FOSTER AND KINSHIP CARE EDUCATION PROGRAM

COLLEGE OF THE REDWOODS

ADHD, ASD & Medication

Neurodivergent Youth in Care

Trainer: Deb Gee, LMFT

CR COLLEGE OF THE REDWOODS

1

Welcome

- Introduction of trainer
- Introduction of participants: first name & any experience you have with ADHD or ASD
- Questions

2

Training Objective

Provide participants with clinical and practical knowledge and strategies for understanding and supporting foster children and youth with ADHD and/or ASD. Reinforcement of the trauma lens and an emphasis on positive parenting techniques as well as information on medications and the CPS/Juvenile Court process will be provided.

3

Training Overview

- Welcome & Introductions
- Goals, Overview & Group agreements
- Neuro-trama Intersection & Emotion Regulation
- Felt Safety & the Three R's
- ADHD Diagnostics & Support
- ASD Diagnostics & Support
- Break

4

Training Overview con't

- Video comparing ADHD & ASD
- Medication & the JV-220
- Support techniques & Resources
- Q&A
- Wrap up questions:
  - What is one thing you learned from this training?
  - Which areas would you like to learn more about?

5

Group Agreements

- Emotional safety
- Confidentiality rules
- Self-care expectation

6

The Neuro-trauma Intersection

- California's Continuum of Care Reform (CCR) - trauma lens
- Overlap - Developmental trauma vs. genetic diagnoses
- A real-world example: hypervigilance

7

Emotion Regulation in Caregivers

- Why is it so important?
- What does it look like?
- Concept of co-regulation

8

Caregiver Reflex Assessment

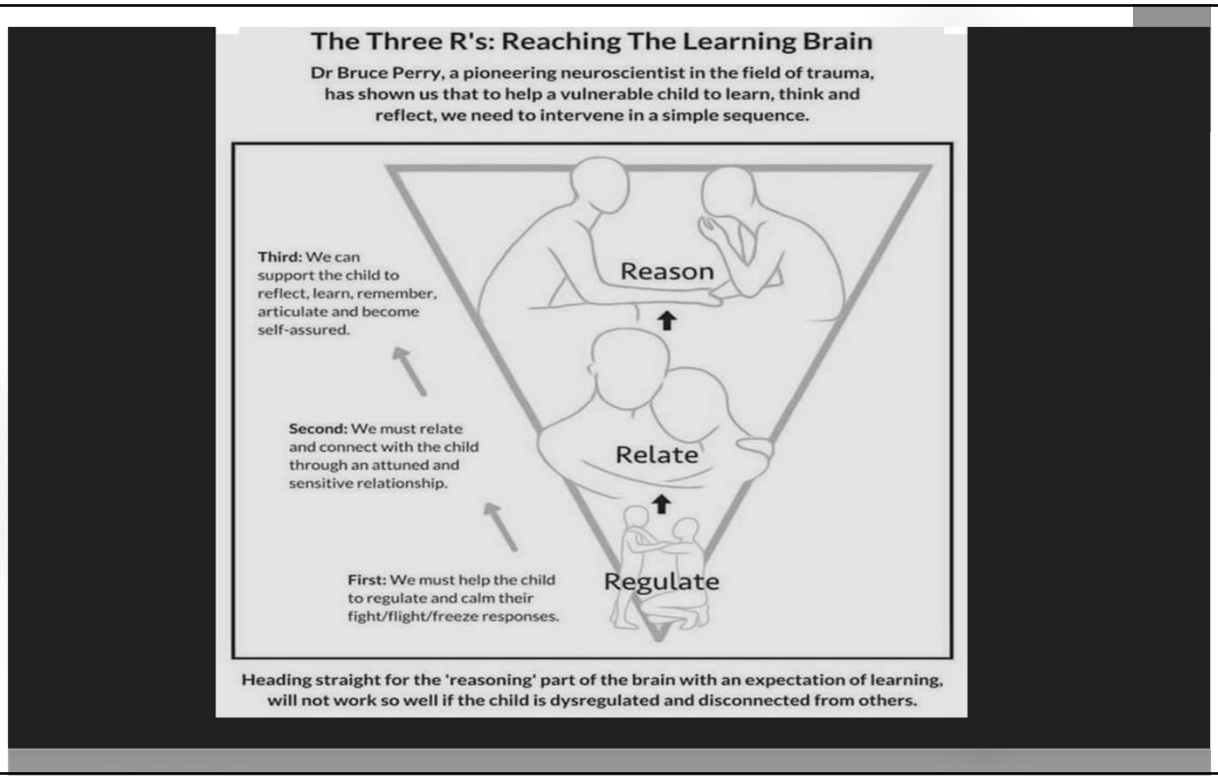
- What happens to you when a child is struggling?

9

Establish Felt Safety First

- Connection over correction
- Felt safety vs. actual safety
- Somatic tools
- Lower voice
- Drop shoulders
- Hands open
- Remove environmental demands

10



11

Attention Deficit Hyperactivity Disorder

- DSM-V-TR diagnostic criteria
- A person must show a persistent pattern of of inattention and/or hyperactivity-impulsivity
- Symptoms must:
- Last for at least 6 months
- Begin before the age of 12 years old
- Cause problems in at least 2 area of life (home, work, school, etc.)

12

ADHD Diagnostics con't

- Children and teens up to 16 years old must show at least 6 symptoms from either the inattention or the hyperactive-impulsivity list
- Adults aged 17 years and older must show at least 5 symptoms from either list

13

ADHD Inattention Symptoms List

- Fails to give close attention to details or makes careless mistakes
- Has trouble holding attention on tasks or play
- Does not seem to listen when spoken to directly
- Does not follow through on instructions or finish chores/work
- Has trouble organizing tasks and activities
- Avoids or dislikes tasks that take a lot of mental effort
- Loses things needed for tasks or daily life
- Is easily distracted by external things
- Is forgetful in daily activities

14

ADHD Hyperactivity and Impulsivity List

- Fidgets with hands or feet, or squirms in seat
- Leaves seat in situations when staying is expected
- Runs about or climbs in places where it is not allowed
- Unable to play or take part in quiet activities
- Is often on the go as if driven by a motor
- Talks too much
- Blurts out answers before a question is finished
- Has trouble waiting their turn
- Interrupts or intrudes on others (e.g. cuts in to games or conversations)

15

3 Types of ADHD

- Combined presentation: meets criteria for both inattention and hyperactivity-impulsivity
- Predominantly Inattentive presentation: meets criteria for inattention but not hyperactivity-impulsivity
- Predominantly Hyperactive-Impulsive presentation: meets criteria for hyperactivity-impulsivity but not inattention

16

The ADHD Brain

- Interest-driven vs. Importance-driven
- Dopamine scarcity
- May seem contradictory
- Reframing laziness

17

Executive Dysfunction

- Working memory
- Time blindness
- Emotional dysregulation

18

Support Techniques

- Body doubling
- Visual & tactile scaffolding
- AB 490 School Rights

19

Autism Spectrum Disorder

- Previously conceptualized as a spectrum, including Asperger's Disorder
- DSM-V-TR criteria
- Symptoms must be present in early childhood (but may not become fully manifest until social demands exceed limited capacities)
- Symptoms together limit and impair everyday functioning

20

ASD: Criteria A

- Persistent deficits in social communication and social interaction across contexts, not accounted for by general developmental delays, and manifest by all 3 of the following:
  1) Deficits in social-emotional reciprocity
  2) Deficits in nonverbal communicative behaviors used for social interactions
  3) Deficits I developing and maintaining relationships

21

ASD: Criteria B

- Restricted, repetitive patterns of behavior, interests, or activities as manifested by at least 2 of the following:
  1) Stereotyped or repetitive speech, motor movements, or use of objects
  2) Excessive adherence to routines, ritualized patterns of verbal or nonverbal behavior, or excessive r esistance to change
  3) Highly restricted, fixated interests that are abnormal in intensity or focus
  4) Hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of environment

22

ASD Support Levels

- Level 1: Requiring support (difficulty initiating social interactions; organization and planning problems can hamper independence)
- Level 2: Requiring substantial support (social interactions limited to narrow special interests; frequent restricted/repetitive behaviors)
- Level 3: Requiring very substantial support (severe deficits in verbal and nonverbal social communication skills; great distress/difficulty changing actions or focus)

23

How to Help

- Sensory profiling
- Stimming as regulation
- High masking

24

Home Sensory Audit

- What are environmental factors in your home that you suspect impact those with ASD?

25

Tantrum vs. Meltdown

- Clinical distinction
- Behavioral tantrum
- Neurological meltdown
- The wrong intervention

26

Safe-environment Collapse

- The school to home explosion
- The compliment reframed
- The low-demand transition window

27

Break

28

Video: ADHD vs. Autism: 4 Key Differences

https://www.youtube.com/watch?v=xQc5Feyl2GE

29

Psychiatric Medications

- Multiple medications that address ADHD
- Stimulants: Adderall, Ritalin, Concerta, Vyvanse, Dexedrine, Daytrana
- Non-stimulants: Wellbutrin, Strattera, Qelbree, Intuniv, Kapvay
- Watch for the late afternoon rebound effect
- There is no medication to directly treat ASD

30

California JV-220 Mandate

- What is the JV-220?
- Child & Family Team (CFT) Meetings

31

JV-220 **Application for Psychotropic Medication**

A completed and signed *Physician's Statement—Attachment (form JV-220(A))*, or *Physician's Request to Continue Medication—Attachment* (form JV-220(B)) with all its attachments must be attached to this form before it is filed with the court. Read form JV-217-INFO, *Guide to Psychotropic Medication Forms*, for more information about the required forms and the application process.

Clerk stamps date here when form is filed.

Fill in court name and street address:
Superior Court of California, County of

Fill in child's name and date of birth:
Child's Name:
Date of Birth:

Court fills in case number when form is filed.
Case Number:

① Information about where the child lives:
a. The child lives ☐ with a relative ☐ in a foster home ☐ with a nonrelative extended family member ☐ in a group home, level ____ ☐ at a juvenile custodial facility ☐ in a short-term residential therapeutic program ☐ other *(specify):* _____
b. If applicable, the name of the facility where the child lives:
c. Contact information for a responsible adult where the child lives:
(1) Name:
(2) Phone:
d. The child has lived at the placement in (a) since *(insert date):*

② Information about the child's current location:
a. ☐ The child remains at the location identified in ①
b. ☐ The child is currently staying in:
(1) ☐ a psychiatric hospital *(name):*
(2) ☐ a juvenile hall *(name):*
(3) ☐ other *(specify):*

③ Child's ☐ social worker ☐ probation officer
a. Name:
b. Address:
c. Phone: E-mail: Fax:

④ Number of pages attached:

Date:

Type or print name of person completing this form

Signature

☐ Child welfare services staff *(sign above, complete items ①–⑬, and sign on page 4)*
☐ Probation department staff *(sign above, complete items ①–⑬, and sign on page 4)*
☐ Medical office staff *(sign above)*
☐ Caregiver *(sign above)*
☐ Prescribing physician *(sign on page 6 of JV-220(A) or page 4 of JV-220(B))*

Judicial Council of California, www.courts.ca.gov
Revised January 1, 2016, Mandatory Form
Welfare and Institutions Code, §§ 369.5, 739.5
California Rules of Court, rule 5.640

Application for Psychotropic Medication

JV-220, Page 1 of 4

32

Medication Compliance

- The power struggle reframed
- The biological vulnerability
- Collaborative tracking of experience

33

DROP, MATCH, ROLL Technique

- Use when co-regulation is needed
- DROP your system
- MATCH intensity - not emotion
- ROLL with the crisis

34

In-home Crisis Examples

- Scenario A: The late afternoon ADHD stimulant rebound (evening crash)
- Scenario B: The Autistic sensory overload meltdown
- Scenario C: The medication refusal/autonomy stand-off

35

Resources

- Book: The Connected Child by Dr. Karyn Purvis
- Book: The Whole-Brained Child by Dr. Dan Segal & Tina Payne Bryson
- Book: The Out-of-Sync Child by Carol Stock Kranowitz
- Book: Uniquely Human: A Different Way of Seeing Autism by Barry M. Prizant
- Website: CHADD (Children and Adults with ADHD)
- Website: ASAN (Autistic Self Advocacy Network)

36

Any questions?

37

Wrap Up

- What is one thing you learned from this training?
- Which areas would you like to learn more about?

38

Thank you for all you do to support foster kids and youth!

Website: www.redwoods.edu/foster

Facebook: Foster/Kinship Care Education Program-College of the Redwoods

Phone: (707) 476-4455

Email: foster-kinship@redwoods.edu

39