



# Attention Deficit/Hyperactivity Disorder (AD/HD)

## Information and Guidelines for Schools

April 2007



## Introduction

These guidelines have been produced by the Milton Keynes Learning and Development Psychological Service in consultation with the Departments of Child Health and Child and Adolescent Psychiatry (DCAP).

They are designed to provide information for staff working in Milton Keynes Schools about pupils who are inattentive, and/or overactive and impulsive. Guidance is offered about the identification, assessment and management of the needs of such pupils.

It is intended that teachers will be able to use this booklet to complement the professional expertise and experience they bring to the management of children's learning, motivation and behaviour. Part 3, which describes classroom management strategies, is intended as a photocopiable resource for teachers and support staff.

These guidelines were originally produced in September 2000. The Milton Keynes Psychological Service, again in consultation with the Departments of Child and Adolescent Psychiatry and Child Health, reviewed these guidelines in 2005/6. This has resulted in some minor changes and updating. As part of this review we requested feedback from teachers about the document. This resulted in high positive teacher ratings for usefulness and for clarity of presentation, confirming our view that this revised publication would be of value to schools.

## Part 1 What is AD/HD?

The concept of Attention Deficit/Hyperactivity Disorder is used to describe a clinical condition in which the child exhibits long term difficulties that include inattention and/or hyperactivity and impulsiveness

**Attention Difficulties** are manifested by children being easily distracted both in task and in play activities. They often find it very difficult to complete a school task, appearing inattentive, forgetful and disorganised.

**Hyperactivity** is manifested by children showing high levels of restlessness, fidgeting and movement. They tend to be continually on the go, often noisy and talkative.

**Impulsivity** is manifested by children who lack reflection before action, as shown by children having a tendency to interrupt conversations, talk out of turn and having difficulties in waiting for their turn.

For the label to be correctly used, such behaviours need to:

- last for longer than six months
- have been present before the age of seven
- have significant functional impairment, and
- be evident in more than one setting; for example at home and at school

Only if these conditions are met, can the AD/HD label be used correctly.

Distinctions are made between children who show significant difficulties in attention and those who in addition show difficulties with impulsivity and high levels of over activity. The former are described as having an attention deficit disorder (ADD) and the latter as having an attention deficit/hyperactivity disorder (AD/HD). In this booklet the expression AD/HD is used to encompass both types.

It should also be noted that children may have difficulties maintaining attention, controlling their own behaviour and inhibiting impulses for a number of different reasons. Such difficulties are more likely to be seen, for example, if a child has difficulty understanding work they are required to do or if they have a raised level of anxiety. It is therefore important that assessment looks at the child and their situation holistically, attending to the range of possible underlying issues that may show up in restless, impulsive and inattentive behaviour.

**Co-existing/secondary difficulties:** Attention Deficit/Hyper-Activity Disorder behaviours may well co-exist with, or lead on to, other difficulties for a child with AD/HD. It should be emphasised that these are not core aspects of, or evidence for, AD/HD.

### **Emotional:**

- May feel socially isolated, unpopular with other children
- May feel different or misunderstood
- May be affected by frequent telling off
- May be labelled lazy, disobedient, naughty etc.
- May lose self-confidence

### **Learning:**

- Not accessing teaching because of inability to concentrate, listen, stay with set task
- Not remembering because of inability to organise in their mind what has been learned
- May have particular difficulties with literacy, numeracy or language skills

### **Behaviour:**

- May become disruptive, defiant or aggressive
- May seek popularity with peers through misbehaviour
- May use misbehaviour to mask attentional problems and underachievement

## Part 2 AD/HD as a special educational need

Where a child's difficulties affect their capacity to benefit from opportunities to make satisfactory educational progress, AD/HD is best regarded by the school as a form of special educational need. The DfES' Special Educational Needs Code of Practice provides a structure for schools to address children's particular difficulties. As reflected in the **Code of Practice**, special educational needs are not restricted to problems with academic ability, literacy or numeracy. They embrace a wide range of circumstances including emotional, behavioural and health issues. An individual child can therefore have several areas of special educational need, of which AD/HD may be identified as one.

All Milton Keynes Schools work to the Code of Practice and to Milton Keynes Council's guidelines for identifying and assessing children's special educational needs, irrespective of the source of concern.

For many children with difficulties related to AD/HD, their educational needs will be met by their schools, under their internal special needs resources, using the sorts of management techniques which will be outlined in this booklet. Where a school feels that the measures they have adopted are not meeting the pupils' needs, they may wish to seek external support. ***This includes requesting a consultation with their link educational psychologist, the Special Educational Needs and Disability Inclusion Service (SENDIS) or the Behaviour Support Team.***

Children who do not show the hyperactivity component of AD/HD tend to be overly placid, lethargic, prone to daydream and sometimes anxious. As they frequently go unnoticed in comparison with other more disruptive behaviours, it is important that schools are vigilant to make sure that their needs are recognised.

Early identification is important for all children with learning difficulties including those with AD/HD. An observation checklist has been included in the appendices to aid school staff in their observations and provide a focus for their strategies. We recommend that this is completed and used with the link EP.

***It is the degree of severity of a pupil's emotional and behavioural difficulties and the impact on learning that determines the appropriateness, or not, of proceeding through the Code of Practice. This is more important for deciding an educational intervention or provision than whether or not someone has given a label or diagnosis. AD/HD is like most other developmental disorders in that the difficulties range from mild to severe.***

### Parental Involvement

As in any area of special education need, close partnership between parents/carers and school is essential in helping a child. This is particularly important in the case of AD/HD to prevent misunderstandings or breakdown in working relationships in the sensitive area of children's school behaviour. The aims of parent partnership in AD/HD should be:

1. to share information on the child's circumstances in school and at home that might be relevant to behaviours associated with AD/HD
2. to share knowledge about what works
3. to promote a spirit of 'shared care' for the child, avoiding any sense of allocation of blame for the child's behaviours
4. to agree a plan of action to help the child
5. to monitor, evaluate and review the agreed plan of action

### Involvement of Other Agencies

As a teacher you will encounter situations where the parents have sought advice from their GP. They in turn may have referred on to a Paediatrician in the Department of Child Health or the Department of Child and Adolescent Psychiatry. These services may request information from schools as part of an initial or ongoing assessment. This may involve usage of standardised assessment tools, such as the Conners' Rating Scale.

Where significant problems continue both at home and school and appropriate intervention either at home or school has proven unsuccessful, a medical practitioner with expertise in AD/HD may decide to prescribe medication. The medical practitioner or parent should inform the school concerning any medication, and in order for any effects on the child's emotional, physical and behavioural state to be monitored, may request further information from the school.

Irrespective of initial referral routes, either from the school or from the family, it is essential that a common plan is agreed by the school, family and all external agencies involved. The Milton Keynes Learning and Development Psychological Service is committed to working together with health based professionals for the good of the child and family.

## Part 3 AD/HD: Management Strategies

The educational needs of AD/HD pupils are best met with good teaching and classroom management techniques that have relevance to all pupils. Pupils with AD/HD pose particular challenges to their teachers. Teachers will need to adapt the learning environment and their teaching styles to compensate for distractibility, limited organisational skills and low tolerance of frustration. In particular teachers will need to

- maintain eye contact during verbal instructions
- keep instructions short, clear and concise; break up long explanations and instructions into short and manageable elements
- check that students have listened
- repeat instructions in a calm, positive manner if required

Here are some practical ideas which may help you achieve any targets you have set. You are a skilled, experienced teacher, with your own preferred methods. Select the ideas that best sit with your own methods. You will probably think of many more yourself.

### 1. Physical Arrangement of the Classroom

- Sit the pupil near the teacher, as close as possible without being punitive or permanently isolated from other pupils.
- Avoid placing the pupil in a busy part of the classroom e.g. near the door/window/class library, where there would be most distractions: some pupils may like to work for short periods in a private quiet area.
- Remove distractions on and around the desk.
- Different seating arrangements may suit different activities for the pupil's group e.g. seated around desks, facing each other, for group projects; more traditional rows for independent work. You don't need to change the whole class: only the group with a pupil who has AD/HD related difficulties.

### 2. Classroom Organisation/Teaching Strategies

#### (a) for the whole class:

- Establish a daily classroom schedule.
- Make a few clearly stated rules and display them to ensure the pupils know what happens if these rules are kept or broken.
- Be clear about when pupil movement is permitted and when it is discouraged, such as during independent time.
- Show you value organisation by periodically allowing the children time to organise their desks.
- Give rewards for efforts to be tidy.
- When you give out instructions to the class, get their quiet attention first, then be clear and concise. Do not shout over a noisy class.
- Include a variety of activities and use a multi-sensory presentation if possible. Make sure teaching aids relate directly to the material to be learnt i.e. keep distractions to a minimum. Vary the type and duration of activities.
- A well ordered classroom helps everyone, but is especially important for the child with AD/HD.

#### (b) For the pupil with AD/HD:

- Using an individual or group work schedule i.e. a simple list (in the form of words or pictures, depending on age and literacy level) of the activities for the day or part of the day. Ticking off the completed task gives the pupil a feeling of structure and achievement.
- A similar schedule can be used within an individual assignment, showing the desired sequence of activities.
- Divide longer assignments into shorter chunks, with progress checks or encouragement in between. Try to decide what is currently a reasonable, achievable concentration period for the pupil on a particular task: you can lengthen it later. A kitchen timer (or other age appropriate prompt) can be used to keep the child reminded and motivated.
- Make a simple progress chart recording time spent 'on task' for a particular task (a timer makes this easier) so you and the pupil can see progress over time.
- Colour code exercise books etc. to make it easier for the pupil to locate the right books quickly when needed.
- Help the pupil from time to time to clear away unessential materials from his desk or bag and to organise what is left.
- Get the pupil's attention before presenting instructions. Try to maintain eye contact.
- Give one clear, short, simple instruction at a time.

- Make sure you give instructions in the order you want them carried out.
- When instructions have been given, check that the pupil knows exactly what to do.
- Actively involve the pupil in lesson presentation e.g. get him to write points on the board.
- Use a pupil's name to focus his attention on the lesson e.g. "Paul has some interesting books about....".
- Keep worksheets clear, simple and uncluttered.
- Use a home-school book to allow easy communication between yourself and the parents/carers.
- Agree checklist for parents to use in helping their child to bring to school only the necessary books for the day. These can also be used to help the pupil bring correct P.E. kit equipment etc.
- Ensure set homework is appropriate to the child's academic attainment and concentration span.
- Agree the amount of time to be spent on homework and monitor this through the home-school book.
- Use a clear homework notebook. The pupil may need help in using this.

### **3. Relating to the pupil with AD/HD**

- Show the pupil you understand their particular needs and are there to help. This will help their own situation better and will boost their self-confidence.
- Arrange a comfortable setting, away from other pupils, to talk to the pupil, listen to their views and let them express their feelings.
- Agree arrangements for particular situations e.g. tap on their desk to remind them to return to work (avoid giving verbal prompts that alert other pupils to their difficulties which can affect their self-confidence). When they are unsure of instructions which have been given to the class, or have forgotten them, encourage sitting with their hand up so that you can come to help.
- Keep a good supply of praise, encouragement and success with positive feedback. Keep in mind the areas of strength and interest that you recorded for the pupil.

### **4. Encouraging Friendships**

- The child who has poor self-confidence or self-image, self-organisation or co-ordination may have difficulty making and keeping friends.
- Such a child is also at increased risk of teasing or bullying.
- Show the class you value the child's strengths and interests.
- Avoid frequent public reprimands in class: this brings their weakness to the attention of potential bullies.
- Consider using peer support approaches to support the child, e.g. a buddy system.
- Arrange joint activities in class with likely friends.
- Think of structured activities e.g. computer games, with others (for the pupil who appears isolated or uninvolved at playtime).
- Check with support staff how the child is mixing in the playground, lunch etc.
- Suggest to parent/carer some after school activities/clubs etc. in the area, suitable to achieve the child's strengths/interests as useful social outlets.

### **5. Self-Help Strategies (for older pupils)**

For the older pupil, as well as support strategies previously described, consider introducing self-help strategies, so they can begin to learn ways of dealing with their own problem:

#### ***Lists***

- Tasks for the day; equipment needed for P.E.; book/materials needed for each subject area.
- You can prepare suitable 'tick lists' for the pupil.

#### ***Timetable***

- Ensure it is clear and uncluttered, with all necessary information e.g. times for each period; room numbers; even teacher's name, for each subject.

#### ***Note Taking***

- Taking notes while following a lesson requires concentration and organisation.
- If it is a problem, teach effective note taking, e.g. the use of diagrams, or bullet points.
- If necessary, arrange for lesson notes to be photocopied for the pupil.

- Show the pupil how to arrange and store well structured notes for revision and exam preparation.
- Some pupils may find it helpful to be able to tape-record information and instructions given during the lesson.

### **Writing**

- Essay writing depends on organisation and sequencing skills.
- Teach essay planning skills, presentation skills e.g. use of headings; topic list; skeleton-outline.
- Teach alternatives to essay type presentation e.g. note form; diagrams; bullet points.
- If handwriting is untidy, make arrangements for assignments to be completed on word processor.

## **6. Other Issues**

### **Behavioural Approaches**

Many of the interventions that have been described are derived from behavioural approaches. Most children respond very well to a positive approach to behaviour using rewards and praise for good behaviour. This is true of all children with attention difficulties and over-activity to varying degrees. For them, however, it appears that it may also be important to couple this with a response cost management strategy. For example, this may involve pupils losing tokens for specific undesirable behaviours. These seem to be the most effective. It is recommended that schools and teachers consult the Educational Psychology Service to ensure that behaviour principles are being applied correctly.

#### **ii) Educational Interventions**

The matching of the curriculum to the abilities and skill of the pupil is considered extremely important. The secondary effects of attention difficulties and over-activity are frequently very poor peer relationships, low academic attainments and a very poor self-image. So the sensitivity to failure and need for success tends to be high.

#### **iii) Counselling and Individual Therapy**

This can be used to help children to understand their emotions and behaviours and how to manage them. Some children may respond better in peer group situations.

#### **iv) Dietary Approaches**

Parents often feel that diet plays a role in their child's AD/HD. Current scientific evidence suggests that:

food allergies and intolerances can be important in some (but not all) cases

food additives and preservatives may have an impact on behaviour

A food diary is one way of trying to find out whether there is any link between behaviour and food in an individual child. Elimination diets (i.e. avoiding specific foods) are sometimes recommended by specialists, although these may in the end turn out to be effective for a minority of children only.

Fish oils are a more recent treatment. However, there is not enough evidence to recommend one way or another.

#### **v) Medication**

The medicines licensed in the UK for children with AD/HD are – Methylphenidate (Ritalin, Equasym, and Concerta), Dexamfetamine (Dexedrine), and Atomoxetine (Strattera). There are also some longer acting once-daily preparations of stimulants currently available in the UK (Concerta XL, Equasym XL). Depending on which preparation is prescribed, the effect of the medicine may last up to 4, 8 or 12 hours.

Methylphenidate has been proven to be effective in many clinical studies. This is frequently the first choice of medication made by specialist teams.

Dexamfetamine and methylphenidate belong to the same class of medicines called stimulants, and are controlled drugs. Sometimes, a child who does not respond to methylphenidate will respond to dexamfetamine.

For most children, the stimulants methylphenidate and dexamfetamine rapidly reduce the symptoms of AD/HD – the child should be less restless and aggressive, and have better concentration and self-control. However these benefits only last for the duration of the effect of the drug.

Atomoxetine acts in a slightly different way. It is a non-stimulant, non-controlled medicine, which works to relieve the core symptoms of AD/HD, namely hyperactivity, impulsiveness and inattention. It needs to be taken once daily and the effect may last continuously for 24 hours.

While these drugs frequently provide effective treatment they also have side effects.

Common side-effects of stimulants:

1. Sleeplessness – though this can be a symptom of AD/HD as well as a side effect of treatment
2. Reduced appetite
3. Nervousness and depressed mood – this is relatively uncommon
4. Tics and mannerisms can occur at any stage of treatment
5. Growth may be affected

Common side-effects of Atomoxetine:

1. Abdominal pain
2. Decreased appetite (with short-term weight loss in some patients)
3. Nausea and vomiting
4. Somnolence and fatigue
5. Possible effect on growth

Length of Treatment – This is not fixed in advance. It may need to continue for years and some adults are helped by medication.

Methylphenidate is a '**Controlled Drug**' – What does that Mean?

The following guideline is from DfES/D of H document on 'Managing Medicines in Schools and Early Years Settings':

1. The supply, possessions and administration of some medicines are controlled by the Misuse of Drugs Act and its associated regulations. Some may be prescribed as medication for use by children, e.g. methylphenidate.
2. Any member of staff may administer a controlled drug to the child for whom it has been prescribed. Staff administering medicine should do so in accordance with the prescriber's instructions.
3. A child who has been prescribed a controlled drug may legally have it in their possession. It is permissible for schools and settings to look after a controlled drug, where it is agreed that it will be administered to the child for whom it has been prescribed.
4. Schools and settings should keep controlled drugs in a locked non-portable container and only named staff should have access. A record should be kept for audit and safety purposes.
5. A controlled drug, as with all medicines, should be returned to the parent when no longer required to arrange for safe disposal (by returning the unwanted supply to the local pharmacy). If this is not possible, it should be returned to the dispensing pharmacist (details should be on the label).
6. Misuse of a controlled drug, such as passing it to another child for use, is an offence. Schools should have a policy in place for dealing with drug misuse.

**Medication frequently reduces some of the problem behaviours and creates an opportunity for learning through effective parenting and structured teaching. In other words, medication does not teach new skills, but it may provide a window of opportunity for learning to take place.**



## Appendix 1

### A Either 1 or 2:

Features of AD/HD include the following:

#### 1. Inattention

- (a) often fails to give close attention to details or makes careless mistakes in schoolwork, or other activities
- (b) often has difficulty 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 tasks 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. Hyperactivity-impulsivity

##### 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 where it is appropriate (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 if driven by a motor
- (f) often talks excessively

#### 3. 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 symptoms that cause impairment were present before age seven.

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

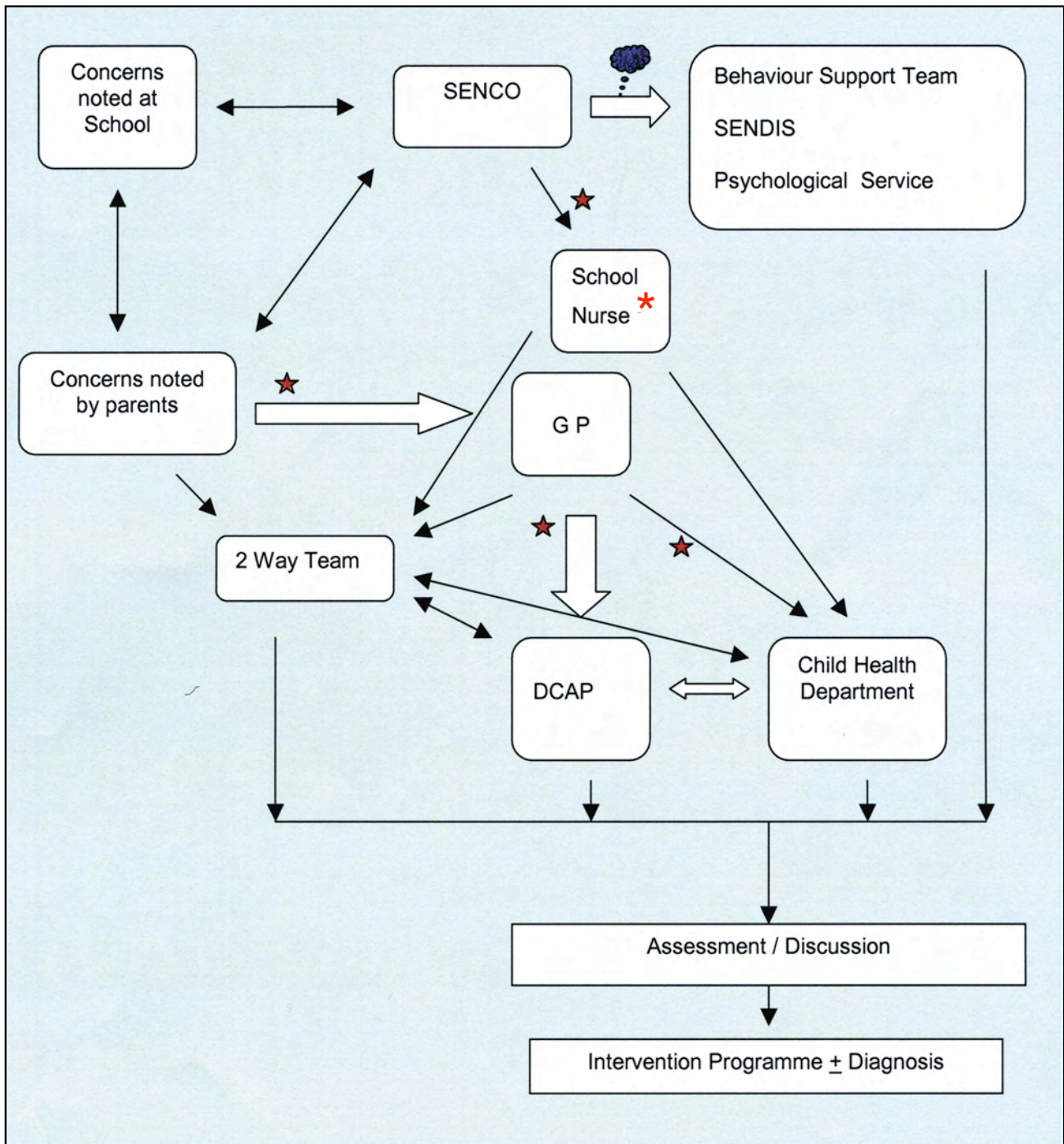
**D** There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.

**E** Does not occur exclusively during the course of a pervasive developmental disorder, schizophrenia or other psychotic disorder and is not better accounted for by another mental disorder (e.g., mood disorder, anxiety disorder, dissociate disorder, or personality disorder).

Reprinted from *The diagnostic and statistical manual of mental disorders*, fourth edition, American Psychiatric Association 1994

Appendix 2

# Flowchart of Local Referral Pathway for Children with Suspected AD/HD



★ Remember written accounts

\* If the primary issue is parental concern about the child's behaviour at home, then refer directly to the 2 Way team. If there are associated developmental concerns, refer to Paeds + 2 Way Team, with indication to both of the referrals

☁ This route should be used by the school whenever there is concern about behaviour or learning at school, but if the concerns are present both at home and school, then we recommend parallel referrals.

⇒ The broad arrows represent the preferred referral route.

## Appendix 3

# Observation Checklists

The following checklists may be useful to school staff to aid their observations and focus their strategies, and could, for example, be useful prior to consultation with the attached EP

Name: ..... DoB: .....

Date: ..... Completed by: .....

### A INATTENTION

	Frequent	Sometimes	Seldom
1. Makes careless mistakes in school work			
2. Stops work on a set task after a very short time			
3. Doesn't seem to listen when spoken to directly			
4. Doesn't follow through on instructions			
5. Poor at organising tasks and activities			
6. Avoids tasks that require effort over a period of time			
7. Loses things needed for school work			
8. Easily distracted when working			
9. Seems forgetful in daily Activities			

## Appendix 3

# Observation Checklists

### B HYPERACTIVITY/IMPULSIVENESS

	Frequent	Sometimes	Seldom
1. Fidgets or squirms in seat			
2. Leaves seat when staying seated is expected			
3. Walks around or runs about in situations where it is not appropriate			
4. Is more noisy than other pupils in play/leisure activities			
5. 'On the go' as if 'driven by a motor'			
6. Talks excessively			
7. Blurts out answers before question is finished			
8. 'Jumps in' before his/her turn			
9. Intrudes on the conversations of others			

Additional Comments:

## References

1. Attention Deficit (Hyperactivity) Disorder[AD/HD] – Hampshire County Council – 1996.
2. Attention Deficit / Hyperactivity Disorder [AD/HD] – South Eastern Education and Library Board.
3. Scottish Intercollegiate Guidelines Network (SIGN), Attention Deficit and Hyperkinetic Disorders in Children and Young People - June 2001.
4. National Institute of Clinical Excellence, Attention deficit hyperactivity disorder: pharmacological and psychological interventions in children, young people and adults - March 2006.
5. Managing Medicines in Schools and Early Years Settings, DfES/DH – March 2005.
6. DSM IV Diagnostic Criteria (American Psychiatric Association, 1994) for Attention Deficit / Hyperactivity Disorder (As used by the Psychiatric Profession to aid diagnosis).
7. Conners' Rating Scale - Separate forms each for parent, teacher and self reporting.
8. Strengths and Difficulties Questionnaire - a screening questionnaire for 3 - 16 year olds which looks at social, emotional and behavioural attributes - can be down loaded from [www.sdqinfo.com](http://www.sdqinfo.com)

## Resources and Contacts

- 1 For more information contact –  
MK AD/HD Family Support Group  
31 Ramsons Avenue  
Conniburrow  
Milton Keynes MK14 7BB  
Tel : 01908 675110 / 676779
- 2 ADDISS – AD/HD Information Services  
10 Station Road  
Mill Hill, London  
NW7 2JU  
Tel : 020 8906 9068  
Fax: 020 8959 0727
- 3 Milton Keynes Psychological Service – They provide a range of texts and related information in this area. Please feel free to contact them if you should require any further information  
Tel: 01908 367333



Available in audio,  
large print, braille  
and other languages.

**01908 253980**