

ATTENTION DEFICIT HYPERACTIVITY DISORDER

INFORMATION & GUIDANCE FOR SCHOOLS

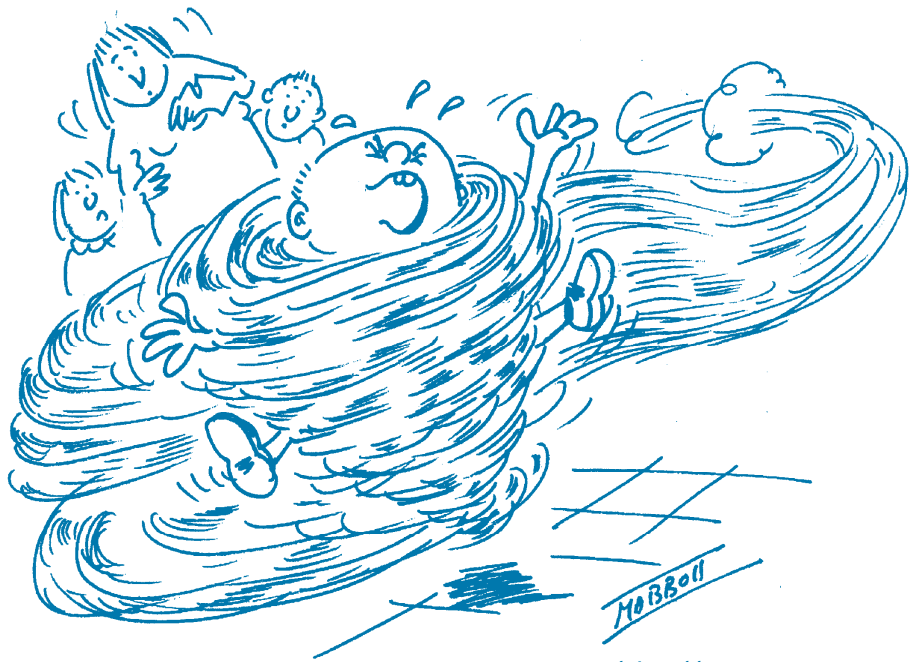


Published by Gateshead Council - April 2003

CONTENTS

Page

1. Introduction/Acknowledgements	3
2. What is attention deficit hyperactivity disorder (ADHD)?	4
3. A brief history of ADHD	5
4. The impact of ADHD	6
5. What causes ADHD?	8
6. Other factors which influence how children with ADHD behave	10
7. Assessment & diagnosis	11
8. Interventions	
Medication: What is Ritalin (Methylphenidate)?	13
Behaviour modification at home	12
Managing ADHD at school	12
Social skills work	12
9. How might a child with ADHD feel at school?	15
10. How does a child with ADHD behave in the classroom?	16
11. The effect of having ADHD on peer relationships and social skills	18
12. Strategies to help children with ADHD in school	
Managing inattention/distractibility	19
Managing impulsivity	20
Managing hyperactivity	20
Organisation and planning of work	21
Encouraging academic skills	22
Maximising potential for success in assessment	23
Encouraging positive behaviour	23
Improving mood & self-esteem	24
Improving social skills	24
13. Resources in the Gateshead Region	26
14. Sources of information used in the development of the booklet	27



© Chris Mabbott 2001

1. Introduction

This booklet is intended to provide information to help teachers better understand and manage children with Attention Deficit Hyperactivity Disorder (ADHD) in school. It attempts to synthesise existing knowledge from a variety of sources into an easily accessible and useable form.

The booklet has been compiled by the Clinical Psychology Department at Gateshead Child and Family Unit in consultation with Gateshead Council's Educational Psychology Service. Throughout its development many members of staff from these departments and Gateshead Council's Behaviour Support Service have generously contributed. Feedback from teachers who participated in a pilot study was also appreciated and helped refine the final booklet.

The Whickham ADHD Support Group has also provided invaluable feedback and contributions which have helped ensure the opinions of families who deal with the daily problems associated with ADHD are represented.

The contribution of original artwork by Chris Mabbott is also appreciated.

2. What is Attention Deficit Hyperactivity Disorder (ADHD)?

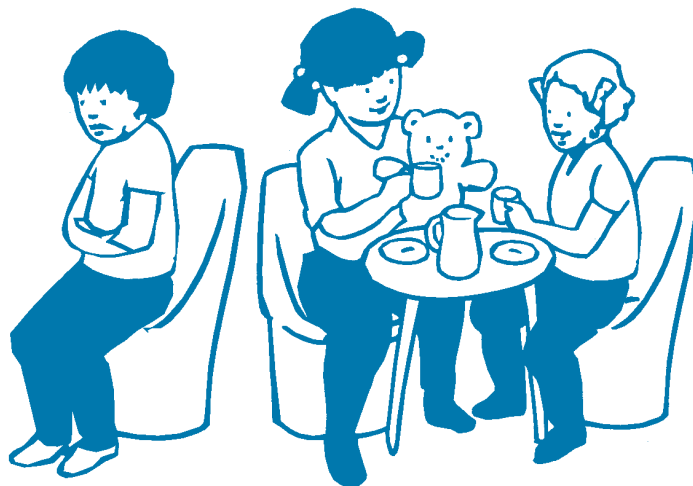
ADHD is a medical condition which is becoming increasingly recognised in children and adults. The disorder has 3 core features:

- Inattention/Distractibility (poor sustained attention to tasks)
- Impulsivity (poor impulse control)
- Hyperactivity (excessive activity and physical restlessness)

In children these features occur to an extent that is unwarranted for their developmental age, and consequently they may perform poorly at school and may be unpopular with their peers, often being perceived as unusual or a nuisance by other children.

Many of the symptoms of ADHD occur from time to time in all children. However, in children with ADHD they occur very frequently and in several settings, such as home, school, or when visiting with friends. The disorder is estimated to occur in between 3% and 5% of children.

Attention Deficit without hyperactivity can also occur in children and is referred to as Attention Deficit Disorder (ADD).



3. A Brief History of ADHD

In 1902, George Still, a British paediatrician first described a syndrome in which children were aggressive, defiant, resistant to discipline, excessively emotional or “passionate”, showing little “inhibitory volition”, lawless, impaired in attention, overactive, prone to accidents, and a threat to other children. According to Still, these children displayed a major, chronic “defect in moral control”.

Still made the then radical suggestion that bad parenting was not to blame; instead he suspected a subtle brain injury. This theory gained greater credence in the years following the 1917-18 epidemic of viral encephalitis, when doctors observed that the infection left some children with impaired attention, memory and control over their impulses. Since that time, the disorder has been given numerous names, including Minimal Brain Damage/Dysfunction, Hyperkinetic Reaction of Childhood, and Attention Deficit Disorder.

In 1937 a Rhode Island paediatrician reported that giving stimulants called amphetamines to children with these symptoms had the unexpected effect of calming them down. By the mid-1970s, Ritalin (Methylphenidate) had become the most prescribed drug for what was eventually termed, in 1987, Attention Deficit Hyperactivity Disorder. The current name reflects the importance of the inattention/distraction element of the disorder as well as the hyperactivity/impulsivity element.

There remains, however, a great deal of debate as to the prevalence of the disorder, with some clinicians arguing that in many cases the behavioural manifestations of the disorder can be explained in terms of learned patterns of behaviour rather than an organic brain disorder. European nations like France and England also report only one-tenth of the U.S. rate of ADHD and in Japan the disorder has barely been studied. It is possible, however, that these variations are due to different cultural, educational, health and diagnostic differences rather than a true disparity in the prevalence of the disorder.

4. The Impact of ADHD

ADHD (written by an 11 year old child with ADHD)

Having ADHD in school without medication is very upsetting because you get picked on a lot; you get frustrated with everything you do. Sometimes it feels so annoying that you feel like you're going to cry. If people know a lot about your behaviour problem or ADHD problem they will do it all the more, so it is best not to let them know about it.

Having ADHD at home is hard to understand, you get wrong almost every day of the week. Mostly you can't remember what you have done. Without medication you will find it quite hard to control your behaviour.

Now that I'm on medication I feel much more confident in doing my school work and I don't get wrong as much at home.

From a parent of a child with ADHD

My child is now 9 years old. All through pre-school, reception and Key Stage 1 he was labelled simply as a naughty boy. Then, when he reached Key Stage 2, his teacher asked if we had considered having him assessed for ADHD. By the time my son had been diagnosed with ADHD a lot of damage had been done and my son had very little self-esteem and self worth and hated school.

Following a change of school and starting on Ritalin my son's life changed. The school took time to understand his problems and wanted to learn about ADHD.

A good relationship between home and school is vital. I work very hard with my son's teacher and as a result I'm not frightened to talk to her and she is happy to talk about any problems with me. Now he loves school and has received numerous certificates for various things from behaviour to good work in the class.

I let people know about my son's condition, not so I can make excuses when things go wrong, which they do from time to time, but so everyone can see past the ADHD and see my son for the child he is.

From a parent of a child with ADHD

My son is now 11 years old. Since he has been 2 years old I have known from the bottom of my heart there was something different about him.

He used to go through the house like a tornado; it was like waiting for a bomb to explode. His mood swings were atrocious, one minute he would be fine, the next minute he would be like a raging bull. This sort of behaviour could be caused by something as simple as not being able to open a bottle of juice.

Things got so bad that before talking to him I would think to myself “am I going to get a nice answer or get a nasty snarling answer “. We tried everything from monitoring his diet to star charts with rewards but nothing worked. For 7 years the family was in turmoil and as a parent I began to think that I had done something wrong in the way we had brought him up.

He had a battle all the way through school. He was classed as a naughty boy and took the blame for things he didn't do. I would often get phone calls from school for me to go and get him.

Then I read an article in the local newspaper about children with behaviour problems and it described my son down to a tee. I took medical advice and they started to look into his behaviour problems. He was given the diagnosis of ADHD and two weeks later he started medication called Ritalin. There was a dramatic improvement in his behaviour, he was able to complete all of his tasks at school, his social skills have improved and he has a lot more friends.

Home life has improved, my family now feels complete and things are much calmer and happier.

5. What Causes ADHD

While the exact cause of ADHD is as yet unknown, it is generally accepted that it is likely to be biological in nature. A great deal of scientific and medical research has identified a number of factors which appear to influence its development.

An imbalance in chemicals which are used to transmit messages (neurotransmitters) between cells in the brain (neurones)

Some stimulants, such as Ritalin (methylphenidate), have the unexpected effect of calming children down and have become widely used in the treatment of children with ADHD. This type of medication works through stimulating the release of neurotransmitters, which are used by the brain to allow communication between neurones. The powerful effect of medication as well as other evidence suggests that ADHD may result from dysfunction in neuronal communication.

Genetic influence

A great deal of research suggests that genetics play a major role in ADHD. Between 10% and 35% of children with ADHD have an immediate relative with past or present ADHD and approximately half of parents who have been diagnosed with ADHD themselves, will have a child with the disorder. Studies of twins have also shown ADHD to be more likely to occur in identical twins (who share the same genes) than non-identical twins (whose genes are no more similar than ordinary children, but who share the similar environments)

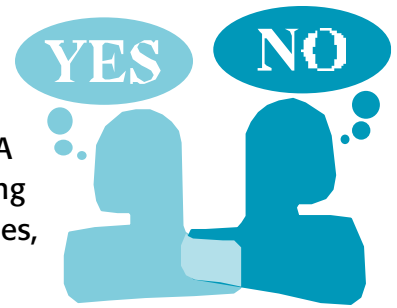


Dysfunction within areas of the brain which regulate attention, impulsivity and emotions.

Recent models describing what is happening in the brains of people with ADHD suggest a number of areas of the brain are affected by the disorder, each of which is associated with various functions. The 3 main areas that have been implicated are:

1. *The frontal lobes:* this area normally helps us pay attention to tasks, focus concentration, make good decisions, plan ahead, learn and remember what we have learned, and behave appropriately for a given situation.
2. *The inhibitory mechanisms of the cortex:* these mechanisms normally help us inhibit our behaviour which keeps us from being hyperactive, saying things out of turn, and from getting angry at inappropriate times.

3. *The limbic system:* This area is the basis of our emotions helping us to react quickly to situations (e.g. danger). If over-activated or over-aroused, a person may have severe mood swings, temper outbursts, and be easily startled or hyper-vigilant. A dysfunctional limbic system produces widely fluctuating emotional changes and levels of energy, disturbed sleep routines, and difficulty coping with stress



Dysfunction may affect one, two, or all three of these areas, resulting in different “profiles” of children (and adults) with the disorder and can help explain why Attention Deficit can occur with or without hyperactivity.

Other factors include exposure to toxins (e.g. lead), complications during pregnancy (e.g. oxygen deprivation) and low birth weight. Low levels of Omega-3 essential fatty acids have also been implicated in the development of ADHD.

Although there is evidence that the factors mentioned above influence the development of ADHD there is still a great deal more research required in order to establish the extent and significance of these and other factors.

6. Other Factors which Influence how Children with ADHD Behave

Although there is a great deal of evidence which points towards the biological basis of ADHD, it is important not to lose sight of the impact which other factors have on how a child copes with the disorder. Each child is unique and exists within a complex system of environmental (external), psychological and biological (internal) influences and it is the interaction of these that determines their behaviour in a given situation.

EXTERNAL/ENVIRONMENTAL INFLUENCES			
Life Events	Home/Care	School	Culture
<i>For example</i> <ul style="list-style-type: none"> ● Bereavement ● Changes in family structure ● Changes of school ● Critical incidents 	<i>For example</i> <ul style="list-style-type: none"> ● Parenting skills ● Home environment ● Family structure ● Family expectations ● Attitudes & understanding ● Relationship with school 	<i>For example</i> <ul style="list-style-type: none"> ● School ethos ● Teaching style ● Classroom management ● Class size ● Teacher expectations ● Attitudes & understanding ● Appropriate materials and activities ● Relationship with family/carer 	<i>For example</i> <ul style="list-style-type: none"> ● Society ● Peers ● Ethnicity



<ul style="list-style-type: none"> ● DISTRACTIBILITY/INATTENTION 	ADHD	<ul style="list-style-type: none"> ● IMPULSIVITY ● HYPERACTIVITY
--	-------------	--



INTERNAL INFLUENCES	
Psychological Characteristics	Other Neurological/Biological Influences
<i>For example</i> <ul style="list-style-type: none"> ● Motivation ● Personal style ● Emotional state (e.g. depressed, anxious) ● The child's views ● Developmental history ● Cognitive functioning ● Communication difficulties ● Learning difficulties ● Educational achievements 	<i>For example</i> <ul style="list-style-type: none"> ● Age ● Gender ● Genetic factors ● Hearing ● Vision ● Chronic illness ● Trauma ● Medication

Adapted from: ADHD: A Psychological Response to an Evolving Concept. Report of a Working Party of the British Psychological Society (1996).

7. Assessment/Diagnosis

Given the uncertainties that still surround the underlying cause of ADHD, and the complex nature of factors which can influence the disorder the diagnosis must be given with caution and only after a comprehensive assessment by specialists. **Part 6.** outlined factors which could impact on the presentation of a child with ADHD. However, any combination of these factors alone could also result in a child showing problems very similar in nature to those of a child with ADHD. The influence of environmental, psychological and biological factors on a child's behaviour must therefore, be fully assessed and discounted before ADHD can be confirmed as the primary factor in their difficulties.

The complexity of the diagnosis makes it essential that assessment is carried out by professionals (e.g. psychiatrist and psychologist) with specialist training. Assessment involves the collection of as much information as possible about all aspects of the child's life from the people who know them best (e.g. parents/carers, other family members, school, and the child themselves). This is often carried out within the context of a team of professionals from different disciplines (e.g. psychiatry, psychology, social work, occupational therapy and nursing). The information helps provide an understanding of how the child is functioning in various aspects of their life (e.g. at school and home), the characteristic of the problem and how long the difficulties have existed and helps rule out other possible explanations.

For a diagnosis to be made the following characteristics must be present;

A. Either (1) or (2):

1. Six or more of the following symptoms of inattention have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

INATTENTION

- (a) Often fails to give close attention to details or makes careless mistakes in schoolwork, work or other activities
- (b) Often has difficulty in sustaining attention in tasks or play activities
- (c) Often does not seem to listen when spoken to directly
- (d) Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behaviour or failure to understand instructions)
- (e) Often has difficulty organising task and activities
- (f) Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
- (g) Often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)
- (h) Is often easily distracted by extraneous stimuli
- (i) Is often forgetful in daily activities

2. Six (or more) of the following symptoms of hyperactivity-impulsivity have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

HYPERACTIVITY

- (a) Often fidgets with hands or feet or squirms in seat
- (b) Often leaves seat in classroom or in other situations in which remaining seated is expected
- (c) Often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
- (d) Often has difficulty playing or engaging in leisure activities quietly
- (e) Is often 'on the go' or often acts as if 'driven by a motor'
- (f) Often talks excessively

IMPULSIVITY

- (g) Often blurts out answers before questions have been completed
- (h) Often has difficulty awaiting turn
- (i) Often interrupts or intrudes on others (e.g., butts into conversations or games)

B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years.

C. Some impairment from the symptoms is present in two or more settings (e.g., at school [at work] and at home).

D. There must be clear evidence of clinically significant impairment in school, academic or occupational functioning.

E. The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g. Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

American Psychiatric Association (1994) Diagnostic and Statistical manual of Mental Disorders (4th Ed.) Washington, D. C.

8. Interventions

(i) What is Ritalin (Methylphenidate)?

Ritalin is the most well known of a number of Central Nervous System (brain & spinal cord) stimulants, which have been found to be effective in the treatment of ADHD. It has effects similar to, but more potent than, caffeine and less potent than amphetamines and cocaine. Ritalin is the name given to the drug/chemical Methylphenidate by its developers, the CIBA-Geigy Corporation.



How does the drug work?

Although the exact mechanism by which the drug works is still unclear it is believed that methylphenidate amplifies the release of dopamine, a naturally occurring chemical (neurotransmitter) within the brain. Dopamine is one of many different types of neurotransmitters which interact in complex ways enabling cells in the brain to communicate. One of the functions of dopamine is to moderate attention and the ability to focus. It is believed that children with ADHD have weak dopamine signals and that the drug acts to enhance these signals and thus improve attention and concentration.

Are there any side effects?

Dopamine does not, however, have a single role in the Central Nervous System (i.e. moderate attention and concentration), and nor does methylphenidate act specifically on the dopamine system. This results in the possibility of unwanted effects of the drug on other systems or unwanted effects as a result of overactivity of the dopamine system. These unwanted effects are referred to as side effects and a number have been identified. It is important to remember, however, that each individual reacts differently to the drug; some will have no noticeable side effects, others minor side effects and only a small proportion will have side effects which will require them to stop taking the drug. The main identified side effects are: insomnia or trouble sleeping; nightmares; daydreaming; becoming uninterested in others; decreased appetite; irritability; stomach aches and headaches (especially early in treatment); sadness/unhappiness; anxiety; tics or nervous movements. If there are concerns about side effects while the child is at school these should be discussed with the parent/carer.

What are the benefits of the drug?

The effect of Methylphenidate varies from individual to individual but has been shown potentially to improve all the defining symptoms of ADHD (Inattention, impulsivity, hyperactivity) and associated aggressiveness. Improvement in any of these symptoms can then have a secondary impact on other difficulties associated with the disorder such as improved self-esteem, mood and social skills.

Drug Administration

Methylphenidate, in its usual form, has a short half-life (the time it takes for the drug concentration in the body to decrease by half) as it is broken down quickly by the body. It therefore needs to be administered 2 to 3 times per day. Doses are normally given either morning, lunchtime or before 4pm. A second form of Methylphenidate, called Concerta, is long acting and only has to be taken once a day.

Can it be abused?

Methylphenidate is a valuable medicine and research has shown that people with ADHD do not become addicted to stimulant medications when taken in the form prescribed and at treatment dosages. Because of its stimulant properties, however, in recent years there have been reports of abuse of methylphenidate by people for whom it is not a medication. It is generally abused for its stimulant effects such as, appetite suppression, wakefulness, increased focus/attentiveness and euphoria.

(ii) Behaviour modification at home

In common with all children, the behaviour of a child with ADHD is greatly influenced by their interactions with others (e.g. family and peers). The fact that they may be on medication does not change this. It is important, therefore, that, along with medication, these interactions are assessed (e.g. how do parents respond to tantrums) and if necessary the family are helped to find ways to improve their child's behaviour by modifying the manner in which they interact. This booklet does not deal with this in any detail but it is important that it is addressed by the family in order to provide the child with consistency of acceptable behaviour both at school and at home. Advice on management of children with ADHD at home can be accessed through The Gateshead Child and Family Unit at the Queen Elizabeth Hospital.

(iii) Managing ADHD at school

As with behaviour at home the behaviour of a child at school even when taking medication is to a large degree determined by the way people interact with them as well as their physical environment. The aim of this booklet is to provide guidance on how best to interact with children with ADHD and also how best to structure their lessons and environment to maximise their potential and reduce the risk of disturbance to the rest of the class.

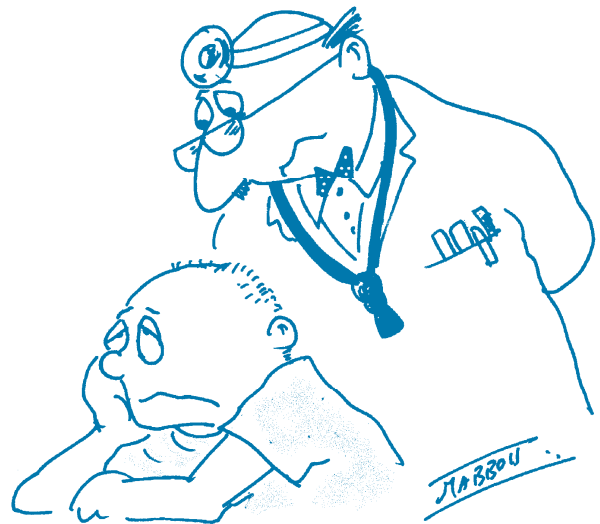
(iv) Social skills work

By the time a child is recognised as having ADHD they may already be lacking in social skills when compared to their peers. This is largely as a result of difficulties they experience in interacting with their peers. Even following diagnosis, difficulties may remain and the fact that they have missed out on the early development of basic social skills makes the development of further social skills even more difficult. Assistance can be given at home and at school (see Part 12 (9)) to help the child learn these basic social skills and thereby catch up with their peers.

9. How might a child with ADHD feel at school?

The difficulties children with ADHD have at school and the reactions of others to them might cause them to feel;

- Demoralised and a failure
- Isolated and lonely
- As though they are always being singled out
- Confused by what goes on around them
- Unable to understand the feelings of others
- Unable to understand the reactions of others towards them
- Unable to understand the consequences of their actions
- As though school is hostile towards them
- Anxious about going to school



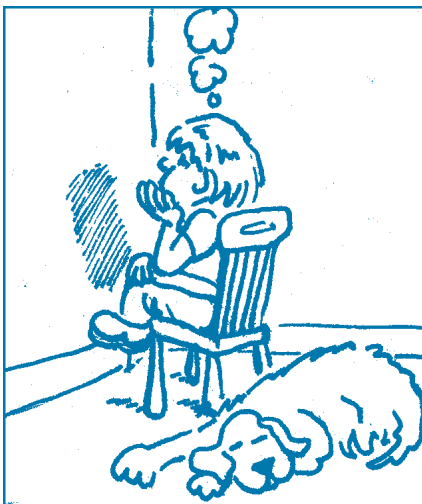
© Chris Mabbott 2001

10. How does a child with ADHD behave in the classroom?

The classroom behaviour of children with ADHD can be marked by any combination of the following:

Inattention/Distractibility

- Easily distracted by things going on around them
- Often appearing not to be paying attention or listening when spoken to
- Very short attention/concentration span
- Working in a careless or casual manner, paying little attention to detail or accuracy
- Seldom completing tasks
- Finding it difficult to follow instructions
- Avoiding tasks which require sustained mental effort
- Often losing or forgetting things (pencils, books, assignment, etc)
- Having difficulty with tasks which are unstructured or involve little supervision
- Often seeming to be day dreaming



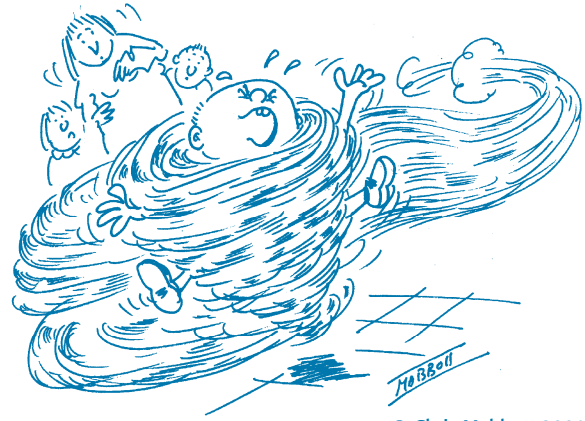
"By the time I think about what I'm GONNA do...I've already done it!"

Impulsivity

- Seeming to do things without thinking
- Seeming to be afraid of nothing and not learning from their mistakes
- Seeming to be deliberately disobedient
- Interrupting others and intruding on their activities
- Blurting out answers before questions have been completed
- Talking excessively
- Lacking appropriate responses to social demands or norms
- Showing aggressiveness towards classmates
- Bothering classmates by chatting to them or by distracting them from their work
- Having difficulty waiting for their turn

Hyperactivity (often the most obvious symptom)

- Frequently out of seat in class
- Unable to work or play quietly
- Fidgeting or squirming in their seat
- Always “on the go”, rushing round the room
- Persistent overactivity which is not moderated by social demands



© Chris Mabbott 2001

11. The effect of having ADHD on peer relationships and social skills

The development of friendships during childhood serves not only as a rewarding and enjoyable experience but also acts to provide the building blocks for future social skill development needed to establish and maintain relationships throughout life. The development of friendships during childhood is largely achieved through play. Studies have shown 80% of parents of children with ADHD reported their children as having serious problems playing with other children compared to 10% of parents of children without ADHD. Unfortunately, children with ADHD are least able to cope with the frustration of peer rejection and often a vicious circle develops. In response to rejection the child attempts to exert more control over other children, which results in further rejection. Children with ADHD have a number of problems which make it difficult to make friends, including:

- Having great difficulty picking up other's social cues, and often acting impulsively.
- Having little awareness of their effect on others.
- Over-personalising other's actions as being criticism.
- Not recognising or responding well to positive feedback.
- Often getting along better with younger or older students where their roles may be more clearly defined.
- Tending to repeat self-defeating social behaviour patterns and rarely learning from experience.
- Often rambling in conversations and saying embarrassing things to peers.
- Tending to get into trouble during times with little structure or supervision.
- Having difficulty with turn-taking.
- Tending to be frustrated easily during games or activities and often losing their temper.

12. Strategies to help children with ADHD in school

The characteristic problems experienced by children with ADHD often lead to an education which is characterised by underachievement and behavioural difficulties which are not only detrimental to them but can also be disruptive to others. There are relatively simple strategies that can help the teacher maximise the potential of the child and reduce the chance of disruptions.

The difficulties faced by each child with ADHD will, however, be unique to that individual and, as a result, some strategies will work better for some individuals and others will work better for others. To some degree a process of trial and error may, therefore, be necessary to discover which strategies best suit the individual.

1. Managing Inattention/Distractibility

- Seat in quiet area.
- Seat near the teacher (or stand near them when giving instructions).
- Seat child near good role model.
- Reduce distractions from computers and other equipment with audio functions or use designated work areas with earphones.
- Increase distance between desks.
- Give private, discrete cues to child to stay on task.
- Cue the child in advance before calling on him, and cue before an important point is about to be made (example: "This is a major point.").
- Instruct child in self-monitoring using cueing.
- Give short instructions and avoid lists of things to be done.
- Allow the child to begin an assignment and then go to the teacher after the first few problems are done.
- Modify classroom and homework assignments to match attention span (for example: have the child use a timer and draw a line across their homework page at the end of 15 minutes of sustained work).
- Incorporate activities which the child enjoys or is interested in. They can concentrate better on these activities, just like anyone else.
- Minimise movement around the room, by ensuring necessary equipment is at hand.

2. Managing Impulsivity

- Ignore minor, inappropriate behaviour.
- Increase immediacy of rewards and consequences.
- Use time-out procedure for misbehaviour.
- Plan supervision during transitions (subjects, classes, lunchroom, assemblies, etc).
- Think ahead, plan for potential problems and explain what is expected of the child in each situation.
- Use “prudent” reprimands for misbehaviour (e.g.. avoid lecturing or criticism).
- Attend to positive behaviour with compliments and plenty of attention
- Seat near role model or near teacher.
- Set up behaviour contract.
- Instruct in self-monitoring of behaviour, i.e. hand raising, calling out.
- Call on only when hand is raised in appropriate manner.
- Praise when hand is raised to answer question.

3. Managing Hyperactivity

- Ensure the child gets the opportunity for plenty of exercise to work off excess energy.
- Give the opportunity of breaks from sitting still by allowing the child to take a break in an acceptable way (e.g. run errands, wash the blackboard, get a drink of water.)
- Provide short break between assignments.
- Plan supervision during transitions (between subjects, classes, lunchtime, assemblies, etc).
- Remind the child to check over their work.
- Make sure the child always has their daily breaks. Don’t withdraw them as a punishment.
- Use feedback that helps the child become self-observant and give information in a constructive way. For example, ask questions like, “ do you know what you just did”, “how do you think you might you have said that differently” or “why do you think that other girl looked sad when you said what you did”.
- Allow the child to play with small objects kept in their desks that can be manipulated quietly, such as a soft squeeze ball.
- Keep alert for signs of over-stimulation.

4. Organisation and planning of work

- Give clear, concise instructions, pairing written with oral instructions.
- Give short instructions and avoid lists of things to be done and allow adequate time to give instructions (avoid rushing at the end of a session).
- Give assignments one at a time to avoid overload.
- Provide a consistent, predictable schedule (Post the schedule in the classroom or on the inside of their desk or other personal space).
- Provide regular guidance and appropriate supervision on planning assignments (model examples of how to plan).
- Provide the child with a homework assignment book and supervise writing down of homework assignments.
- Review instructions when giving new assignments to make sure of understanding.
- Allow tape recording of assignments or homework.
- Allow plenty of time for oral answers and extra time to complete written work.
- Break long assignments into smaller parts so the child can easily see the end of the work (dividing into “mini-assignments”).
- Provide reinforcement and the opportunities for feedback at the end of each “mini-assignment”.
- Let parents know the timetable and ask for parental help in encouraging organisation.
- Send daily/weekly progress reports home.
- Meet with parents regularly; avoid just meeting around problems or crisis.
- Prepare for changes in routine (field trips, transitions from one activity to another, etc).
- Plan supervision during transitions (between subjects, classes, playtime, lunchtime, assemblies, etc).
- Encourage the use of notebooks with dividers.
- Provide peer assistance in note taking.
- Regularly check the child’s desk and notebook, encouraging neatness rather than penalising sloppiness.
- Encourage learning of keyboarding skills.

5. Encouraging academic skills

- Provide a weekly syllabus, in advance.
- Provide assistance/guidance to the child in how to use a planner on a daily basis and for long-term assignments; help the child plan how to break larger assignments into smaller, more manageable tasks.
- Teach the child efficient methods of proof-reading own work.
- Teach the child how to scan a large text chapter for key information, and how to highlight important selections.
- Teach the child how to identify key words, phrases, operations signs in maths.
- Write down key words on the board to aid in note taking during sections that are “lecture-based.”
- Help the child set up a system of organisation using colour coding by subject area.
- Focus on quality rather than quantity of work. Reduce the workload while trying to ensure underlying concepts are learned
- If reading is weak:
 - Provide additional reading time
 - Use “previewing” strategies
 - Select text with less on a page
 - Shorten amount of required reading
 - Avoid oral reading
- If oral expression is weak:
 - Encourage child to tell about new ideas or experiences
 - Pick topics easy for child to talk about
- If written language is weak:
 - Accept non-written forms for reports (e.g. displays; oral responses; projects)
 - Accept use of word processor and tape recorder
 - Avoid assigning large quantity of written work
 - Test with multiple choice or fill-in questions
- If maths is weak:
 - Allow use of calculator
 - Use graph paper to space numbers
 - Provide additional maths time
 - Provide immediate correctness feedback and instruction via modelling of the correct procedure



6. Maximising potential for success in assessment

- Type tests using large type.
- Keep pages simple with as little distracting information as possible.
- Put the instructions next to the questions to which they relate.
- Before tests, provide the child with information, in writing if necessary, about what will be on the test.
- Allow tests to be taken in a quiet place.
- Allow more time to complete tests, exams and other skill assessments when needed.



7. Encouraging positive behaviour

- Designate one teacher as the co-ordinator for the child and the implementation of the management plan.
- The co-ordinator should periodically review the management plan and act as the link between home and school.
- Work with family/carer to co-ordinate efforts to target behaviours which are a particular problem at any give time.
- Permit the child to check-in with this co-ordinator first thing each week (Monday mornings) to plan/organise the week and last thing each week (Friday afternoons) to review the week and to plan/organise homework for the weekend.
- Seat child near teacher.
- Set up behaviour contract which clearly states rules, expectations and the consequences of breaking the rules.
- Work out a reward system by negotiation with the child.
- Provide immediate feedback.
- Praise in public, reprimand in private.
- Praise good behaviour.
- Use teacher attention to reinforce positive behaviour.
- Ignore minor misbehaviour.

- Use “prudent” reprimands for misbehaviour (i.e. avoid lecturing or criticism).
- Plan supervision during transitions - between subjects, classes, play time, lunchtime, assemblies, etc.
- Instruct in self-monitoring of behaviour.
- Support the formation of study groups, and the child seeking assistance from peers, encourage collaboration among students.

8. Improving mood and self-esteem

- Provide reassurance and encouragement.
- Give praise and rewards for small achievements and efforts and ignore as much of their misbehaviour as possible.
- Frequently compliment positive behaviour and work.
- Speak softly in non-threatening manner.
- Look for opportunities for the child to display leadership role in class.
- Send positive notes home.
- Make time to talk alone with the child.
- Encourage social interactions with classmates.
- Reinforce frequently when signs of frustration are noticed.
- Look for signs of stress build up and provide encouragement or reduced workload to alleviate pressure.
- Provide brief training in anger control: encourage the child to walk away; use calming self-talk; tell nearby adult if getting angry.
- Share good news with parents/carer.

9. Improving Social Skills

- Praise appropriate behaviour.
- Monitor social interactions.
- Set up social behaviour goals and implement a reward program.
- Prompt appropriate social behaviour either verbally or with private signal.

- Encourage co-operative learning tasks with other pupils.
- Provide small group social skills training.
- Praise frequently.
- Praise in public, reprimand in private.



- Assign special responsibilities to the child in presence of peer group so others observe them in a positive light.
- Avoid bringing attention the child's different needs in front of his peers.
- Use guided observation of peers in the playground. Point out the way other children initiate activities, cooperate in games, respond to rejection, deal with being alone, etc.
- Try role playing situations with the child.
- Try to encourage participation in clubs and activities.

13. Resources in the Gateshead Region

Child & Family Unit (Gateshead Health)

Provides a specialist service for children and their families where there are worries about a child's development, behaviour and or, emotions. This includes a multidisciplinary approach to the assessment and treatment of ADHD.

Referrals can be made by family doctors or other professionals involved with the child.

Contact: Queen Elizabeth Hospital, Sheriff Hill, Gateshead. Tel: 0191 403 2417

Educational Psychology Service (Gateshead Council)

Provides an educational psychology service to schools, children, young people and parents in Gateshead. This includes providing support and guidance for parents and teachers in relation to learning, emotional and behavioural needs of children and young people who are experiencing difficulties in their educational or personal development.

Referrals are normally agreed after discussion between the school's SEN Coordinator and its psychologist but, exceptionally, parents and others may make referrals by direct contact with the service.

Contact: Psychological Service, Dryden Road Professional Development Centre, Evistones Road, Gateshead NE9 5UA. Tel: 0191 433 8550

Behaviour Support Service (Gateshead Council)

Provides behavioural support to schools in Gateshead. This includes direct work with children and young people who are experiencing difficulties in coping with the behavioural expectations of schools, for instance, as a result of ADHD.

Referrals can be made by schools

Contact: Behaviour Support Service, Millway Centre, Millway, Gateshead. Tel: 0191 420 0606

Whickham ADHD Support Group

For parents/carers of children with ADHD.

Meets every Thursday between 1.00pm and 3.00pm only during term time.

At Whickham Health Centre (off Priory Road)

Contact: 0191 496 0361

ADHD Support Group North East

14 Norham Court, Oxclose, Washington, Tyne & Wear, NE38 0JJ

Telephone 01642 4192295

Gateshead Carers Association

Offers a confidential support and information service to carers and those working with carers. Available from 10.00am to 3.00pm Monday to Friday on 0191 478 3502 (answer phone is available at all other times).

Contact: 0191 487 2224

14. The following sources were used in the development of this booklet:

- **ADHD: A Psychological Response to an Evolving Concept.** Report of a Working Party of the British Psychological Society (199).
- **Attention Deficit Hyperactivity Disorder (ADHD): Information and Guidelines for schools.** Bexley Council with Oxleas NHS Trust.
- Dr Harvey C. Parker. **ADAPT: Attention Deficit Accommodation Plan for Teaching**
- Sam Goldstein, Michael Goldstein (1992). **Hyperactivity: why won't my child pay attention.** John Wiley & son, Inc, Chichester.
- Christopher Green, Kit Chee (1997). **Understanding ADHD: a parents guide to attention deficit hyperactivity disorder in children.** Vermillion, London.
- Dr Edward M. Hallowell, & Dr John J. Ratey (1992). **50 Tips on the management of Attention Deficit Hyperactivity Disorder in the Classroom.** At <http://member.aol.com/BevKPrice/HTML/web37.html>
- <http://www.add.org>
- <http://www.miningco.com/health/add>
- <http://www.addinschool.com>
- <http://www.addresource.com>
- <http://www.nimh.nih.gov/publicat/adhd.cfm>
- <http://www.pavilion.co.uk/add/>

Produced by David Millar as part of submitted work for the Doctorate in Clinical Psychology, University of Newcastle. Supervised by Jessica Brown.

