ASD(ASC) and ADHD

Val Harpin
September 2019.

Why is it good to know about ADHD?

DSM IV, 1994

- ASD diagnosis meant should not diagnose ADHD
- Clinicians and families recognised that this was wrong
- NICE, SIGN and then DSM 5 confirm that ASD and ADHD co-exist

Neurodevelopmental Disorders DSM 5 (2013):

- Intellectual disability
- Communication Disorders

Autism Spectrum Disorder

ADHD

- Specific Learning Disorder
- Motor Disorders

  DCD

  tics and Tourette's,

  stereotyped movements

ASD

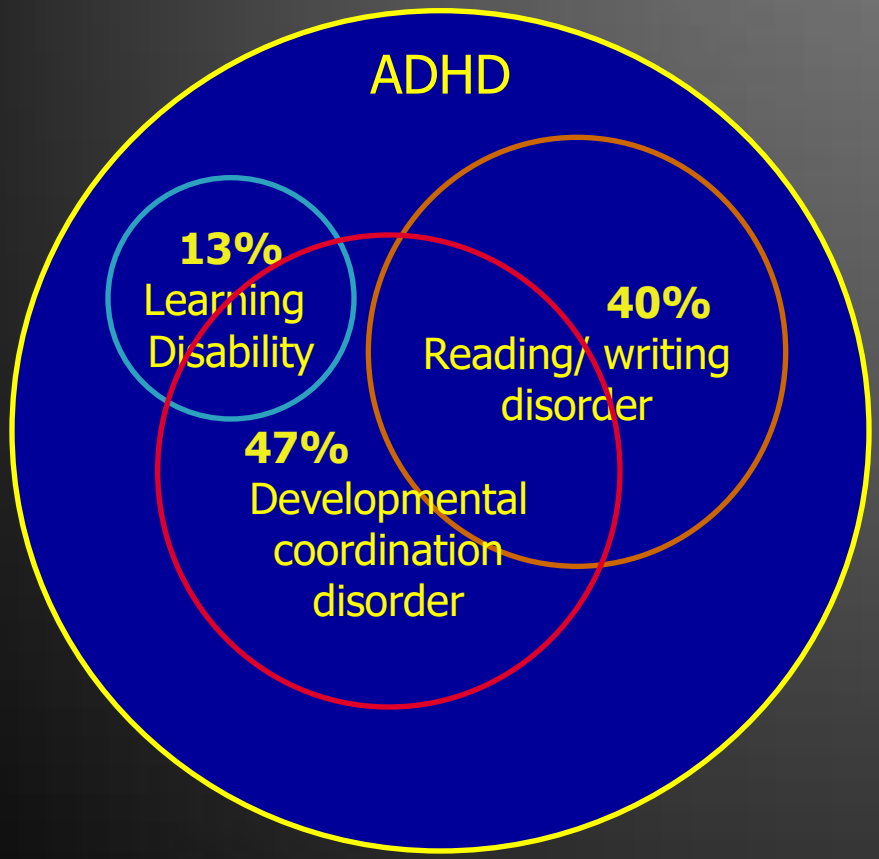
1% of childhood population (Baird et al, 2006)

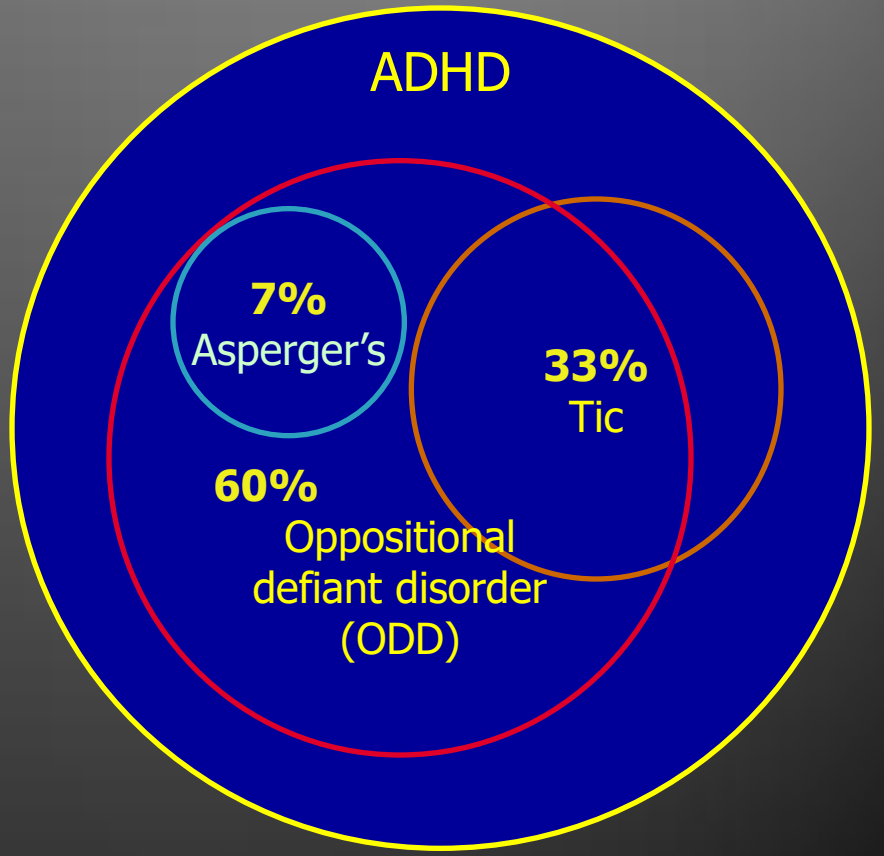
ADHD

3 to 5% of school-age children (NICE 2008)

COMORBIDITY

Swedish school-age children





Mood and anxiety disorders not included

Fig 1. Comorbidity in ADHD.

Kadesjö & Gillberg 2001

How many children have autism?

A new US government survey of parents suggests that 1 in 45 children, ages 3 through 17, have been diagnosed with autism spectrum disorder (ASD).

Science ...https://www.autismspeaks.org/.../new-government-survey-pegs-autism-prevalence-1-45

Individuals born in Sweden between 1987 and 2006

Overall and sex-specific prevalence of ASD, ADHD and comorbid cases in the population under study (n=1 899 654)

	Overall	Males	Females
ASD	28 468 (1.50%)	19 734 (2.03%)	8 734 (0.94%)
ADHD (2.98%)	82 398 (4.34%)	54 759 (5.63%)	27 639
ADHD + ASD	13 793 (0.73%)	9 805 (1.01%)	3 988 (0.43%)

Ghirardi, et al, 2017.

Which means:

- 48% of those with ASD also had ADHD
- 17% of those with ADHD had ASD

WOW!

Why does it matter?

- Children with ASD and ADHD symptoms scored significantly lower in all areas of life quality (social, communication, etc.) and functioning (school, physical, emotional, etc.) compared to children with ASD alone

Only 11% were receiving medical treatment for their ADHD

ADHD symptoms delay ASD diagnosis

1 in 5 children diagnosed with autism had an earlier diagnosis of ADHD.

Children initially diagnosed with ADHD received their autism diagnosis 3 yrs later

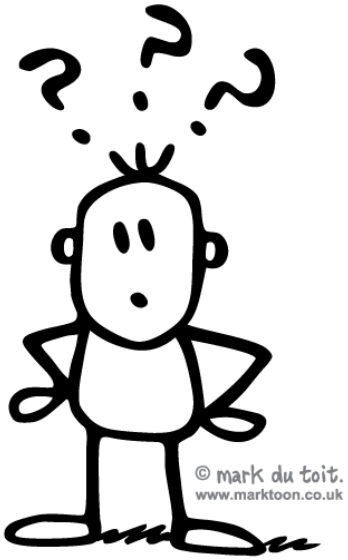
Children with ADHD were nearly 30 x more likely to receive their autism diagnosis after age 6.

The delay in diagnosis occurred regardless of the severity of ASD symptoms.

Miodovnik et al, Pediatrics 2015

Why do they coexist?

Is it just chance?



Risk Factors:

Genetic:

Twin studies suggest 50 -70% of covariance of ASD and ADHD is due to shared additive genetic factors

(Reiersen et al, 2008)

Other biological factors:

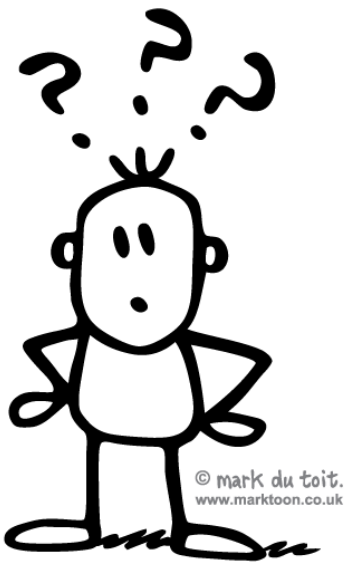
e.g. Preterm birth

Maternal diabetes

Pre-eclampsia

Psychosocial:

e.g. Romanian orphanages

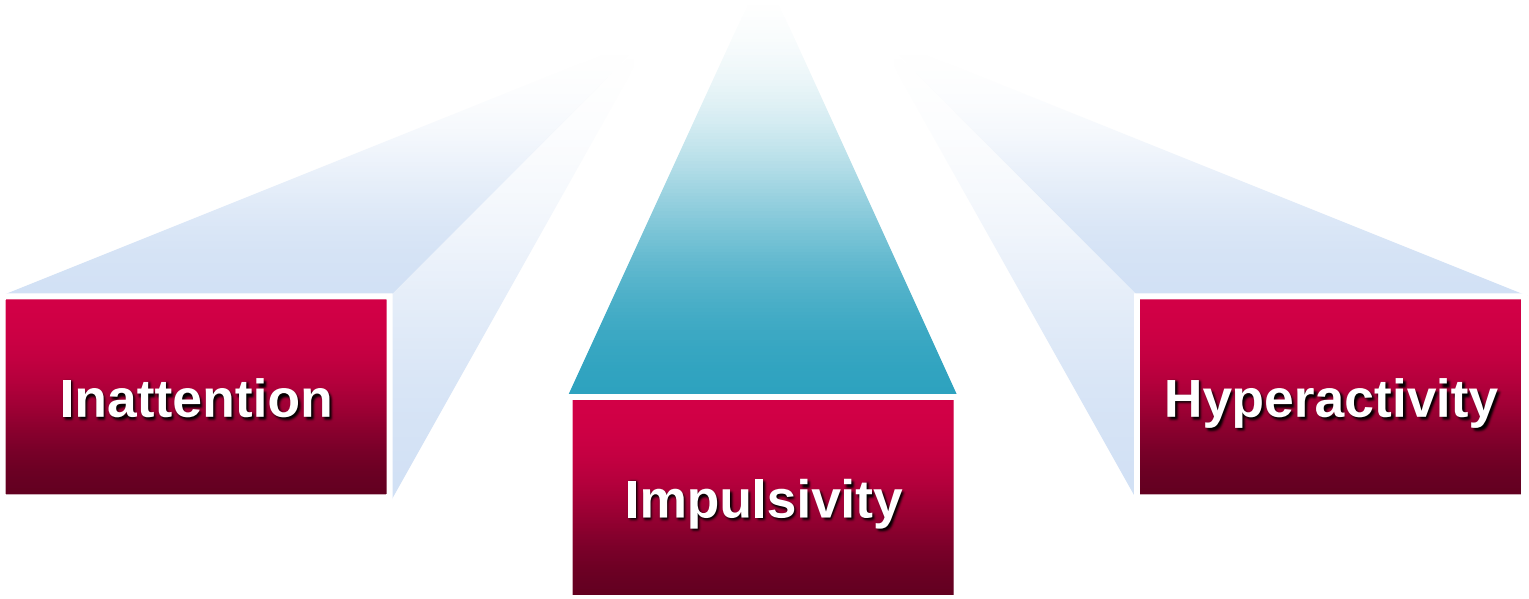


What is ADHD?

- ADHD stands for Attention Deficit Hyperactivity Disorder which is a recognised medical condition with specific symptoms[1]
- ADHD is a behavioural disorder where the brain grows and works in a different way from those not affected[1]
- Children with ADHD have functional impairment across multiple settings including home, school and peer relationships
- If not managed correctly, a child with ADHD can make it difficult for teachers to be the sort of teacher they want to be; a different approach is sometimes needed

References:
1. National Institute of Clinical Excellence Full Guidance – Attention deficit hyperactivity disorder. Diagnosis and management of ADHD in children, young people and adults, March 2009.

Core symptoms



These symptoms occur in every child from time to time but when they are persistent and impact on daily functions, more investigation is needed

What are the signs?

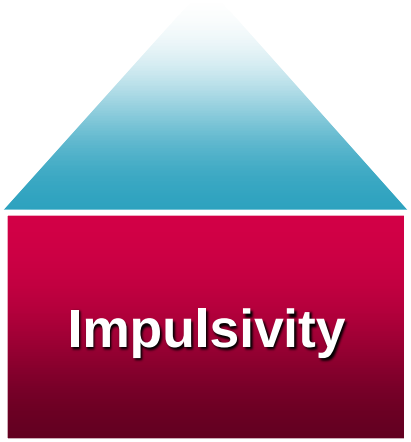
Inattentive symptoms

- Is easily distracted
- Does not appear to be listening when spoken to directly
- Has difficulty sustaining attention during activities
- Avoids or dislikes tasks requiring sustained mental effort
- Is forgetful in daily activities
- Finds it difficult to follow through instructions and fails to complete tasks
- Finds it difficult to organise tasks and activities
- Fails to give close attention to detail/makes careless mistakes
- Loses important items

Hyperactive symptoms

- Squirms and fidgets
- Cannot remain seated
- Runs or climbs excessively in inappropriate situations
- Often ‘on the go’ or acts as if ‘driven by a motor’
- Talks excessively
- Cannot perform leisure activities quietly

Impulsive symptoms



- Blurts out answers before questions completed
- Has difficulty awaiting turn
- Interrupts or intrudes on others
- Gets into trouble by mistake

ADHD or bad behaviour?

To be clinically diagnosed with ADHD a child has to have:

- Six or more symptoms persisting for at least six months to a degree that is maladaptive and inconsistent with developmental level[1]
- Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 12
- Some impairment from symptoms is present in two or more settings, for example, at school and at home[1]
- Clear evidence of significant impairment in social and/or school functioning[1]

Classroom behaviours

- Flitting from activity to activity
- Problems sharing
- Difficulties following short instructions
- Fidgetting, running around
- Constant chattering
- Difficult temperament, emotional
- Interrupting, calling out

Classroom Behaviour

- Difficulties learning songs, the alphabet
- Problems completing activities
- Lots of accidents, breakages
- Exuberance, ‘big’ personalities, fun loving, thrill seeking
- Exhausted parents (& teachers!)

Aren't All Children Like that?

- Hyperactive children show the behaviours to a degree which *interferes* with normal day to day activities, in all settings (home, nursery, school & at play)

Toolkit.

Diagnosis

Careful history is key:

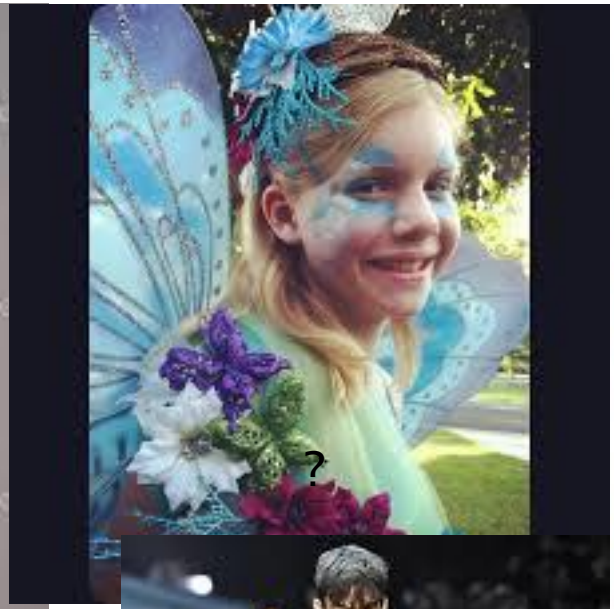
Is behaviour due to ADHD, ASD or BOTH?

Remember this can change

If a C/YP has ADHD and we wonder about ASD:

- Eye contact
- Greeting
- Facial expression

Clothing?



Image?

Behaviour

Interaction in clinic

In and out of school

Obsessional Traits:

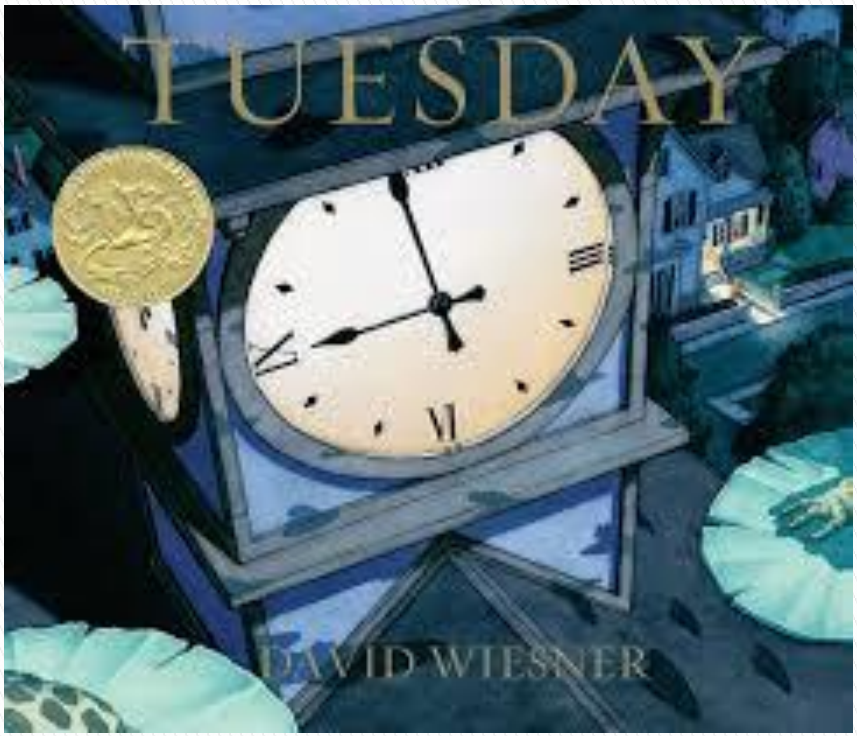
Obsessional traits:

Past history is relevant

Collecting?

Conversation/language?

- Topic?
- Complexity?
- Reciprocal/interest in others?
- Humour?
- Literality?



Literal understanding:

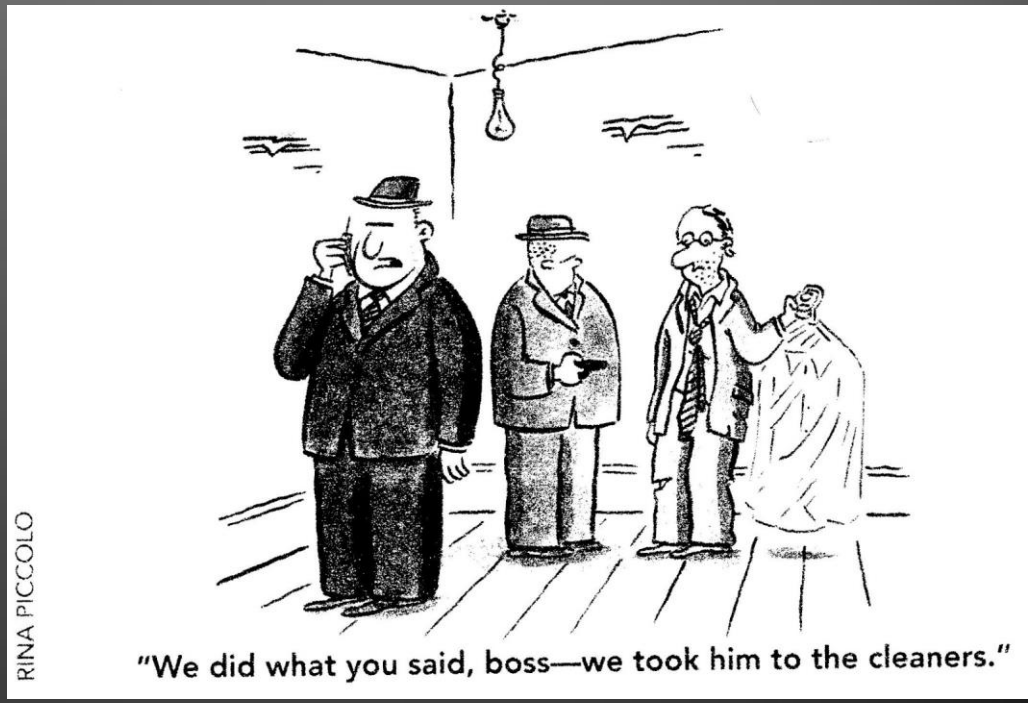
‘Pull yourself together’

‘I’m going to lose my rag with you!’

‘You can go swimming when this glass is empty’

‘That’s a bit of a kick in the teeth’

‘Yeah. Course I’ll go out with you.’



At initial ADHD assessment.

- Understand the information you have gathered
- Listen
- Ask
- Watch
- Examine
- Look for all possible explanations
- Work out what other information you need, if any
- If things are not clear what can help make them clearer?

Involving schools and colleges:

- When ADHD is diagnosed,
- when symptoms change,
- when there is transition between schools or from school to college

NICE 2018

School Observation Checklist.

Sheffield Multi-professional ADHD Steering Group
Time Sampling
Behaviour Observation Sheet

Pupil Details
Name:
Date of Birth:
School:

STEPS involvement LST / BST / EP	Code of Practice School Action / School Action Plus	Current I.E.P Yes / No	School Year

Glossary

On Task:	The pupils is on the set task. This may involve relevant discussion with another.	Teacher:	Interacting with teacher appropriately.
Disengaged:	The pupils is neither working nor disturbing others e.g. playing with equipment, Glazing around.	Disruption:	Disrupts / Distracts others / Unable to wait or disruptive while waiting.
Impulsivity:	Calls out to teacher/makes inappropriate noises.		The pupil is engaged in social activity, not task related, with peers.
Wandering:	The pupil is walking round the classroom or out of their seat.		

NB *If child fidgets during observation mark f as well as √ in appropriate box.*

Context – eg class, group, carpet, individual, transition, break, dinner time (variety in contexts is valuable)

		0.00	0.02	0.04	0.06	0.08	0.10	0.12	0.14	0.16	0.18	0.20	0.22	0.24	0.26	0.28	0.30	0.32
On Task	T																	
	C																	
Teacher	T																	
	C																	
Disengaged	T																	
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Disruption	T																	
	C																	
Impulsivity	T																	
	C																	
Wandering	T																	
	C																	
Social	T																	
	C																	

Analysis of the observation

☐ = Target Child

Number of
Times on task: _____ Teacher: _____ Disengaged: _____ Impulsivity: _____ Wandering: _____ Social: _____

Fidgeting ☐ Comments:

(Total number of times)

Analysis of the observation

☐ = Comparison Child

Number of
Times on task: _____ Teacher: _____ Disengaged: _____ Impulsivity: _____ Wandering: _____ Social: _____

Fidgeting ☐ Comments:

(Total number of times)

Comparison with ‘control’ child

Mark your assessment of the **target child** on the following continua over the observation period

Attention	a Concentrates on work b Listens to teacher c Switches attention appropriately	---------- ---------- ----------	Staring, not working Doesn’t listen to teacher Distracted or fails to switch
Motor	a Sits or stands straight b Sits or stands still c Remains in place appropriately d Moves from place appropriately	---------- ---------- ---------- ----------	Sits/stands awkwardly, leans/ Shuffles Wriggles, fidgets, swings, drops things Remains in place inappropriately Moves from place inappropriately
Vocalisation	a Talks to peers appropriately b Talks to teachers appropriately c Quiet when working d Timely response to questions	---------- ---------- ---------- ----------	Disrupts peers/self by talking Calls to teacher when working Makes noises/mutters when working Impulsive untimely responses
Disruption	a Doesn’t disrupt others work b Complies with instructions c Waits patiently for attention	---------- ---------- ----------	Disrupts/distracts others Doesn’t comply with instructions Impatient or disruptive

Mark your assessment of the **class generally** on the following continua over the observation period

Attention	a Concentrates on work b Listens to teacher c Switches attention appropriately	---------- ---------- ----------	Staring, not working Doesn’t listen to teacher Distracted or fails to switch
Motor	a Sits or stands straight b Sits or stands still c Remains in place appropriately d Moves from place appropriately	---------- ---------- ---------- ----------	Sits/stands awkwardly, leans/ Shuffles Wriggles, fidgets, swings, drops things Remains in place inappropriately Moves from place inappropriately
Vocalisation	a Talks to peers appropriately b Talks to teachers appropriately c Quiet when working d Timely response to questions	---------- ---------- ---------- ----------	Disrupts peers/self by talking Calls to teacher when working Makes noises/mutters when working Impulsive untimely responses
Disruption	a Doesn’t disrupt others work b Complies with instructions c Waits patiently for attention	---------- ---------- ----------	Disrupts/distracts others Doesn’t comply with instructions Impatient or disruptive

Comments:

Signature: _____ **Professional Role:** _____

Comparison with whole class

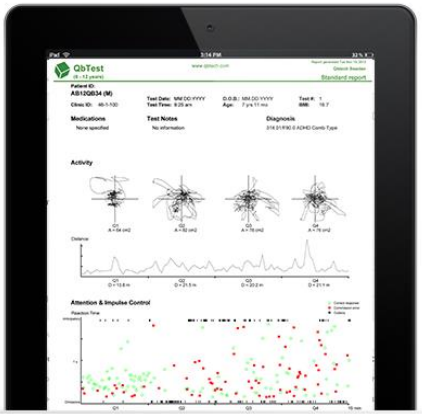
School observation

- 80% of children with a score of 27 and above had ADHD.

"Although ideally carried out by a skilled observer who is able to interpret the observation qualitatively and may identify additional information e.g. features of comorbid conditions, our study suggests that a structured scoring system could still be useful in the hands of less experienced observers e.g. teaching assistants. The checklist could be considered as a screening tool to inform referrals for full ADHD assessment."

Qb Test

1. Objective measures of all three ADHD core symptoms
2. A 15 to 20 minutes test with instant analysis
3. Smart reports with unbiased norm group comparison



QbTest is now the first objective test cleared by FDA for treatment follow-up of ADHD

QbTest
(6 - 12 years)

www.qbtech.com

Report generated Fri Oct 19, 2012

Standard report

Patient ID:
AB12QB34 (M)

Clinic ID: 44-0-100

Test Date: DD/MM/YYYY
Test Time: 9:25 am

D.O.B.: DD/MM/YYYY
Age: 7 y. 11 m.

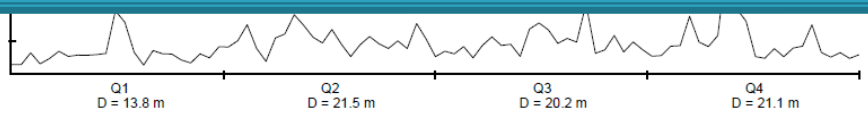
Test N°: 1
BMI: 16.7

Medications
None specified

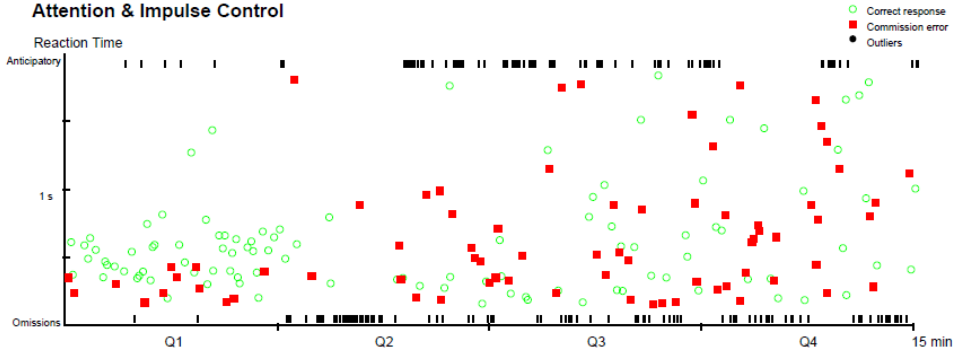
Test Notes
No information

Diagnosis
314.01/F90.0 ADHD Comb Type

Combined type ADHD 9 year old boy



Attention & Impulse Control



Outliers = 0

Activity Measures

	Measure	-3 0 +3	Q-score	Percentile
Time Active	95 %		1.9	97
Distance	76.7 m		3.0	99
Area	271 cm2		3.2	99
Microevents	28900		2.9	99
Motion simpl.	53.6 %		1.1	86

Attention & Impulse Control Measures

		Measure	-3 0 +3	Q-score	Percentile
Attention	ReactionTime Var.	403 ms		4.1	99
	Omission Error	37.8 %		2.3	99
	Reaction Time	617 ms		1.8	96
	Normalised Var.	65 %		3.9	99
Impulse	Commission	32.0 %		1.5	93
	Anticipatory	16.4 %		1.7	96
	MultiResponse	32.9 %		2.4	99
	Error rate	51.3 %		2.5	99

Diagnostic and treatment decisions should be made by a qualified, professional following a comprehensive evaluation.

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QbTest
(6 - 12 years)

www.qbtech.com

Report generated Fri Oct 19, 2012

Standard report

Patient ID:
AB12QB34 (M)

Clinic ID: 44-0-100

Test Date: DD/MM/YYYY
Test Time: 11:54 am

D.O.B.: DD/MM/YYYY
Age: 7 y. 11 m.

Test N°: 2
BMI: 16.7

Medications

Name	Dose	Post
Methylphenidate	15.0 mg	2:00

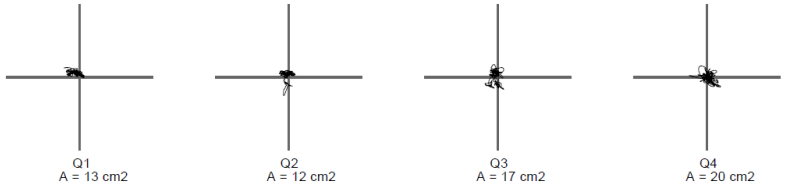
Test Notes

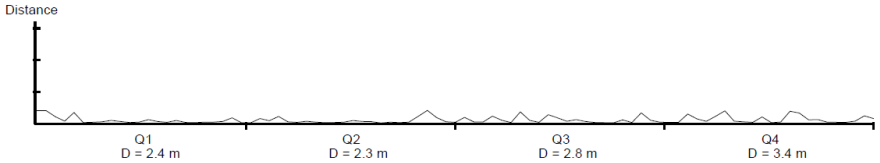
No information

Diagnosis

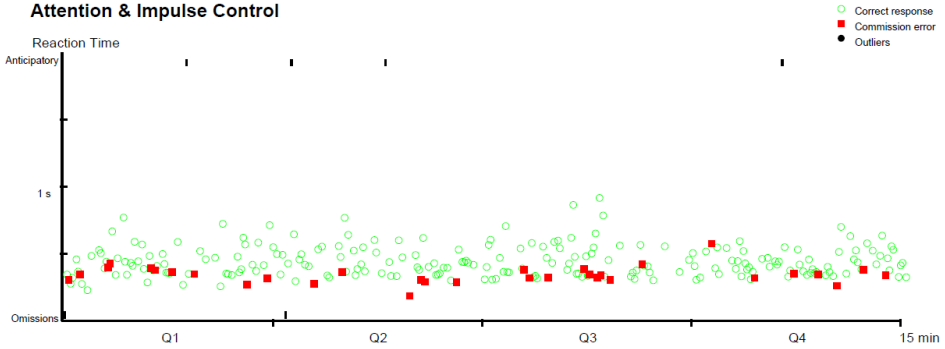
314.01/F90.0 ADHD Comb Type

Activity





Attention & Impulse Control



Outliers = 0

Activity Measures

	Measure	-3 0 +3	Q-score	Percentile
Time Active	31 %		-0.4	34
Distance	10.9 m		-0.4	34
Area	45 cm2		-0.3	38
Microevents	7400		-0.4	34
Motion simpl.	41.1 %		-0.6	27

Attention & Impulse Control Measures

		Measure	-3 0 +3	Q-score	Percentile
Attention	ReactionTime Var.	115 ms		-0.9	18
	Omission Error	0.9 %		-1.2	12
	Reaction Time	447 ms		-0.5	31
	Normalised Var.	26 %		-0.8	21
Impulse	Commission	14.2 %		0.2	58
	Anticipatory	0.9 %		0.9	82
	MultiResponse	0.7 %		1.2	88
	Error rate	8.4 %		-0.3	38

Diagnostic and treatment decisions should be made by a qualified, professional following a comprehensive evaluation.

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0.0 - 0.0 - 450 - 0.0

Response to Stimulant medication

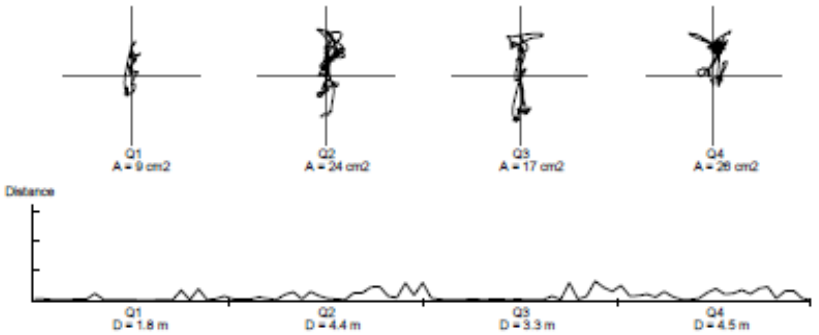
QB report: Not ADHD.

Medications
None specified

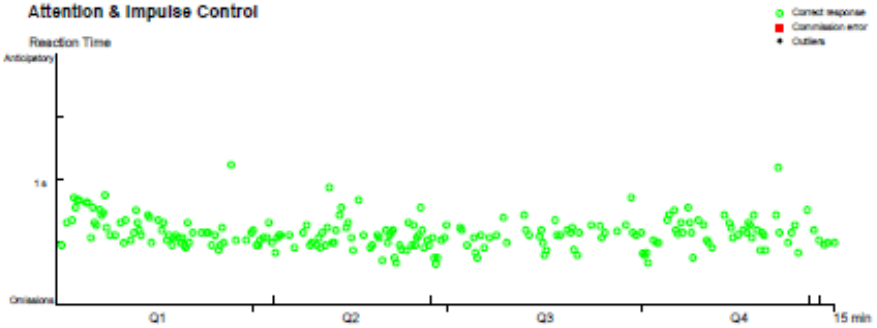
Test Notes
No information

Diagnosis
No information

Activity



Attention & Impulse Control



Outliers = 0

Activity Measures

	Measure	-3 0 +3	Q-score	Percentile
Time Active	29 %		0.2	58
Distance	13.9 m		0.7	76
Area	72 cm2		1.0	84
Microevents	7900		0.4	66
Motion simpl.	57.1 %		1.8	96

Attention & Impulse Control Measures

		Measure	-3 0 +3	Q-score	Percentile
Attention	ReactionTime Var.	122 ms		0.5	69
	Omission Error	1.8 %		0.3	62
	Reaction Time	578 ms		2.6	99
	Normalized Var.	21 %		-1.2	12
Impulse	Commission	0.0 %		-2.6	1
	Anticipatory	0.0 %		-1.1	14
	MultiResponse	0.0 %		-0.7	24
	Error rate	0.9 %		-1.8	4

Impairment?

Assessment of impairment

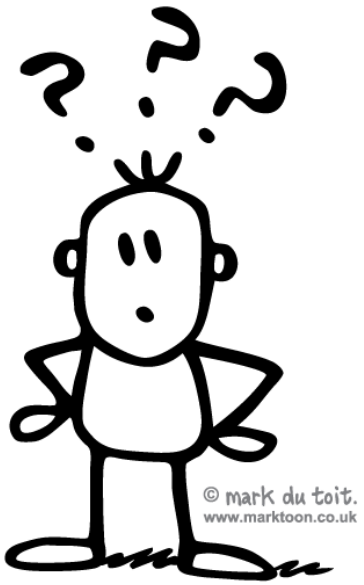
Impairment of at least moderate clinical +/- psychosocial significance in >1 domains

Pervasive i.e. in 2+ situations (home/school/work)

NICE, 2008

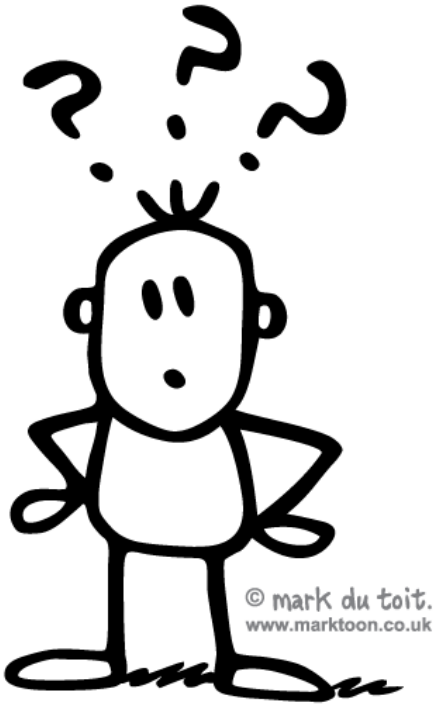
Childhood domains:

- self-care;
- travelling independently;
- making/keeping friends;
- achieving in school;
- forming positive relationships in family;
- positive self-image,
- avoiding criminal activity;
- avoiding substance misuse,
- emotional states free of excessive anxiety and unhappiness;
- understanding risk
- avoiding common hazards



Adult/adolescent domains

- Occupational/educational underachievement,
- dangerous driving
- problems in intimate relationships (eg excessive discord and jealousy)

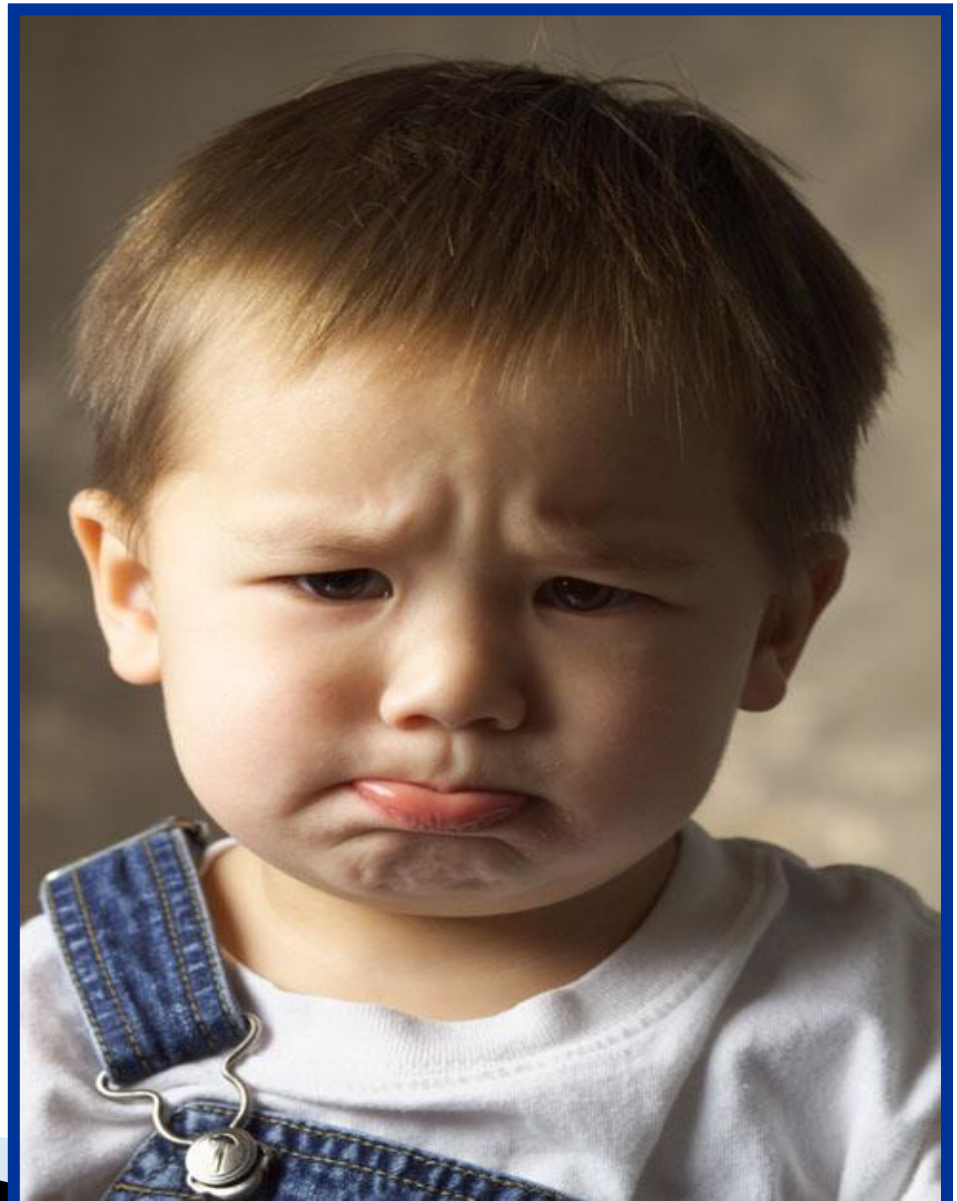


Impairment?

Thanks to Ian Male

Effective management?

Pre-school Overactivity: Interventions



Preschool

- Parent training programmes should be offered as first line treatment (BOR 2002, SONUGA-BARKE 2001)

Programmes should be:

- Structured with a programme built on principles of social-learning
- Include relationship enhancing strategies
- Offer 8 to 12 sessions

Preschool

- Enable parents to identify their own parenting objectives
- Be delivered by appropriately trained facilitators
- Adhere to the programme to ensure consistency
- Include both parents if feasible
- Consider difficulties of access which could exclude families

What Helps?

- Understanding
- Home/ nursery/Classroom management
- *CREATIVITY !*
- *ENERGY !*

Specific Techniques

- Attention & Turn Taking
- Visual Memory Games
- Auditory Memory Games
- Impulse Control / Waiting
- Emotional Sensitivity

Effective management for school age children with;

ADHD:

- Psychoeducation
- Education modification
- Behavioural therapy
- ? Medication
- Treating coexisting difficulties
- Supporting families
- Cross agency working

ASD

- Psychoeducation
- Education modification
- Behavioural therapy
- ? Medication
- Treating coexisting difficulties
- Supporting families
- Cross agency working

Management strategies for children with ASD+ADHD in school

Includes:

Visual timetables, structure/ routine:
supporting understanding and language development and giving clarity to what will happen and what is expected

Simple concrete language
Used when you have the child's attention to reduce misunderstanding

Low stimulation areas:
reducing sensory difficulties

Social stories:
helping the understanding of social interaction in school and beyond

Top ten hints and tips

1. Construct positive relationships with the members and teachers and aim to share the same approach.

Good communication and consistency is key

Top ten hints and tips

2．Allow time for processing of information. For example by reducing the amount of language they have to concentrate on and allow for flexibility in amount of time needed to complete a project

Top ten hints and tips

3.Give an overview of what you want them to do then break it into smaller, prioritised steps.

Children with ADHD have difficulty with planning activities and doing them in the right order so establishing small tasks leading up to a completed project will help

Top ten hints and tips

4. Sit the child close to you and pair them with a calm pupil away from potential distractions. ASD+ADHD children are easily distracted, so where they sit in the classroom can make a difference e.g. away from windows and doors

Top ten hints and tips

5. Provide opportunities to be physically active and try to find a way to allow them to fidget e.g. let them be the one to go and fetch something and allow the use of squeeze balls

6 Explain in advance what's going to happen, especially if different to what they expected.

Top ten hints and tips

7. Promote self esteem by praising them in public for positive behaviour. When necessary discipline them quietly on a one-to-one

8 Keep a chart to track their tasks or their behaviour. Rewards can then be given when they reach their target

Top ten hints and tips

9 Be aware that bullying by other pupils may be a problem.
When things go wrong, it may not always be the fault of the child with ASD+ADHD. Be willing to hear their side of the story

10 Help show them how to make friends and play appropriately with others

Medication

Medication in ASD/ADHD

- Does it work?
- What are the side effects?
- Which is the best medication?

Medication?

Amfetamine?

Methylphenidate?

Guanfacine XR?

Atomoxetine?

Medication Pathways:

Review question:

What is the most clinically and cost-effective sequence of pharmacological treatment for children and young people with ADHD?

Preschool children and medication:

- 4 studies
- Methylphenidate
- Risperidone

Recommendation for behavioural management

Schoolage children:

Offer medication for children and young people with ADHD aged 5 years and over

IF their ADHD symptoms are having a persistent significant impact in at least one domain of their everyday life

✓after environmental modification

First-line:

Offer methylphenidate as first-line pharmacological treatment for children aged 5 years and over and young people with ADHD.

Then:

Consider lisdexamfetamine for children aged 5 years and over and young people whose ADHD symptoms are not responding adequately to methylphenidate.

Consider dexamfetamine for children aged 5 years and over and young people whose ADHD symptoms are responding to lisdexamfetamine but who cannot tolerate the longer effect profile.

Then:

Offer atomoxetine or guanfacine if:

- cannot tolerate methylphenidate and lisdexamfetamine,

- symptoms have not responded to separate 6-week trials of lisdexamfetamine and methylphenidate,

Baseline assessment: pre medication

A review of mental health and social circumstances, including:

- presence of coexisting mental health and neurodevelopmental conditions
- current educational or employment circumstances
- risk assessment for substance misuse and drug diversion care needs

A review of physical health, including:

- a medical history, taking into account conditions that may be contraindications for specific medicines current medication
- height and weight (measured and recorded against the normal range for age, height and sex)
- baseline pulse and blood pressure
- a cardiovascular assessment

Family history

Comprehensive, holistic shared treatment plan that addresses psychological, behavioural and occupational or educational needs.

Take into account:

- the severity of ADHD symptoms and how these affect or may affect a person's life
- their goals
- the level of impairment and impact on their everyday life
- their resilience and protective factors
- the relative impact of other neurodevelopmental or mental health conditions.

Coexisting difficulties:

Follow the same pathway for people with ADHD and co-existing conditions

No evidence of worsening co-existing conditions.

'dearth of evidence'

groups were not distinguished within the analysis or were excluded from trials.

Consensus view:

- consider the same medication choices
- consider the individual circumstances
- slower dose titration
- more frequent monitoring.

Use of medication for ADHD in the presence of ASD

- Methylphenidate improves ADHD symptoms
- Side effects not more common or severe

Santosh PJ, Baird G, Pityaratstian N, Tavare E, Gringras P.

Other ADHD medications and ASD.

- Atomoxetine also good in some trials (Harfterkamp et al, 2012) (Harfterkamp et al 2013.)

- Prolonged release guanfacine, (Intuniv) a selective alpha 2 agonist, offers an additional choice (Scahill et al 2012)

Follow-up and monitoring

- Symptom control
- Side effects
- Growth
- Sleep
- Worsening behaviour
- Adherence

When behaviour difficulties are severe

Detailed analysis is needed.

What is the child/YP trying to communicate?

e.g. self harming or aggressive behaviour may be prompted by anxiety in which case management of the cause of the anxiety is needed.

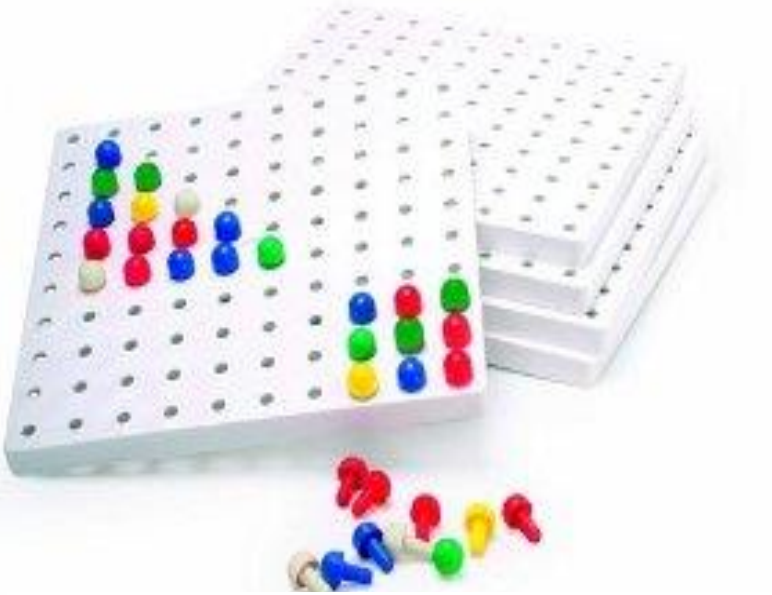
So? If definite ADHD diagnosis in C/YP with ASD and no contraindication:

- Try behaviour management
- Consider medication
- Start low, go slow
- Set realistic goals
- Monitor
- Monitor
- Monitor!

Developmental Coordination Disorder.

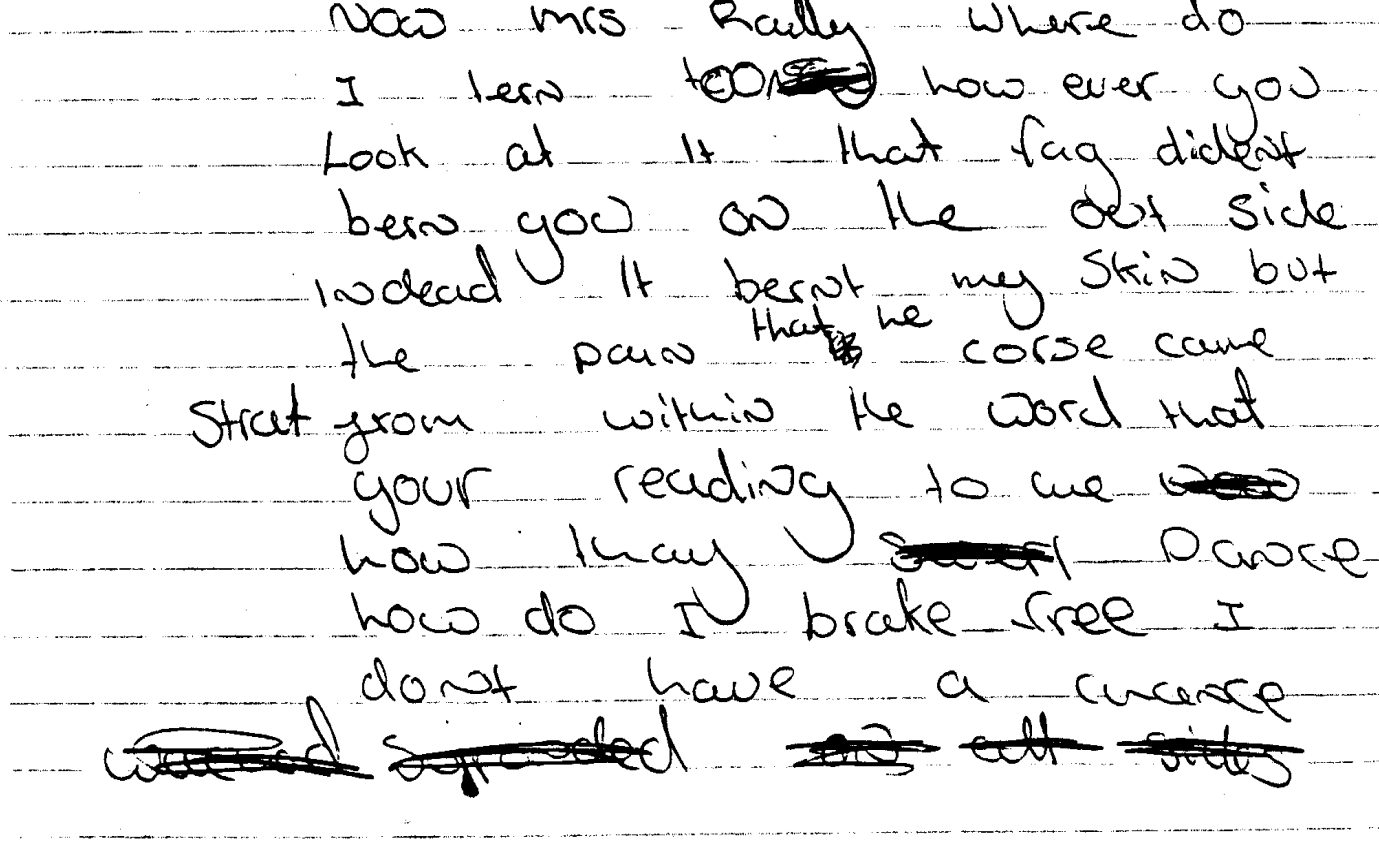
- 20 to 50 % of individuals with ADHD
- http://www.eacd.org/publications.php

Simple screens: for motor problems



Spotty dogs.

Writing



- The effects of methylphenidate on the handwriting of children with minimal brain dysfunction .Lerer RJ,et al . J Peds 1977
- Effects of **methylphenidate on quality of life in children with both developmental coordination disorder and ADHD. Flapper BC et al,**
- **Dev Med Child Neurol. 2008**
- **.Fine motor skills and effects of methylphenidate in children with attention-deficit-hyperactivity disorder and developmental coordination disorder.Flapper** et al, Dev Med 2006.

Anxiety Disorders (10–40% in ADHD > in those with ASD+ADHD)

- Related in part to poor emotion regulation
- Anxiety disorders more likely in parents and family
- Interview child/young person not just carer
- Treat most severe problem first
- Ensure ASD strategies in place

Sleep disorders (30-56%)

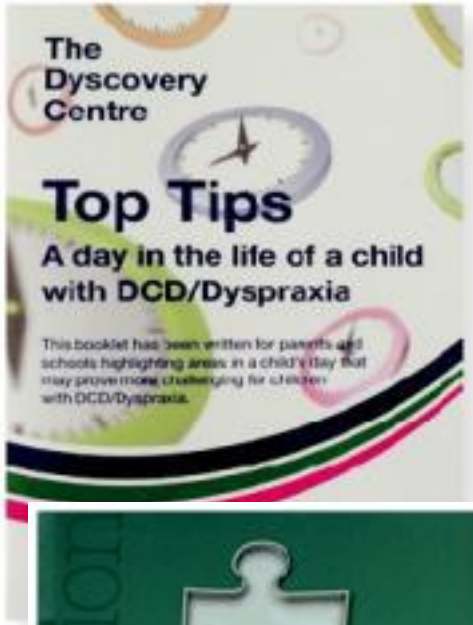
- Mainly delayed onset and greater night waking leading to shorter sleep time
- More activity during sleep
- May exacerbate attention problems in school

Management

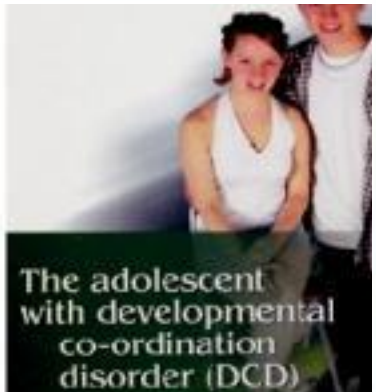
- General sleep hygiene
- Melatonin
- Monitor role of medication (diary)

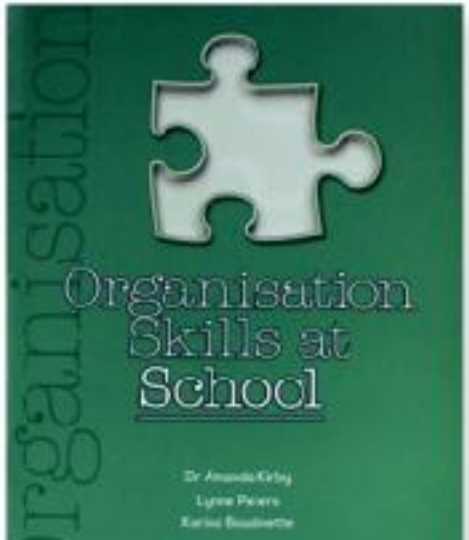
Resources:

http:/www.boxofideas.org/ideas



The National Autistic Society





National Autistic society:

http://www.autism.org.uk

BUT:
Children and
Young people
don't often fit into
neat boxes!

Why treatment is important:

‘I wanted to let you know we are 3 days into meds and it has literally revolutionised our life. She has just spent 20 minutes looking through recipe books for a pudding we can make to take to a friend’s house. And she is engaging so much more in responsive conversation, following instructions and her entire body is stiller. She has read books with me without moving once.

I am astounded at the impact.’

Message left by the mother of a girl with ADHD, ASD and learning disability after starting LA methylphenidate

And:

Dear Val,

……. ‘I have finished my degree and got a really good job in Italy.

How can I get my concerta here?

I need it to manage my job.’

Specific Techniques

- Overactive children need different teaching (& parenting) approaches
- Use strategies that target the core underlying difficulties (overactivity, inattention, impulsivity, working memory)
- Exaggerated emotion, action & colour work well ie the more ridiculous the better!

Attention & Turn Taking

- Recruit attention, clear non-verbal signals
- Short instructions
- Eye contact “Good looking”
- Repeat instructions back
- Simple card games SNAP (limited cards)
- Extending play using language & song (!)
- Snack time (P.O.P)
- Visual cues, eg carpet spot, listening rabbit, story bear, Tidy Up Time, Snack Time, Story Time cards (P.O.P)

Auditory Memory Games

- Simon Says …..
- I went to market ….
- I Spy
- Repeating simple rhythms eg drum beats

Scaffold

What can they do – extend– consolidate – rescope

Impulse Control / Waiting

- Visual cues – countdowns – timers
- Delayed rewards
- Ready…, steady…, go activities (1.., 2..,3..)
- Sleeping lions
- Hiding in the ‘cave’ (P.O.P)
- Key game
- Stop watch challenge !

Emotional Sensitivity

- Focus on positives (“good looking” & thumbs up)
- Eye contact for positives (not just negatives)
- ‘We’ commands to reduce individual focus
- Choices to increase sense of control
- 1:1 quiet / calm down time with adult support to model calming techniques & discuss alternatives
- Time out for hurting & destructive behaviour (but ideally above)


Thank you.