HD has many challenges but you can work on them and make them better. If you think "I will never do well in school, I can not focus on my work or pay attention to what the teacher is saying, or my parents and teachers are always mad at what I say or do," it is like they do not think that I am trying. But I have to remember everyday I am an important and good person. I am always learning new ways to pay attention, stay still and make good choices.

After me talking to you about AD/HD I am sure that you have learned a lot. If you see someone struggling, help them out and give them any advice on how to pay attention or anything else that may help them. AD/HD is going to be a long journey for me and I will have a ton of challenges but I have to remember to stay positive, believe in myself and always work to do better.

Always remember that AD/HD is not a bad thing!

Jake – Grade 5 student – Niagara Region 2007

Parenting Tips for AD/HD Children

- Appreciate your child as an individual with many strengths and talents.
- Educate yourself about AD/HD and the resources that are available.
- Realize that you must be an advocate for your child with the medical profession, the education system as well as family and friends.
- Hug first, ask questions later.
- AD/HD children are psychologically immature. Parent as if your child is 3 years younger. For example: They may be 15 years old but act like a 12 year old.
- You will need to help your child with organization skills.
- Post house rules in a positive language.
- Provide consistent routines every day.
- These children want consistent authority at the top. If both parents do not agree, one person should make the decision while the other keeps his mouth shut.
- Find an enjoyable activity to engage in at least a couple of times a week.
- Encourage outside physical activity to use up extra energy.
- Encourage involvement in activities that are a particular interest e.g. music, art, sports, computers.
- Plan transition from one activity to another. Example “In five minutes, we will eat supper”.
- Provide choices if possible.
- Avoid situations that you know will cause difficulty for your child.
- Avoid multiple requests. Keep instructions simple.
- Bargain with your child “If you want it, I want to give it to you. What are you going to do for it?”
- Choose battles carefully.
- Talk openly about consequences of drugs, alcohol and sex.
- Provide ongoing social skills training. AD/HD children have trouble making friends.

- Work with school to avoid homework battles.
- Use tutor if necessary.
- AD/HD children haven't learned to apply the word "No" to themselves. Direct your child to do what you want them to do. Eliminate using the words "STOP", "DON'T" and "NO" except for dangerous and socially inappropriate behaviour.
- Use ignoring to decrease behaviour.
- The ability of an AD/HD child to push your button is greater than another child. A parent may fuel a child's behaviour if you do not turn off your button.
- Try to speak in a calm quiet voice.
- Make eye contact to obtain his attention.
- Ask yourself "Why am I arguing with a child?"
- Take a Parental Time Out.
- Catch your child being good.
- Remember a child with AD/HD needs more frequent predictable and consistent rewards. Both praise and tangible rewards should be provided regularly. Allow a child to earn 3 to 5 times the amount of rewards for good behavior verses what is lost for bad behaviour. For example: A child may earn 5 chips for doing something right and lose 1 chip for doing something wrong.
- Consequences must be provided quickly and consistently.
- Take care of yourself. Understand the impact an AD/HD child has on your whole family. Try to deal with problems in a positive way rather than a frustrated angry way.

REMEMBER YOU HAVE A GREAT CHILD !

How to Improve Peer Relationships in AD/HD Children

Peer relationship difficulties are common in AD/HD children. These deficits severely impact every aspect of their lives and must be addressed early. The following is an outline for training of core social skills.

I. Communication

A) What does communication mean?

1. Talking to others about interesting things.
2. Listening to others.
3. Making eye contact when listening and talking.
4. Expressing the way you feel.
5. Asking questions (open-ended information seeking).
6. Giving information about yourself (hobbies, interests, family).
7. Greeting or saying hello to others.

B) Positive examples:

1. Talking about things that are interesting to the other person, things you both know about (e.g. TV, school, sports, mutual friends).
2. Asking questions to start a conversation (e.g., "Where do you live?, go to school?, Who's your teacher?, What's your favourite TV show?").
3. Talking about things while you're playing a game (e.g., "Do you like this game?, What's the score?").
4. Looking at another person when he or she is talking.
5. Answering questions or complying with requests to show you are listening.

C) Negative examples:

1. Doing something else while someone is talking to you.
2. Ignoring the person who is talking.
3. Interrupting another person.
4. Always talking, not giving the other person a turn.
5. Always changing the topic of conversation.

D) Why is communication important?

1. If you talk to others and show them you are listening, they will like you and want to be your friend.

II. Cooperation

A) What does cooperation mean?

1. Sharing, taking turns.
2. Following rules, not cheating.
3. Not getting mad if there's a problem, working things out, compromising if there's a problem.
4. Being a good sport, whether you win or lose.
5. Deciding fairly who goes first.

B) Positive examples:

1. If someone isn't taking turns, saying things like "I think you forgot it was my turn," or "We're supposed to take turns. Let's do that one over."
2. If you lose a game, saying "It was still fun," "You're a good player."
3. Playing by the rules.
4. Inviting someone to join you in a game.
5. Handling mistakes and frustration appropriately: e.g., "Oh, it's okay to make a mistake," "Nobody's perfect," "This must take a lot of practice," "It's still fun."

C) Negative examples:

1. Yelling, hitting, grabbing to solve a problem.
2. Not letting someone play with you or share your toys.
3. Quitting if someone won't share.
4. If you lose a game, saying "you cheated."
5. Being a bad sport if you strike out at baseball or kickball.

D) Why is cooperation important?

1. Games are fun and work well only when everyone cooperates.
2. People like you if you share and take turns.

III. Validation

A) What does validation mean?

1. Being supportive.
2. Offering help.
3. Being friendly-smiling and laughing.
4. Being nice-complimenting other people.
5. Being fun.
6. Saying please and thank-you -- having good manners.

B) Positive examples:

1. Telling someone they're doing a good job.
2. Helping someone clean up.
3. Smiling at someone, laughing at a joke someone tells.
4. Complimenting someone "Good kick", "I like playing with you", "You're nice."
5. If you win, making the other person feel better -- "Boy, that was close!" "You tried hard."
6. Showing another child how to play a game.

C) Negative examples:

1. Teasing, name-calling, making faces.
2. Complaining, frowning, crying.
3. When you win, making fun of the loser.

D) Why is validation important?

1. If you're nice and helpful, it makes people feel good and they'll like being around you.

IV. Participation

A) What does participation mean?

1. Getting involved.
2. Initiating or joining a game (asking nicely to join, not interrupting).
3. Being interested in the activity.
4. Not quitting.
5. Paying attention to the game.

B) Positive examples:

1. Let's pretend you want to play with someone. What are some ways of getting started?
 - a) Initiate the game, "I'd like to play with you. Would you like to play with me?"
 - b) Decide on the game, "What would you like to play? How about the Pac Man game?"
 - c) Decide on the rules, "What are the rules? How do you win? What happens if you break a rule?"
 - d) Start the game, "Who goes first? Would you like to go first?"

2. When other people are already playing, and you want to join them, how do you do that?
 - a) Don't butt in.
 - b) Stand on the side of the group and watch them play for a while to see what the rules are.
 - c) After a while, ask nicely if you can join in.
 - d) If they say "no," tell them you'll wait a while to see if someone quits and they need an extra.
3. Stick to a game even if you are not winning.
4. Pay attention so you don't miss your turn and people don't have to wait for you to play the game.

C) Negative examples:

1. Wandering off in the middle of a game.
2. Interrupting rather than asking nicely to join a game.
3. Standing alone and refusing to play.
4. Not paying attention.
5. Forgetting the rules of the game.

D) Why is participation important?

1. To make other kids feel included so they'll want to play with you.
2. People will enjoy playing with you if you are interested and involved.

Pelham, W. E., Greiner, A.R. & Gnagy, E.M. (1997). Children's summer treatment program manual. Buffalo, NY: Comprehensive Treatment for Attention Deficit Disorders. (adapted from Oden & Asher, 1977). Available for purchase at summertreatmentprogram.com.

IDEAS FOR HOME INTERVENTION

Here are a variety of generic suggestions to assist AD/HD children adjust successfully at home.

1. Set up specific time periods for waking, bedtime, chores, homework, playtime, TV time, dinner, etc. Changes in schedule are disturbing to AD/HD children, so be as consistent as possible. Explain any changes in routine ahead of time so that the child understands and can anticipate the changes.
2. Set up clear and concise rules of behaviour for the family, including the AD/HD child. Rules, as well as consequences for breaking them, and rewards for appropriate behaviour can be written down and posted in a prominent place. Consistency is the key here. If a rule is broken, consequences should follow every time. If the child behaves appropriately, reward him often! Be firm on setting limits, but give plenty of love and affection too.
3. Give instructions as simply and clearly as possible, demonstrating if necessary. Ask your child to repeat them back to you, then praise him when he responds correctly. Do not give more than one or two instructions at one time. If a task is difficult, break it into smaller parts and teach each part separately.
4. Provide her with her own “special” quiet spot without distraction in which to do academic work or quiet work. Face the desk toward a blank wall, minimize clutter, avoid bright, distracting colours or patterns in decor. Remember that the child may have difficulty filtering out unnecessary stimulation.
5. Try to keep your child’s stimulation level as low as possible. Have him play with one child at a time, involve him in one activity at a time, remove needless background noise such as radio or TV, put unused toys, games, etc., out of sight.
6. Repeated messages, directions, requests, etc., are inefficient disciplinary techniques and create a variety of unpleasant behaviours in the family. To stop this ineffective process, try the following: say what you need to say, but say it once – briefly- clearly-completely-firmly-calmly. Follow through with a logical consequence or restructuring technique. **ACT – DON’T YAK!!!**
7. Provide supervision by being physically near the child.
8. Allow the child choices within the limits you have set. (Help him develop his initiative and self-control and give a sense of personal influence.)

9. Help your child find avenues of self-expression that will help him express his wants in acceptable, useful manner. Children sometimes use misbehaviour to communicate. Teach appropriate verbal communication skills. Ask yourself “what does my child want to have happen as a result of this behaviour?” and help him search for other ways to gain it.

10. Use a timer with small chores to help give your child a sense of passing time.

11. The AD/HD child’s behaviour can often be very irritating. However, should you become excessively angry (anger is normal, but can be controlled) your effectiveness with your child will be greatly reduced. Strive to keep your voice quiet and slow when managing your AD/HD child.

12. Separate behaviour which you may not like from the child’s person which you like (e.g. “I like you. I don’t like you to track mud through the house”).

13. Above all else, the AD/HD child needs compassionate understanding. His parents and teachers should not pity, tease, be frightened by, or overindulge this child. They must understand that the condition is real; it involves essential deficits; that they did not cause the condition; and much can be done to help the AD/HD child at home and at school.

Author Unknown

Achieving Success in School

A key component in helping a student with AD/HD or ADD is the co-operation between home and school. Keep these tips in mind when working together.

- Prepare to work together as a team.
- Try to stay calm and support each other.
- Realize that these children may have a great deal of potential. They can be very successful if helped to minimize the disruptive behaviour and develop their strengths.
- Meet frequently to discuss progress (every 2 weeks).
- Share useful resources.
- Together examine the strategies that work for the student.
- Share pertinent observations and information from physicians.
- Agree together on consequences. These students need recess and class outings more than regular students.
- Don't ignore the importance of friends and a social life for the student.
- Key in on student's special talents (art, music, etc.) and interests to enhance the school experience.
- Decide how the medication is to be handled taking into account the feelings of the student.
- Encourage mom and dad to bring a support person to school meetings.
- Work to keep the school meeting as productive and non threatening as possible.
- Include the student in decision making process as much as possible.
- Celebrate the progress but realize there will be set backs and frustration.
- Laugh together and take pride in the good things that you are making happen for this child.

**AT THE END OF EACH MEETING SET THE TIME AND DATE
OF THE NEXT MEETING.**

MAKING THE CLASSROOM FIT THE CHILD

The rules and procedures of a mainstream classroom can be very difficult for the child with attention deficit/hyperactivity disorder (AD/HD). To help these children succeed and learn; educators have developed a number of classroom modifications. Here are some of the adaptations that parents can expect – or insist on.

Memory and attention

- Seat the child close to the teacher
- Keep oral instructions brief, and give them more than once.
- Provide written directions (state when a report is due, for example, or outline the steps in a math problem).
- Walk the child through assignments to make sure the task is understood.
- Break up tasks and homework into small steps.
- Use visual aids
- Teach active reading (underlining), active listening (note-taking), and reading for detail.
- Provide remedial help in short sessions.
- Teach subvocalization (whispering) as an aid in memorizing lists (spelling words, for instance).

Impulse control

- Remind the child to slow down, especially in multiple choice tests.
- Teach the child to monitor the quality of work before turning it in.

Classroom atmosphere

- Provide a structured classroom in which expectations for when and how tasks are to be done are clear and known in advance.
- Impose moderate but consistent discipline, with consequences for unacceptable behaviour clearly stated.
- Rely on positive reinforcement of good behaviour rather than negative sanctions.

Organizational skills

- Establish a daily checklist of tasks.
- List homework assignments in a special notebook, with due date and the necessary resources. (library books or art supplies, for example).
- Follow up on homework assignments that are not turned in.

Productivity problems

- Divide work sheets into sections.
- Reduce the amount of homework and written class-work assigned.
- Cut down on the number of math problems that must be completed, especially if the child knows how to do them accurately.

Written expression

- Give the student extra time to complete written tests and assignments
- Provide special help with handwriting
- Allow the child to dictate reports, take tests orally.
- Reduce the quantity of written work the child is expected to produce.
- Don't mark down written work for untidiness, spelling errors, or poor handwriting.

Self-esteem

- Reward progress, even if actual achievement does not meet standard requirements.
- Encourage performance in the child's area of strength (artwork, music, athletics, or drama, for instance)
- Avoid humiliation. The child shouldn't be asked to perform difficult tasks (writing on the blackboard, for example) in front of others or have papers graded by other students.
- Give hand signals only the child can see, as private reminders of appropriate behaviour.

Social relationships

- Provide feedback about behaviour in situations involving other children.
- Make sure classmates don't feel the child with AD/HD is getting away with less work or worse behaviour by making modifications available to all the children if necessary.

Adapted from Patient Care Canada, Vol. 7 NO.7/July-August 1996

AD/HD AND LEARNING DIFFICULTIES

Although often very bright, children with AD/HD are at risk for difficulties in learning or not achieving to their potential given their underlying difficulties in regulating their attention, initiating and following through on tasks, and planning and organization. Children with AD/HD may also have additional learning/processing (e.g., memory, language, visual-motor skills) deficits that impact their performance within the classroom and represent a learning disability. Children with AD/HD are also at greater risk for difficulties regulating their emotions and problems with anxiety, depression, and/or self-esteem can impact their development and functioning within the classroom. A psychological assessment is essential in diagnosing AD/HD and any additional learning or emotional concerns.

PSYCHOEDUCATIONAL/PSYCHOLOGICAL ASSESSMENT

Definition: A psychological assessment is a comprehensive evaluation of a child's learning, academic, and emotional functioning. It identifies the child's strengths and areas of need, providing important information to parents and teachers about how best to teach the child and how to provide accommodations to ensure that the child continues to develop to meet their full potential.

Who should have a psychoeducational/psychological assessment: Any child who has difficulties in school with achievement, behaviour, and/or attention. This would include any children who have been identified with AD/HD, speech and language difficulties and/or emotional problems (e.g., aggressive behaviour, anxiety, depression), or who exhibit any developmentally inappropriate behaviours, such as unusual fears, preoccupations, or ritualized behaviours. Psychological testing is also completed with children who are thought to be gifted learners.

Signs to look for (maybe in one or more areas):

- Poor academic performance in one or all areas (reading, comprehension, writing, mathematics)
- Difficulties with organization, memory, or attention/distractibility
- Children who do not appear to be reaching their potential
- Doesn't learn information the way others do – slow to pick up new concepts, requires repetition or needs extra assistance
- Academic excellence (gifted students)
- Poor social skills – has difficulty making or keeping friends, aggressive with peers or adults, difficulty following rules
- Has extreme temper or anger outbursts
- Shows signs of sadness, is unusually tearful or becomes withdrawn
- School avoidance (often sick, somatic complaints common, refusal to go to school)
- Is not mastering the typical tasks for his/her developmental stage (e.g., separation from parents)
- Has experienced a significant stressor (e.g., parental divorce, death of a family member, bullying)

What is involved in a Psychoeducational/Psychological Assessment? A complete assessment includes the following:

- Parent Interview to obtain relevant background information (e.g., developmental history, academic performance), review reports, and understand the nature of the concerns (1-1 ½ hours)
- Testing with the child to evaluate learning, academic, and social-emotional issues if warranted (5-10 hours)
- Interviews with teacher, school staff, review of report cards and any relevant reports from other professionals involved with the child
- Feedback with the parents (and child where indicated) to review assessment findings (1-1 ½ hours)
- Report – written review of assessment findings and recommendations to utilize areas of strength and remediate areas of need.

Where can you obtain a psychoeducational/psychological assessment? An assessment can be completed by the child's school or by a private registered psychologist or psychological associate. Private assessments are not covered under OHIP but all or part of the assessment may be covered by most extended health care plans.

For more information, please feel free to contact:

Dr. Michelle Bell
Registered Psychologist
P.O. Box 381, Beamsville, ON
(905) 563-9900

**This could be a silent message from *your* child to you about their profound feelings of
ISOLATION, ANXIETY and DEPRESSION.**

PLEASE HEAR THEM. YOU MAKE THE DIFFERENCE.

**By Debra Charlesworth
DEBRA CHARLESWORTH & ASSOCIATES**

...no one knows what it is like to be me; no one wants to know. I do not know how to be who you want me to be. Why can't I be me? When no one listens to me; I feel that I do not exist. I am not one of you; I do not fit. I do not belong. I am alone. I do not know how to regulate myself; I do not know how to change myself. Why do I have to change? What is *wrong* with me? I do not know the words to say... "I am afraid; I am sad...I feel bad".

The diagnosis of AD/HD conveys a significant risk for other coexisting psychiatric disorders. Up to 44% of AD/HD children may have at least one other psychiatric disorder, 32% have two others, and 11% have at least three other disorders (Szatmari, Offord, & Boyle, 1989a).

Phobic Behaviour, Panic Disorder, Generalized Anxiety Disorder, Separation Anxiety, Social Anxiety, and Depression are co morbid conditions I see most often in my office...and, they are usually...a "family affair".

The centrality of AD/HD symptomatology within the family system causes profound circular effects that could either exacerbate preexisting conditions of anxiety and depression (and/or others) or contribute to causative factors of these co morbid conditions for child and family members alike. Knowing how to identify, accept, understand and manage AD/HD, the effects and the co morbid conditions is a huge undertaking and crucial to family health and well being – peace and joy...and hope.

Treating the multifaceted challenges of this "family affair" is to say the least, very complex. But what can you do to make things better *right now*? **RECOGNIZE THE SIGNS of anxiety and depression.** A *must have* reference book to help in early identification of co morbid conditions is, *When Something's Wrong, Ideas for Families*, published by the Canadian Psychiatric Research Foundation, www.cprf.ca and **SEE YOUR DOCTOR.** Also - a small but mighty gem from me to help you in your work towards peace and joy...and hope...

Refrain from using these "angry, blaming" phrases:

How many times do I have to *tell* you? Why can't you be more like ____? I *told* you so! Why don't you *think*? Why do you *do* that? Why do you have to *be* this way? You ruin *everything*. You *know* better. I expect *better*. Act your age. Get out of my *face*. You don't *listen*. You are *lazy*. You didn't even *start*. You don't finish *anything*. You're going to have to learn *sometime*. You should *know* this stuff...Cursing, swearing and yelling further drive these "stakes" through the heart.

Like drops of water on a stone, these phrases can inadvertently contribute to feelings of anxiety and depression from a very early age. They are cutting and enduring and can cause emotional wounds that bleed long into adult life. Self medication – drugs and alcohol is a common antidote to pain in teens and adults. "Workaholism" is another major escape behaviour. Trouble with law is a reality. Suicide is an ultimate and terrible price.

Your kid needs you and your support – *more* than the average bear. No matter how exasperatingly maddening your child is being – hold yourself together and find something - anything - *positive* to say. Start with just one thing in the A.M. and one in the P.M. Be sincere. Make it short. Make it count.

Try these:

Physical contact – go slowly – a hug may be too much. Close your mouth and open your ears – listen. Honesty and openness – dare to be *wrong* and *human*. Humour – that suits *your child*. Say - It's OK, we can start over. We can try this again together. Hey, you remembered. I like that. You're right. I love you. I'm glad that you are my kid. I'm sorry that it's so hard for you. Let's get some help.

Look deep into your soul and ask when the last time is that you gave an *unconditional* smile to your child – spontaneously and straight from the heart? Do it now. Do it again later on. Do it more. Your child *will* feel the difference. Your *family* will feel the difference. So will *you*.

The following was written by one of my young clients. She is 15.

WHAT IT'S LIKE TO BE ME

Breathe in breathe out breathe in breathe out
You have No idea how much energy this takes
Chairs scraping, lights bright, music blaring, people talking all at once chaos magnified a thousand times to my ears
Someone is talking to me but I'm a thousand miles gone
Y=12x=11...WHAT??? Wait what is this supposed to mean??? Blinking back for a second, but then it's too late I'm gone
Bells ring chairs scrape people shove through the halls mass commotion
I feel dizzy
Why are they all in such a rush? To get where?
Where am I going and why am I going there?
I try to explain myself but THEY have no idea
Words can't explain how I feel
I speak a language I'm the only one in the world who understands
I'm yelling for help but no one can hear me
Breathe in Breathe out u can only imagine
I'm walking in a dream-or is it a dream that I'm walking in?
I'm not really here
Your faces don't make sense to me because I'm an alien living in a human's world
HOW FRUSTRATING
You can only imagine what it's like to be me
Maybe one day you will wake up and feel what it's like to be me
But for now I'm just sleeping
Because really I'm just living in a dream.

I work day and night for kids like this. Everything counts, especially them. So do you.

Remember – Peace and Joy...and Hope. I'll be thinking of you.

Deb Charlesworth

Debra Charlesworth & Associates
Family Behavioural Coaching and Counselling
Ph: 905 892-8543
Nov 05

This list represents the minimum a young person needs to be successful. Check off the items that are already in place and try to implement as many of the remaining items as possible.

Adolescents with AD/HD

1 strength

1 friend

1 adult who likes – supports – appreciates- believes in him/her

School

- 1 adult contact – good sense of humour!
- Communication between teachers
- Choice of teachers (tolerant, strict) whenever possible
- Resource support re: organizational skills and skill gaps

Home

- Contracts – respect for each other's rights
- Trust within limits
- Structure
- Reasonable consequences – with understanding
- Counselling with knowledgeable person
- Mediation within family
- Building understanding with siblings
- Social – “club”
“sports”
- suitable job placement
- Need to be own unique person – not forced to conform
- Confidentiality and involvement with medical management

Adapted from material presented by: Dr. Wendy Roberts, Toronto Sick Children's Hospital

Principles for Parenting Adolescents with AD/HD

- Gradually shape appropriate independence-seeking behaviour. For example, give the adolescent a half-hour extension on curfew. If the adolescent comes home on time for a month, then extend the curfew another half-hour. Eventually, over several years, the curfew might gradually become several hours later, based upon responsible behaviour.
- Maintain adequate structure and supervision longer than you think you should. For example, continue to monitor homework through all of high school, even though this may not be necessary for non-AD/HD adolescents.
- Establish “bottom line” rules for living in your home and enforce them consistently (e.g. no drugs, alcohol, violence, treat people with respect).
- Involve adolescents in decision-making regarding all other issues which are not “bottom lines” through mutual problem-solving and negotiation.
- Use consequences wisely ... Use incentives before punishments. For example, many parents issue “grounding for life”. Not only is this excessive, it is impossible to enforce. Grounding the adolescent for several nights is equally effective. It is important to build in the opportunity to earn positive privileges for appropriate behaviour.
- Maintain good communication. Listen to your teenager when he or she wants to talk, and guard against bad habits of your own (put downs, lectures, etc.). Try to practice positive alternative communication behaviours.
- Focus on the positive by being your adolescent’s cheerleading squad, and helping your adolescent build on his/her strengths.
- Keep a disability perspective, practice forgiveness, and don’t personalize your adolescent’s problems.
- Develop reasonable expectations. Don’t expect perfection in chores and homework, but do expect responsible behaviour and genuine effort. Don’t predict disaster when you give more freedom, but do expect poor judgement at times.

Adapted from Adolescent Health Update, American Academy of Pediatrics, July 1998

Attention Deficit Hyperactivity Disorder

Management of Medication

at Home and School

Drug treatment is only part of a comprehensive program. Child and parental support and behaviour management also provides a very significant part of the treatment. Scientific studies show stimulants do not promote substance abuse and are non addicting if taken as prescribed. Medication is prescribed for improvement in symptoms in the home, school and other settings.

Positive Changes to Expect

- Often dramatic improvement in the ability to attend, decreased impulsivity and activity.
- Increases in child's ability to reason, focus and stay on task.
- Better social interaction with friends and family.
- Less negative and aggressive behaviour.
- Better self-esteem.
- Better school performance.

Initial Medication Treatment

Parents...

- Learn as much as possible about AD/HD, other overlapping conditions and why medication was chosen as a treatment.
- Learn about the specific medication e.g. dosage, possible outcomes and side effects from the physician and pharmacist.
- Consult your physician for follow up after the medication has started.
- Include your child in discussion of diagnosis and treatment when possible.

Resource – “Putting on the Brakes”, Quinn, P., Stern, J.

Safe Management of Medication at Home

Parents....

- Store medication in a secure, childproof location.
- An adult should give the correct dosage at the appropriate time.
- Monitor your child to be sure he/she takes the medication.
- Observe effects of medication on your child.
- Concerns should be reported to your physician.
- For older children, monitor carefully the number of pills and the number of pills remaining to prevent abuse.
- Teenagers may also need supervision to make sure the medication has been taken.

Medication at School

Parents...

- Learn about the school policy for dispensing medication i.e. Forms to be filled out, storage and routine for dispensing.
- Assess how your child feels about taking medication at school.
- Inform your child's teacher and principal about the medication and any future changes in drug treatment.
- Share observations of school personnel with your physician.
- Medication may be necessary during weekends and during summer holidays, but withdrawal may be suggested by your physician.
- An adult should take the medication to the school – never send it with the child.
- The school should not send outdated medication home with the child.
- The local pharmacy will dispose of the medication safely.
- The pharmacist, on request, may provide an extra-labelled container for use at school.

Common Side Effect – Appetite Suppression

- Depending on the type of medication prescribed, appetite is least at lunch and supper.
- Appetite rebounds at 8-9 p.m.
- Allow your child to eat a nutritious high calorie meal or snack.
- Height and weight should be monitored on a regular basis.

Adjusting the Dosage

- The parent and physician will work together to find the correct dosage.
- Medication can be adjusted to accommodate the child's schedule.
- The drug or the dosage may be adjusted to deal with sleep disturbance, irritability and hyperactivity when the medication wears off or adverse reactions occur.
- Follow up may be done every two weeks to a month initially, then less frequently as the situation stabilizes.
- After six months to a year, medication may need to be reviewed or changed.

Medication used in conjunction with good behavioral techniques at home and school will maximize your child's learning. All problems will not necessarily disappear and children will continue to experience "bad days" regardless of dosage or drug. Clear communication lines between home, school and physician will ensure the most effective treatment for your child.

SUGGESTED DIAGNOSTIC CRITERIA FOR ATTENTION DEFICIT DISORDER IN ADULTS

BY: Edward M. Hallowell, MD and John J. Ratey, MD

Note: These criteria are based on extensive clinical experience but have not yet been statistically validated by field trials. Consider a criterion met only if the behaviour is considerably more frequent than that of most people of the same mental age.

A. A chronic disturbance in which at least twelve of the following are present:

1. A sense of underachievement, of not meeting one's goals (regardless of how much one has accomplished).

We put this symptom first because it is most common reason an adult seeks help. "I just can't get my act together," is the frequent refrain. The person may be highly accomplished by objective standards, or may be floundering, stuck with a sense of being lost in a maze, unable to capitalize on innate potential.

2. Difficulty getting organized

A major problem for most adults with ADD. Without the structure for school, without parents around to get things organized for him or her, the adult may stagger under the organizational demands of every day life. The supposed "little things" may mount up to create huge obstacles. For the want of a proverbial nail—a missed appointment, a lost check, a forgotten deadline- their kingdom may be lost.

3. Chronic procrastination or trouble getting started

Adults with ADD associate so much anxiety with beginning a task, due to their fears that they won't do it right, that they put it off, and off, which, of course, only adds to the anxiety around the task.

4. Many projects going simultaneously; trouble with follow-through

A corollary of #3. As one task is put off, another is taken up. By the end of the day, or week, or year, countless projects have been undertaken, while few have found completion.

5. Tendency to say what comes to mind without necessarily considering the timing or appropriateness of the remark

Like the child with ADD in the classroom, the adult with ADD gets carried away in enthusiasm. An idea comes and it must be spoken, tact or guile yielding to child-like exuberance.

6. An ongoing search for high stimulation

The adult with ADD is always on the lookout for something novel, something in the outside world that can catch up with the whirlwind that's rushing inside.

7. A tendency to be easily bored

A corollary of #6. Boredom surrounds the adult with ADD like a sinkhole, ever ready to drain off energy and leave the individual hungry for more stimulation. This can easily be misinterpreted as a lack of interest; actually it is a relative inability to sustain interest over time. As much as the person cares, his battery pack runs low quickly.

8. Easy distractibility, trouble focusing attention, tendency to tune out or drift away in the middle of a page or a conversation, often coupled with an ability to hyperfocus at times.

The hallmark symptom of ADD. The "tuning out" is quite involuntary. It happens when the person isn't looking, so to speak, and the next thing you know, he or she isn't there. The often extraordinary ability to hyperfocus is also usually present, emphasizing the fact that this is a syndrome not of attention deficit but of attention inconsistency.

9. Often creative, intuitive, highly intelligent

Not a symptom, but a trait deserving of mention. Adults with ADD often have unusually creative minds. In the midst of their disorganization and distractibility, they show flashes of brilliance. Capturing this “special something” is one of the goals of treatment.

10. Trouble going through established channels, following proper procedure

Contrary to what one might think, this is not due to some unresolved problem with authority figures. Rather it is a manifestation of boredom and frustration: boredom with routine ways of doing things and excitement around novel approaches, and frustration with being unable to do things the way they’re supposed to be done.

11. Impatient; low tolerance for frustration

Frustration of any sort reminds the adult with ADD of all the failures in the past. “Oh no.” he thinks, “here we go again.” So he gets angry or withdraws. The impatience has to do with the need for stimulation and can lead others to think of the individual as immature or insatiable.

12. Impulsive, either verbally or in action, as in impulsive spending money, changing plans, enacting new schemes or career plans, and the like

This is one of the more dangerous of the adult symptoms, or, depending on the impulse, one of the more advantageous.

13. Tendency to worry needlessly, endlessly; tendency to scan the horizon looking for something to worry about alternating with inattention to or disregard for actual dangers.

Worry becomes what attention turns into when it isn’t focused on some task.

14. Sense of impending doom, insecurity, alternating with high-risk taking

This symptom is related to both the tendency to worry needlessly and the tendency to be impulsive.

15. Mood swings, depression, especially when disengaged from a person or a project

Adults with ADD, more than children, are given to unstable moods. Much of this is due to their experience of frustration and/or failure, while some of it is due to the biology of the disorder.

16. Restlessness

One usually does not see, in an adult, the full-blown hyperactivity one may see in a child. Instead one sees what looks like “nervous energy”: pacing, drumming of fingers, shifting position while sitting, leaving a table or room frequently, feeling edgy while at rest.

17. Tendency toward addictive behaviour

The addiction may be to a substance such as alcohol or cocaine, or to an activity, such as gambling, or shopping, or eating, or overwork.

18. Chronic problems with self-esteem

These are the direct and unhappy result of years of conditioning: years of being told one is a klutz, a spaceshot, an underachiever, lazy, weird, different, out of it, and the like. Years of frustration, failure, or of just not getting it right do lead to problems with self-esteem. What is impressive is how resilient most adults are, despite all the setbacks.

19. Inaccurate self-observation

People with ADD are poor self-observers. They do not accurately gauge the impact they have on other people. This can often lead to big misunderstandings and deeply hurt feelings.

20. Family history of ADD or manic-depressive illness or depression or substance abuse or other disorders of impulse control or mood.

Since ADD is genetically transmitted and related to the other considerations mentioned. It is not uncommon (but not necessary) to find such a family history.

Computer Solutions for Kids With Attention Problems

Computers can be wonderful resources for: children with short attention spans, students who make numerous careless errors in written work and young people with organizational difficulties.

In recent years the consumer market has been deluged with products that promise to provide your child with stimulating and productive learning experiences. Some of them keep that promise and others do not. Almost all the products are fun for kids. A few provide the well-researched learning support that children need. Fewer still are designed to develop specific skills. How do parents avoid wasting money on programs that are unsuitable for the needs of their child? How can parents find quality software products that develop competence in the specific areas needed?

Educational Software for the Inattentive or Distractible Child

The colourful animated graphics of children's software captures and holds the attention of even the most distractible child. Children who can't sit still long enough to finish their dinner will remain seated for extended periods of time to play a computer game. These distractible kids are often slow to develop early literacy skills and continue to use their fingers to perform math calculations. The many repetitions needed to memorize sight reading words and math facts simply requires more sustained focus than their distractible minds can manage. Software programs that provide many repetitions but which vary the activity and provide lots of stimulating visual and auditory rewards are ideal for such children.

Because these programs are not intended for the mass market but designed to meet the needs of a specific group of learners, they tend to be more expensive than the children's programs available through department stores and big box outlets. The somewhat greater price you will pay, however, is balance by the money you will save by not buying a handful of cheaper programs that don't address the learning needs of your child.

There are many fine programs available and we certainly haven't tried them all. Here are three that we use all the time with young children and have found to be excellent.

- Essential Skills Software, a Canadian company, has developed a series of programs that are well researched, suitably stimulating and relatively reasonably priced (approx \$100). The two programs that practice recognition of non- phonetic reading words are Sight Words and Sight Words 2.
- There are a number of programs that drill math facts. The program we have found to be the most fun and effective is Turbo Math from Nordic Software at a cost of about \$35. The program allows the child to choose an addition, subtraction, multiplication or division mode and rewards speed and accuracy in recalling answers. Once a level of success has been achieved the child is rewarded with the opportunity to play a video game. Suitable for students from Grade 3 and beyond.

Word Processing Software for Students Who Makes Careless Errors

Students with attention problems aren't good at noticing when they make careless errors and they are often reluctant to stay with a task long enough to proofread their written work. Word processing software has proven to be a huge benefit to them. Virtually all newer computers have automatic spelling and grammar check features that indicate, with a visual cue, when an error has been made, prompting the writer to go to the tool bar for further information. This kind of support makes computer use a must for older students (Grades 7 and beyond) and an option worth considering for younger ones.

Using a computer to complete school work at home can be managed with a desktop computer that is shared by the whole family. Students who need support throughout the school day may benefit from having a laptop computer that they take to and from school.

If your child has been formally identified by your school board or independent school as “exceptional”, he or she may be permitted to use a computer to write exams. In this case the school will provide the computer and a separate room for writing the test. Most schools also have a learning resource room equipped with a computer. Your child might be permitted to complete written work there during or after school hours. Approach your school resource staff member and ask for their help in deciding and arranging for appropriate computer supports.

Software for the Disorganized Writer

Impulsive children often approach writing in a haphazard manner. Imaginative thoughts and creative ideas may be poorly communicated if the structure of the written work is weak. Planning the project before starting to write is one characteristic of an organized writing process. For the disorganized student, there are programs that use diagrams to arrange facts and ideas and then, with a click of the mouse, transform the diagram into a written outline for a story or article. Other programs will help the student to access outside sources of information for research purposes. These programs take the student through the steps of : idea brainstorming, creating and sequencing an outline, expanding on the outline to create a first draft and editing and revising to produce the finished product. The process is made enjoyable by providing pictures to represent ideas...great support for the visual learner.

Some good products of this type include:

- Kidspiration (Kindergarten - Grade 5) and Inspiration (Grade 6 –adult) from Inspiration Software Inc. The cost is about \$80. This product is available to all public and Catholic schools in Ontario through a province-wide site license purchase by the Ontario Ministry of Education. A 30 day free trial may be downloaded from the corporate website for home use. www.inspiration.com
- Draft Building has many of the features offered by the Inspiration software but adds support for gathering research data. The program comes from Don Johnston Inc at a cost of about \$280.

Article by: Gail McAdam, Learning Specialist

Gail operates the Learning Associates, a private education service specializing in students with unique learning needs. Services include:

- assessment, program planning and tutoring for students with attention and other learning problems
- consultation with school boards and independent schools
- teacher and parent workshops

Phone: 905-641-4710

Email: learning@vaxxine.com

CARING

Thank-you for your concern. Here are some ideas that parents put together to be helpful.

Helpful Hints

- Learn about the challenges faced by my child and my family
- Respect me as a knowledgeable parent
- Ask me to share information about my child
- Open mindedness is appreciated
- It is helpful to have someone to talk to
- Provide support by attending an educational or medical meeting with me
- Invite my child to social events to play with friends

FOR CAREGIVERS – YOU CAN MAKE A DIFFERENCE

- Stay calm
- Provide relief and respite care for short periods of time
- Follow through on medication or diet that the family is following at home
- Encourage and build up my child's strengths and gifts
- Understand that my child likes to be helpful
- Plan ahead to help my child succeed in different situations
- Take the time to be more creative with my child
- If we are together, allow me to discipline any behaviour
- My child likes to be busy
- Be aware, in situations with other children, my child may be set up to take the blame
- Catch him doing something right
- My child responds extremely well to praise – look for the positive

Not Helpful

- Criticism is hurtful
- Please don't say
 - “You should have started disciplining him when he was younger.”
 - “They will outgrow it.”
- Avoid being judgemental
- If you know my child did something wrong, don't ask him if he did it. Tell him. Therefore, he is not being put in a lying situation.
- Blaming and causing guilty feelings adds to my struggle.

If we all understand and work together my child has a better chance to feel good and succeed.

We as parents will feel supported and less stressed too!!

SUPER SAFETY TIPS

For Very Active and Impulsive Children

These kids don't "get it".

These kids don't believe they will get hurt.

These kids need to be reminded time and time again.

These kids are more at risk to:

- be injured as pedestrians or on a bike
- inflict injury on themselves
- sustain multiple injuries
- suffer head injuries

What Parents Can Do:

1. **SUPERVISE SUPERVISE SUPERVISE**
2. Establish limits and good habits early.
3. Pick your child's playmates, playthings and play areas carefully.
4. Extra measures need to be taken to child-proof your house. Use pictures or words on dangerous objects or off-limit areas as a reminder. (e.g. power tools, attic)
5. Make rules specific and clear. Say clearly the action that you want to happen rather than using the words "no", "stop" or "don't". (e.g. walk in the house)
6. Use role play frequently as a reminder of safety rules and to help promote positive social skills. (e.g. What could happen if you chase your ball onto the road? What could you have done differently?)
7. Plan interesting activities throughout the day to keep your child busy and occupied. (e.g. drawing, colouring, puzzles, games, etc.)
8. Take active kids to public places during less crowded times. (e.g. parks, mall etc.)
9. Supervision is essential around pools and water. (e.g. use safety devices)
10. Be prepared to stop the car if your child gets out of the car seat or the booster seat. (Special safety restraints are available.)
11. Insist on helmets and all safety equipment for all sports and activities.
12. Be sure that caregivers and teachers understand the individual safety needs of your active and impulsive child.

Remember, for very active, impulsive children, consequences should be immediate and appropriate.