Appendix 3

Helping Children with Attention and Concentration Problems

G.P. file

Attention and Concentration Working Party

2006

West Dorset General Hospitals NHS
NHS Trust

Our ability to concentrate at any one time depends on a number of factors: -

- tiredness
- hunger
- whether we are worried about something
- whether we are physically uncomfortable (ie needing to go to the toilet, being too hot or too cold)
- how easily we can be distracted
- how easily we can understand what we are being asked to attend to
- how interested we are in the topic
- how motivated we are to attend
- can we adequately see or hear
- how much we can control our impulses
- how fast we get angry, i.e. our tolerance to frustration

In consequence the ability to concentrate can be considered to be on a spectrum with some children able to concentrate for a long period of time, to other children who find that, in most situations, they are unable to decide what task to attempt, let alone stay on task.

About 10 % of pupils have significant and ongoing problems in concentration and attention. Of these, 1 -3 % of pupils will have a formal diagnosis of Attention Deficit Disorder (ADD) or Attention Deficit Disorder with Hyperactivity (ADHD). 25% of those diagnosed will go on to have significant problems as adults and may continue to require medication to help their concentration.

This file aims to offer some practical strategies for dealing with distractible children, clarify the role for referral, and address specific educational issues for those children with ADD or ADHD.

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What is ADHD / ADD?

'Rather than trying to organize his days on his own, he relies upon assistants to manage his schedule and keep track of his appointments, meetings and deadlines. As a result this highly successful educator is free to influence the lives of hundreds of children each year rather than live frustrated by his ADHD' (D. Kennedy, The ADHD Autism Connection, Waterbrooks, p150)

ADHD is not a disease entity like, for example, diabetes. The normal population of children has a wide variation of abilities to concentrate and stay still. The extreme end of this normal variation is known as ADHD and is defined as pathological, because it frequently leads to educational failure, social distress and long-term consequences.

A variety of terms including ADD, ADHD and hyperactivity disorder are used to describe children who are over active and have difficulties concentrating. '*Hyperactivity disorder'* is the World Health Organisation term that has been the description of choice in Europe, while the terms '*Attention deficit hyperactivity disorder' or ADHD* and '*Attention deficit disorder' or ADD* are American terms, which are also used in Australia and many other parts of the world. Hyperkinetic disorder is a stricter category, and therefore applies to fewer children than ADHD. Many parents seem to prefer 'ADHD', perhaps because much of the literature available for parents uses this American terminology.

Children with ADHD have problems with attention, hyperactivity and impulsivity. These behaviours are extreme, have been obvious since an early age and affect most areas of life – home, school and friends. Most children with ADHD are of normal intelligence. These

children tend to be unpopular with their teachers because their impulsivity leads to behaviours such as blurting out answers at inappropriate times, and fiddling with things during class. They may also struggle maintaining relationships with their peers and can be easily picked on. For example, if they are provoked they will not be able to control the impulse to retaliate until the teacher is looking the other way. They always seemed to be the children who are caught.

Self-esteem inevitably suffers, and in the worst situation these children give up on trying to keep up academically and drop out of learning.

At home, they are more difficult to parent than a child without ADHD and receive more negative critical comments and less praise and affection. Therefore life at school and home may be hard for them, they frequently fail, feel different from their peers, develop low self-esteem and may give up and drop out. This may, in turn, lead to involvement in antisocial behaviour and substance misuse, so they get even further into trouble.

These children are more likely to become juvenile offenders than their peers.

How common is ADHD?

1 in 100 primary school children are thought to meet the diagnostic criteria for hyperkinetic disorder.

In the USA, the diagnosis ADHD is made in up to 5 percent of boys. In the UK the approach is usually far more conservative. At the present time in Dorset we have a diagnostic rate of

1.6%. Most researchers would agree that it is a spectrum disorder within which is a group of children who would be given the diagnosis in all circumstances. This group may correspond to the hyperkinetic diagnosis. However the debate continues as to where the cut off for diagnosis should be placed.

To some extent this is an issue for society. As the pressure increases on schools to achieve the maximum educational potential for each of their children, consideration may be given to prescribing medication for an increasing number of children. There is evidence that methylphenidate improves the performance of even those children who do not fulfil the full diagnostic criteria for ADHD. Should we be treating these children medically or not?

What causes ADHD?

The exact cause is unknown, but 60 - 80% of predisposition is genetic. It affects boys more than girls in a ratio of 5:1, though this may be partly because girls are under diagnosed. Cognitive studies show difficulties in executive function based in the prefrontal cortex. These include difficulties in selective attention, delaying responses, and initiating actions. Communication between the frontal lobes, which is responsible for executive function, and the parietal lobes, where action is initiated, may be slower to mature, than in those children not affected.

Making the diagnosis.

When making the diagnosis it is essential to take the chronological, emotional and educational ages of the child into account. Most toddlers could be considered to have some symptoms of ADHD i.e. they are always on the go, have a low tolerance to frustration, are impulsive, and, have a short concentration span. Their abilities to sit still and attend, improve with age. Some children struggle to acquire these skills, much as others may struggle to acquire more traditional educational skills. They are not simply 'not trying hard enough'.

Research, at present, suggests that about 25% of children with a diagnosis of ADHD will continue to experience significant symptoms in adulthood. These mainly show in poor organisational skills and poor concentration. Activity level does improve with age and rarely causes on going problems in adulthood.

ADHD often exists in conjunction with other conditions. The rate of co morbidity is approximately 60%. Teasing out the differential diagnoses can require time and information from a variety of sources. Unfortunately the tests of cognitive function are not available outside psychology laboratories, therefore the diagnosis continues to be a clinical one. For this reason, together with the long-term implications for treatment, NICE suggest that the diagnosis is made by doctors who are regularly assessing neurological, behavioural and cognitive function of children.

The following box includes the diagnostic criteria for ADHD.

Diagnostic criteria for Attention Deficit Hyperactivity Disorder

The child should have six or more of the following nine symptoms of *inattention:*

- Failure to pay close attention to detail, so frequently makes careless mistakes
- Difficulty in concentrating on tasks or play activities
- Failure to listen when spoken to directly
- Failure to follow through on instructions and finish tasks
- Lack of organisation
- Reluctance to start tasks that require concentration
- Loses items that are necessary to complete tasks
- Distracted by irrelevant activity
- Forgetful in daily activities

The child should have three or more of the following five symptoms of *hyperactivity:*

- Fidgets
- Cannot remain seated
- Inappropriate running or climbing
- Noisy
- Being 'on the go' or often acting as if 'driven by a motor'

The child should have one or more of the following four symptoms of *impulsivity:*

- Blurts out answers before questions have been completed
- Failure to wait in turn
- Interrupts or intrudes on others' conversations or games
- Talks constantly

There must be some impairment of functioning both at home and at school, which must affect either academic achievement or family functioning.

The symptoms must have started before the age of seven years.

The symptoms cannot be accounted for by depression or anxiety

Questionnaires are used to gather information and allow comparisons on and off treatment. These include: -

The Connors Questionnaires, which are a range of questionnaires in short or long, form for parents teachers and the child themselves. They cost £1 per questionnaire. They cover

ADHD symptoms and, when scored, give breakdowns into oppositional, hyperactive, and attention problems. There are more categories for the long version.

The *Strength and Difficulty Questionnaires*, which are also available for parents, teachers and the child. They have a set of 30 questions of which 5 refer to ADHD. The other subsets covered are prosocial behaviours, conduct problems, emotional symptoms, and peer problems. They can be printed off from www.sdqinfo.com. They are a screening instrument.

There are a number of different scales which list the adhd symptoms and ask the scorer to rate them, usually from 0 – 3. One of the most common used is *Barclays.*

The *Social Situation Questionnaire* rates the areas where the child has most difficulty. It is useful in school as it can highlight where the most problems occur, such as break times, group work, arriving at school etc.

Further details of these questionnaires are available from CAMHS West Dorset General Hospital.

Does medication help?

Evidence from a recent large multi-centre study (the MTA trials) suggests that the best medication regime is more effective than the best behavioural regime, and that combined treatment has no benefit over medication (MTA, 1999). This is true for the clear-cut 1% 'hyperkinetic' group. However further analysis showed, for mild to moderate ADHD, behavioural treatments are as effective as medication.

Given the high genetic predisposition to ADHD, there might be an argument in an unusual case, for treatment to be initiated for a mother who has severe ADHD. This would mean that she could provide more structure and flexibility in her parenting style for her child with mild ADHD. The child may then not need medical treatment.

Although effective in about 70% of cases, for improving attention and reducing activity and impulsivity, medication does not help some behaviours such as conduct problems and difficulties in peer relations. Additional, non-pharmacological, strategies are required to deal with these behaviours. There are more details about medication on pages 12 - 20, and behavioural treatments on pages 22 - 35.

Co morbidity

Up to 60% of children with ADHD often have other problems including: -

- Learning difficulties – generalised or specific
- Language disorder
- Autistic spectrum disorder
- Developmental coordination disorder including dyspraxia
- Tourette's syndrome or tic disorder
- Attachment disorder
- Anxiety
- Depression
- Oppositional defiant disorder
- Conduct disorder
- Child protection issues
- Epilepsy

Occasionally children may have a recognised combination of symptoms. For example, 'DAMP' is a term used to describe a combination of attention, motor control and perception difficulties. These children have features of ADHD, dyspraxia and other specific learning impairments or autistic features (affecting perception).

Professionals should always be aware of child protection issues. Children with ADHD are hard work to parent and the burden of care is relentless. In addition, due to the genetic nature of the disorder, one of the parents may be impulsive, and have trouble controlling their temper.

Co morbidity in the parents should also be considered. As well as the relentless nature of the parenting, they often have to fight sigma in their friends, grandparents, and professionals. Mothers of ADHD children, not surprisingly, are at increased risk of depression.

How to refer?

Patterns of referral and service provision vary across the country. In West Dorset two thirds of children with ADHD are seen by the paediatricians, and one third by CAMHS. Referrals can be directed either way. Two of the paediatricians have a particular interest in neurodisability and will take referrals across West Dorset. Referrals to CAMHS may be most appropriate if there is evidence of psychiatric or family co morbidity.

Children can also be referred by SCMOs, CMOs, Schools Psychological Service, and the Behaviour Support Service. Locally, in West Dorset, we have a pathway, shown on page 11, which demonstrates the services available in a particular environment i.e. home or school, and the access routes for further services

New referrals over the age of 16 years are at present being considered by adult mental health teams. Children, who are already being seen, are transferred, if appropriate, at 18 years. The service for adults is developing rapidly and there is a multidisciplinary group looking at how best to respond to this need.

Commonly Used Drugs

The commonly used drugs (in West Dorset) are:-

- 1. stimulants page 13
- 2. clonidine page 15
- 3. risperidone page 16
- 4. melatonin page 17
- 5. atomoxetine page 18

Diet including fish oils page 20

The DfES has recently produced guidelines called Managing Medicines in Early School Settings (2005). These guidelines include recommendations regarding the storage and administration of controlled medication within school.

1. Stimulants

Stimulant medication allows the child to concentrate and pay attention. It provides a window of opportunity for leaning and the application of behavioural strategies. Although their action is not very specific, their efficacy is mediated by raising brain levels of noradrenaline and dopamine. There is increasing evidence that they can prevent some of the long-term consequences of ADHD, which can be very disabling.

'It's like glue. Before my thoughts were all in pieces. The medicines stuck them altogether.'
'It lets me show how smart I am.'
Quotes from 'Putting on the Brakes" by P.Quinn and J. Stern Magination Press, Washington 2002 page 46

All stimulants have controlled drug status. The short acting forms are most at risk of abuse due to their rapid onset of action. There needs to be some caution in prescribing in a very chaotic family, though this may be where medication can have the most effect.
There may be issues about travelling abroad with a child on methylphenidate due to custom regulations. It is therefore usually suggested that a covering letter from the GP is also taken.
There is considerable debate about whether a child who performs well in the sporting arena should be allowed to take methylphenidate. The relevant national sporting organisations are very happy to give advice regarding this.
There are some occupational considerations e.g. The M.O.D. will not look at employing anyone who has been on stimulant medication over the previous two years.
Recent recommendations from the DfES have suggested that changes of medication dosage in schools can only be implemented on the prescriber's instructions, not the parent's. Schools also need the medication to be in the dispensed container which may mean that, as prescribers, we have to ask for the script to be dispensed in two separate containers – one for home and one for school.

Methylphenidate is by far the most common drug used for medication intervention. It comes in short, intermediate, and long acting pills. The **maximum recommended daily dose is 60 mg per day**. This can be either in divided doses for the short acting pills or as a once a day dose for the long acting medication.
Ritalin, and Equasym are the brand names for the short acting methylphenidate. This medication usually starts working in about 20 minutes. Its effects last for about four hours. Ritalin was first commercially released for use in 1957. There is extensive research indicating short-term effectiveness i.e., 70 to 80 percent of children with ADHD find it useful. There is no evidence that it leads to dependency.

The intermediate release versions of methylphenidate include **Ritalin slow-release**. This tablet lasts up six hours but has not proved to be very predicatble in its effects and is therefore not often used.

There are two long acting versions called **Concerta X.L**., which works for 12 hours; and **Equasym XL**, which works for 6 – 8 hours. In school, staff may not be aware if medication has been discontinued or the dosage changed. As these medicines are stimulants they can be abused. At the present time Ritalin appears to have a street value of about 80p per tablet. Because Concerta is absorbed more slowly it does not have the same street value.

Dexamfetamine acts in a very similar way to methylphenidate. The **maximum daily dose is 30mg**

'Dexedrine' is the brand name for dexamfetamine. The effects of dexamfetamine last for about four hours. It is usually used as a second line treatment when a trial with methylphenidate has failed.

It is also available in the USA as a long acting version called **Adderal XR**. This would only be available on special request in this country.

Action of Stimulants

Both **methylphenidate** and **dexamfetamine** have a direct effect on attention, short-term memory, vigilance, reaction time, listening skills and on-task behaviours. Tests on driving abilities show a clear improvement for those on stimulant medication.

It does not treat associated problems such as oppositional and antisocial behaviours, learning difficulties or emotional immaturity. However, as it improves concentration, it may indirectly have a beneficial effect upon some of these behaviours.

These medications are not a cure for ADHD. They provide a window of opportunity. They enable ADHD children to reach their full potential and work towards long-term goals. They can then get the most from interventions such as special education programmes, or social skills training.

Common Side effects

These include loss of appetite, nervousness, crying, irritability, sleep problems, headaches, and stomach aches. Most of these improve after about a week. A rash may occasionally occur and parents are advised to stop medication if this does not settle within a few days. If there are rebound effects such as an increased level of activity and impulsivity beyond that normally experienced by the untreated child, the dosage may need further adjustment.

2. Clonidine

This drug can help with attention and concentration difficulties and behavioural problems. It is the first-line treatment for tics. It can be used alone or in combination with stimulants. It can be particularly useful for sleep problems and aggressive outbursts.
It stimulates the alpha 2 adrenergic receptors in the central nervous system.
Dixarit tablets are blue and are 25 micrograms in size. There are also some generic tablets, which are white and are also 25 micrograms in size.
The **maximum daily dose is 3 - 5 micrograms per kilo of body weight**. It is usually given in divided doses three to four times a day.
It has its highest concentration in the body five hours after taking tablets. The effect lasts for six to eight hours. It may take up to one month for the best benefit.

Side effects
Some patients may be sleepy to start with or when there is an increase in the drug dosage. They may also notice a dry mouth. Occasionally there are problems with dizziness or feelings of faintness. This is unusual at low doses. There are no withdrawal symptoms if you stop the medication gradually. If the medication is stopped suddenly there may be a rise in blood pressure, restlessness, difficulty sleeping, headache, sweating, muscle pains and abdominal pains.

3. Risperidone

Risperidone is an 'atypical antipsychotic'. There have been a number of studies, which suggest that it may be effective for children on the autistic spectrum to help with their poor tolerance to frustration. These studies were often carried out on small numbers. Both parents and children have reported considerable benefits. There are a few small studies suggesting that it might be used for children with ADHD who get impulsively angry. It is often used when home or school situations may be about to break down irreparably. Results can be dramatic. However its use continues to be debated.
The dosage that is commonly used in these two disorders is 0.5mg – 2mg. This is lower than that used for psychosis. There is little evidence regarding optimum dosage.

Side effects
Compared to the older anti psychotics, risperidone is relatively side effect free at the doses used in ADHD and Autistic Spectrum Disorders. The most common side effects include weight gain and drowsiness. Diabetes, significant breast enlargement, raised blood lipids and an increase in cardiovascular accidents are less common side effects.

Their effect on the developing brain is unknown.

In the short term, unusually, a young person may respond to an initial dose with muscle rigidity. Extremely rarely there is a risk of malignant neuroleptic syndrome with muscle stiffness, and very high temperature. This is a medical emergency and requires immediate treatment with supportive care. This can happen at any stage of treatment and is not dose related.

The Maudesley 2005 Guidelines suggest the following monitoring: -

FPG/HBA 1c	12 monthly
CPK	if malignant neuroleptic syndrome is suspected
LFT's	12 monthly
Prolactin	If symptoms occur
U&Es	12 monthly
Blood lipids	3 monthly then yearly
Weight	as needed
Bp	during dose titration

4. Melatonin

Melatonin is sometimes prescribed to help children with ADHD settle to sleep. Its effect lasts for about two hours and has no hangover effect the following morning. It does not help with early morning wakening or restless sleep patterns. It is a synthetic version of a natural hormone.

Dosage ranges from 0.5mg to 15mg nocte.

It is not licensed as a medicine in the UK. Locally it requires two consultant signatures to initiate prescribing and further prescriptions have to be obtained from the hospital.

Side effects

There is a paucity of research for the use of melatonin but the studies that have been carried out suggest that it is well tolerated with few side effects being reported. The long-term effect on a vulnerable developing brain especially at supraphysiological doses is unknown. Some psychiatrists suggest that a break in constant use would be sensible to help prevent suppression of the pineal gland

5. Atomoxetine

This drug has been available locally since July 2004, and is sold under the trade name of **Strattera**. As well as working on concentration it has a slight anti-anxiety effect.

It is a once daily medication, which works, in the prefrontal cortex to increase the availability of noradrenaline. Unlike the stimulants it needs to be given regularly and the maximum benefit is noted after 4 weeks of constant administration. Drug holidays are therefore not recommended.

It covers both the early mornings and the evenings so that it has a positive effect on family life.

Unlike stimulants it is not a 'controlled drug' and, in theory, therefore has no risk of abuse.

Side effects

It can have an effect on appetite that improves on taking the drug regularly. It may also cause headaches, vomiting and dizziness. These again may improve with time. There have been a small number of reports of reversible liver toxicity, and of increased suicidality since it has been widely prescribed. It has only been regularly used since 2003, so there needs to be some caution about long-term effects.

Which Medication ?

Drug	Trade name	Length of effect	Principle effect
Methylphenidate	Ritalin	4 hrs	Improves concentration
	Equasym	4 hrs	Improves concentration
	Ritalin slow release	8 hrs	Improves concentration
	Equasym XL	6-8 hrs	Improves concentration
	Concerta XL	12 hrs	Improves concentration
dexamfetamine	Dexedrine	4 hrs	Improves concentration
	Adderal	8 hrs	Improves concentration
clonidine	Dixarit	4 -6 hrs	Improves impulsivity and angry out bursts
risperidone	Risperdal	12 hours	Improves angry oubursts
melatonin		2 hours	Helps to settle to sleep
atomoxetine	Strattera	3 hours in blood stream, 24 hour effect in the brain.	Improves concentration and impulsivity

Alternative approaches

Diet

About 5% of children with ADHD respond to their diet in a direct and obvious way to particular substances. (Anecdotal evidence from families suggests this figure should be higher.) However healthy eating, with regular varied food, which provides a constant blood sugar level through out the day, is as important. Children from a chaotic home where one or other parent may also have a degree of ADHD may well not be provided with a predictable nourishing lunchbox. It can be an ongoing challenge.

The thinking on Coke or Redbull intake is variable. There are some young children who respond in a very active way to the caffeine or the sugar load in these drinks. However the drug companies in the States have investigated using caffeine as a treatment but found that the efficacy was limited by the side effects such as the shakes, and loss of appetite.

Fish Oils

Efalex and **Eye Q** are over the counter dietary supplements containing fish oils which are marketed 'to improve brain function'. In the States it has been marketed to treat ADHD but at the present time this marketing campaign has had to be withdrawn due to inconclusive evidence. There are a number of studies ongoing, which suggest that there may be an effect on impulsive violence. The balanced view appears to be that it may provide some improvement in brain functioning but not to the same degree as established treatments such as stimulants. When given with stimulants there may be an additive effect of making fits more likely in a susceptible child.

Note: This information is correct at time of going to press. However, as this is a field of considerable interest and research, there will undoubtedly be new information regularly available.

General Management Strategies

Introduction page 22

Structure and consistency page 23

Flexibilty page 24

Breaking down tasks page 25

Communicating page 25

Picking which behaviours to tackle page 26

Playing detective page 27

Further information about these techniques is also available in the books suggested in the resource section on page 36
The next section deals with specific techniques for certain symptoms. This section begins on page 28

Dealing with ADHD Behaviours at Home

Helping people to make changes to their parenting style can be a rewarding but time consuming process.

We all parent according to our own upbringing, either by repeating our good experiences or by determinedly avoiding our bad ones. Parenting is very ingrained and continues to be influenced by grandparent and partner views. Therefore we cannot be glib about the amount of work it takes to implement change.

The first step is establishing trust and rapport between yourself and the parents. They will only be willing to do the work if they feel that you are offering something that they want in a non-judgemental manner. G.P.s and health visitors have a great advantage in this situation as they already have an ongoing relationship with the family. They also have some understanding of the other personalities in the family.

The second step is to present the amount of work in a realistic light. Even as parenting changes, the old behaviours in the child may be slow to improve. They may even deteriorate for a short time. It can be helpful to discuss this early in the therapeutic process.

Behaviour strategies includes:

- Structure and consistency
- Flexibility
- Breaking down tasks
- Communicating desired behaviours
- Picking which behaviours to tackle
- Playing detective

Structure and consistency

All children like predictability. It allows them to learn the consequences of their actions.

Children with ADHD find this particularly important. They have difficulty in accessing their working memory i.e. they know the information but find it hard to put it into action when confronted with a particular situation. They are impulsive and act before they have worked out what might be the best action. Parents often say ‘ How many times do I have to tell him!’ The child needs more encouragement to behave in a certain way than a child without ADHD. Therefore predictability and structure helps him learn to act in desired ways. It sounds straightforward but consider: -

- parents with a degree of ADHD themselves will find that they struggle to be consistent due to their own impulsivity. They will need support and encouragement. This can be an unusual experience for them, particularly given the stigma around parenting ADHD children.
- Structure is also surprisingly difficult to get right. It has to be appropriate to the needs of the child. If a family structure is set which is too ambitious, such as ‘we will sit round the table for a family meal once a day for an hour’, it will lead to failure and a great deal of conflict. A more reasonable structure could be ‘Ben (the child with ADHD), can sit up to eat his main course but he can come back to sit up for pudding if he wants some.’ Getting the family structure right involves some work and ability to reflect on what has happened in the past.
- A structure, which works for the family when ‘Ben’ was 8 years old, will not work when he is 12, if a new baby comes into the family, or, if dad leaves. It has to adapt to the family’s needs. It needs to be a flexible structure.

Flexibility

Flexibility seems to be the opposite of structure, but is the added ingredient, which allows family life to run more smoothly. Let's assume we have a family structure, which generally suits most of the family most of the time. It provides some consistency and gives clear guidance about what is acceptable behaviour in certain situations. The experienced parent understands that some days have started badly. They are aware that their child is particularly fragile and brewing for a blow out. With experience they can sometimes deflect the conflict by adding some flexibility on top of the structure.

For example John usually has to get his P.E. kit ready for school but he is cross because his sister has beaten him into the bathroom. Sally, his mother, has found his P.E. kit and puts it next to his bed so it is easy for him to get together. She does not score points by telling him that she has done this. She has made his task easier.

Some parents feel that their children are not showing them proper respect if they cannot follow the rules. However it is easier for an adult to be flexible than for a child to be flexible. They, as parents, are in control even if they are choosing to help their child out. It does not mean that, on the next occasion, John will not get his P.E. kit, so the structure still stands.

If he struggles to get his P.E. kit every time, maybe it is the wrong structure for John at this age and it needs to be broken down into smaller tasks i.e. John's task is to find his trainers for P.E.

Teachers who are also able to use structure / flexibility are most able to handle a class with a child with ADHD.

Breaking Down Tasks

The cognitive difficulties of ADHD, including difficulty settling to tasks, poor selective attention, poor working memory, and poor impulse control, means that often tasks appear to be unmanageable. Avoidance behaviour therefore comes in play such as irritating a sibling, making lots of noise, going to hide, etc.

Tasks are much more likely to be done if they are broken down into small parts. Breaking them down but continuing to present them as a whole list of instructions may help a little, but drip-feeding the instructions is the most satisfactorily. Short tasks with immediate feedback works best. It is also the most work, for the parent, to carry through. Support and encouragement of the process by the professional can make these behavioural techniques more likely to work.

If the parent has a degree of ADHD, the same applies so that regular short appointments dealing with focused topics works best.

Communicating

Getting any routine across requires communication. Shouting up the stairs randomly is not a good strategy. Therefore basic rules are; -

- to communicate face to face
- encourage attention by suggesting eye contact
- asking for repetition of instructions

All these strategies will help the information enter the long-term memory store, and make it more likely to be recalled and acted upon in the heat of the moment.

Picking which behaviours to tackle

From this perspective behaviours can be put into three categories:-

- those behaviours, which should never happen. This category includes putting oneself or someone else in danger e.g. running into the road in front of a car. Stopping these behaviours are always worth the payback of a tantrum. Let's call these *A behaviours*
- those behaviours which, as a parent you wish to be different. Let's call these *B behaviours*
- those behaviours, which, as a parent, you would prefer did not happen, but are willing to let go. Let's call these *C behaviours*.

A behaviours should always be tackled but they are generally only a small group. Avoid the temptation to put many behaviours into the A basket. These behaviours are serious enough to risk a major tantrum.

C behaviours can generally be ignored for the present at least. This should be a large group. They may include for example having a school shirt hanging out or a tie loose.

It is tempting to have a large number of behaviours in the *B basket.* However it is most effective to work on only a few behaviours at one time. This means that a consistent message will be easier to maintain and will become internalised faster by the child or young person. The behaviours to target might be the more antisocial such as physical retaliation to taunting, or ones that are necessary for the next developmental stage e.g. completing their music or reading practice.

Playing detective

Tantrums happen for many reasons. If you have ever tried reasoning with a child in the middle of a tantrum it becomes clear that you are wasting your breath. It is impossible to listen and have a tantrum at the same time.

Anxiety can make tantrums more likely. Some children with adhd also are on the autistic spectrum. This means that they may become distressed by loud noises, by being in crowded places, by the unexpected or when routines get disrupted. Therefore it can be predicted which events will invariably lead to a tantrum. For other children it is not as clear-cut. Asking the parents to play detective in establishing likely antecedents can help plan interventions so that tantrums can be avoided. This allows for a proactive rather than a reactive response. The proactive response can be: -

- to alter or prevent a particularly frustrating experience for the child,

- to allow an early escape route so that the child begins to learn to recognise their feelings and take himself/ herself out of a situation. Exit cards at school are a type of this approach.

- to prepare the child while they are still receptive to communication. " I want you to come off the play station in 15 min so save your game as soon as you can." Ten minutes later "5 minutes to go."

Impulsivity makes tantrums more likely to occur regardless of the antecedents. As the young person gets older they begin to predict for themselves which situations are likely to be frustrating. Review antecedents with them and encourage them to take control of their impulsivity. The "STOP, THINK, DO. " mantra can be helpful.

Behavioural Advice for Specific Symptoms.

This includes: -

- Attention page 29
- Following directions page 30
- Impulsivity page 31
- Memory page 32
- Social skills page 33

- Relaxation page 34
- Developing Self Regulation page 35

Attention

<table>
<tr><th>Difficulties</th><th>Possible Interventions</th></tr>
<tr><td>Short attention span

Completing homework</td><td>

Describe learning to concentrate in the same way as learning to play a musical instrument. It requires practice and it is hard work.
Indicate steps to be taken to complete tasks
Reduce expectations of written work
Relate tasks to known attention span e.g. ‘you know how you manage to play for half an hour on you football game on the play station, you can do it here too.’ Build up gradually, praise for periods of concentration
Use simple unambiguous instructions
Don’t expect children to be able to generate own activities without support
Restrict homework to what is relevant and essential
Check timing of medication / home environment
Find ways to reduce writing requirements
Use charts instead of written report, e.g. mind map etc
Build in social component
Allow child to use ‘parent secretary’
</td></tr>
<tr><td>Building Skills</td><td>

Give frequent, immediate consistent feedback
Help the child set own realistic short-term goals
Use variety of board games. Useful games include Uno, Sorry, Mastermind, Battleship, Scrabble, Guess Who and Yahtzee
Practice some activities using a stopwatch. This helps to develop a concept of time –
e.g. How long does it take to suck a wine gum?
How many sums or sentences can you do in that time?
Where appropriate encourage the child to explain plans or ideas to others e.g. siblings (builds self esteem and gives agenda to concentrate)
</td></tr>
</table>

Following Directions

Difficulties	Possible Interventions
Difficulty following written instructions	• Use highlighter pen
Difficulty focussing on and responding to relevant verbal information	• Reduce extraneous background noises • Make eye contact • Give clear, concise instructions • Encourage child to repeat back information
Speaking before thinking	• Teach child to stop and think before speaking • Acknowledge child has something to say but help to develop self control e.g. "John, I can see that you are itching to say something. I will ask you in a minute. Praise if quiet.
Obeying instructions	• Encourage routine – stop, think, do • Be clear about what will be coming next • In general rewards and sanctions (consequences) are more likely to be effective if they are implemented as soon as possible. Always ensure that the child knows what the sanction relates to. • Always give choices and remind of consequences
Initiation of activity	• Try to make tasks have a fixed end • Walk through first steps • Make the tasks short • Obtain a verbal commitments e.g. regarding start times

Impulsivity

(see also the text on relaxation which follows this section)

Difficulties	Possible Interventions
Fast /careless Inability to sustain motor control Difficulty executing slow rhythmical movements Constantly on the move Fidgeting / fiddling	• Teach checking skills • Encourage / practise slow controlled movements • Encourage child to think about the movement required before attempting • Break down activity and practise individual component parts • Ensure there is enough space • 'Earth' child by providing specific spot or chair • Give breaks, which allows the child to be less focused for a while • Anticipate problems and have a planned response • Cultivate a calm atmosphere at home • Be aware of early signs of lack of control • Use child for jobs that require activity • If they have to sit still, allow child to fiddle with an agreed object such as blue tack.
Low toleration to frustration	• Reinforce positives i.e. catch them on task • Ensure a high rate of success by making the task appropriate • Give frequent reinforcement and appropriate praise
Craves novelty / hates repetition	• Involve the child in designing activity • This is helped by a parent who also hates repetition

Memory

Difficulties	Possible Interventions
Remembering instructions	• Simplify language/or put it another way • Write it down • Ask child to repeat instructions
Remembering rules	• Keep them simple • Reinforce them frequently • Try to work out when the child may be able to hear and understand what you are saying i.e. when they are in the middle of a tantrum they will not be able to respond to instructions. They will respond better the following morning.
Remembering facts	• Use visual ideas even if they are only stick men • Act things out • Use appropriate computer games • Use lists • Reduce expectations if appropriate
Organisation	• Home / school daily check in • Colour code in homework diary • Use incentives • Have spare sets of some items such as calculators • Have clear appropriate routines

Social Skills

Difficulties	Possible interventions
Difficulty with peers Dealing with arguments	• Social behaviour needs as much attention as other aspects of behaviour. • Define social goals and encourage review of what is and what is not appropriate • Use anecdotes and personal experience • Get student to think about impact of their behaviour and the feelings it may engender in others • Use social stories • Mediation may be necessary in poor peer relationships especially as peers mature and become less tolerant of 'silly' behaviours. This can include advising other students; consider circle of friends at school. • Draw out situations giving the people involved different colours to show their feelings
Low self esteem	• Provide reassurance and encouragement • Positive reinforcement is important, remind of past successes • Use positive language • Emphasise it is the behaviour which you don't like, not the child • Use positive role models • Plan for success, catch them being good and praise • Give appropriate responsibility

Relaxation

The following or a variation of it can be used as a **visualisation and relaxation exercise**. It encourages the idea of inner peace and an inner safe-haven

Close your eyes and imagine you are walking through a beautiful garden. What does your garden look like? At the end of the garden is a gate. What does your gate look like? You open the gate and go through it. The gate leads into a large open space. What is in the space? What does it look like? In the distance you see a house. Is it a large stone one or is it a cottage? You begin to walk towards the house. As you walk look around you. What can you see? When you reach the house you knock and walk in. There is a large room inside. What is your room like? A person walks into the room and hands you a box. What is the person like? What colour is the box? You open the box. What is inside it?

- Encourage self-awareness in relation to relaxing

Self regulation

Each individual is constantly bombarded by sensory information. As children grow up and mature they manage to filter this information and respond appropriately. e.g. when sitting in class to concentrate on what the teacher is saying rather than being distracted by background noise or bodily sensations. Some children, however, cannot do this automatically which can lead to active and sometimes disruptive behaviour. They can be said to have difficulties in selective attention. The result of this is that these children may have difficulties with:-

- Completing tasks on time.
- Following instructions
- Completing tasks independently.
- Playing appropriately.
- Maintaining friendships.
- Concentrating on tasks long enough to achieve success.
- Setting boundaries.

In other words this describes many of the symptoms of ADD/ADHD but with the emphasis on the difficulties in selective attention experienced by the child. An occupational therapist can assess the causes of poor self-regulation and look at developing a programme to maximise the level of arousal for a particular child and thereby encourage selective attention. These programmes make use of tactile stimulation (touch), kinetic stimulation (movement) and proprioceptive stimulation (position of the body). These are called **sensory modulation techniques**

Resources for attention and concentration problems

Sheet for parents

Green C. & Chee K. (1997) *Understanding ADHD*. London : Vermilion.
From the author of 'Toddler Taming' – easy to read and humorous.

Greene R. (2001) *The Explosive Child* New York ; Quill. Excellent book which crosses the diagnostic boundaries regarding children who have a poor tolerance to frustration.

Mental Health Foundation (2000) *All About ADHD*. London : Mental Health Foundation. Useful booklet providing basic information available for £1 from the Mental Health Foundation, 20/21 Cornwall Terrace, London NW1 4QL (tel: 020 7535 7400; fax 020 7535 7474), e-mail mhf@mhf.org.uk ; website www.mhf.org.uk

NICE (2000) *Guidance on the use of methylphenidate (Ritalin, Equasym) for ADHD in childhood*. London: NICE.
Books for parents, teachers, young people. Also available at www.nice.org.uk

Pentecost D London: Jessica Kingsley Publishers *Parenting the ADD Child Can't Do? Won't Do?* Practical Strategies for managing behaviour problems in children with ADD and ADHD.

Positive Parenting (2005) *A Parents Guide to Behavioural Management* published by Positive Parenting Publications, 2A South Street, Gosport, PO12 1ES. Tel 02392528787. www.parenting.org.uk
Straight talking accessible advice.

Quinn P. and Stern, J. (2002) *Putting on the Brakes. A Young Persons Guide to Understanding Attention Deficit Hyperactivity Disorder* Magination Press, Washington.

Quinn P. and Stern, J. (2002) *Putting on the Brakes Activity Book for Young People with ADHD,* Magination Press, Washington. This contains some exercises particularly aimed at the 8 – 12 year old. It gives a basis for behavioural work to help parents provide practical support for their child.
Taylor E (1997) *Understanding your Hyperactive Child: the Essential Guide for Parents*. London : Vermilion. A book full of information by the leading UK authority on the subject.

Other useful websites include:-

- www.web-tv.co.uk/.
- www.additudemag.com/medical
- www.alertmag.com/medical
- www.understandingadhd.com

www.PediatricNeurology.com - an excellent site with information aimed at a number of different groups such as parents, teachers, young people and students.

Local support group

Dorset ADHD Support Group
C/o 3 Mountbatten Close
Wyke Regis
Weymouth
Dorset DT4 9ET

Help line 01305 768297

Email dorsetadhdcharity@btopenworld.com
Website:- **http://www.dorsetadhd.org.uk**

National Support Group

ADDISS
10 Station Road, Mill Hill, London, NW7 2JU
Tel: 020 8906 9068

Email: **info@addiss.co.uk**
Website: www.addiss.co.uk

Websites for Young People with Attention Difficulties

www.mk-adhd.org.uk
www.adders.org
email for local group junior dept ; adhdypforum@btinternet.com

Resources for Attention and Concentration Problems in the Educational Setting

Barkley R. A. *Taking charge of ADHD, The Complete Authoritive Guide for Parents.* Guildford Press. £14.50

Cooper P., O'Regan F. (2001). *Educating Children with AD/HD* Routledge/Farmer £25.00pbk. Whole school resource with photocopiable pages

Cowie H, Boardman, C., Dawkins, J., Jennifer, D. (2004) *Emotional health and Well being – a practical guide for secondary schools* London : Sage

Dupaul G. J, Stoner G. (2003). *ADHD in the schools.* Guildford Press. £28.95.

Green C. & Chee K. (1997) *Understanding ADHD*. London : Vermilion.
From the author of 'Toddler Taming' – easy to read and humorous.

Greene R. (2001) *The Explosive Child* New York ; Quill
Excellent book which crosses the diagnostic boundaries regarding children who have a poor tolerance to frustration.

Hampshire County Council (1996) *Attention deficit (hyperactivity) disorder. AD(H)D: Information and guidelines for school*. Hampshire County Council Education Department.

Jenkinson J., Hyde T., Ahmad S. (2002) *Occupational Therapy Approaches for Secondary Special Needs*, Whurr Publishers, London

McConnell K., Ryser G., Higgins J. (2000) *Practical ideas that really work for Students with ADHD.* Pro Ed, Practical ideas £31.95, additional evaluation forms (25)

Mental Health Foundation (2000) *All About ADHD*. London : Mental Health Foundation.
Useful booklet providing basic information available for £1 from the Mental Health Foundation, 20/21 Cornwall Terrace, London NW1 4QL (tel: 020 7535 7400; fax 020 7535 7474), e-mail mhf@mhf.org.uk ; website www.mhf.org.uk

NICE (2000) *Guidance on the use of methylphenidate (Ritalin, Equasym) for ADHD in childhood*. London: NICE.
Books for parents, teachers, young people. Also available at www.nice.org.uk

O'Regan Finton, (2004)*How to Teach and Manage Children with ADHD,* LDA Wisbech, Cambs.

Quinn P. and Stern, J. (2002) *Putting on the Brakes. A Young Persons Guide to Understanding Attention Deficit Hyperactivity Disorder* Magination Press, Washington

Taylor E (1997) *Understanding your Hyperactive Child: the Essential Guide for Parents*. London : Vermilion.
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- www.additudemag.com/medical
- www.alertmag.com/medical
- www.pediatricneurology.com/chapter.htm

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Dorset DT4 9ET

Help line 01305 768297

Email dorsetadhdcharity@btopenworld.com

Website:- www.dorsetadhd.org.uk

National Support Group

ADDISS

10 Station Road, Mill Hill, London, NW7 2JU

Tel: 020 8906 9068

Email: info@addiss.co.uk

Web: www.addiss.co.uk

A schools pack has been produced by West Dorset Attention and Concentration Party.
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