

Attention Deficit Hyperactivity Disorder - ADHD

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Introduction

Attention Deficit Hyperactivity Disorder, more commonly known as ADHD, is a neurological disorder that contains three core symptoms – hyperactivity, impulsivity, and inattention (Hire, *et al.* 2015). NHS (2021a) describes hyperactivity and impulsiveness as being unable to sit still, constantly fidgeting and having excessive physical movement and describes inattention as being easily distracted, constantly changing activities and being unable to carry out instructions. ADHD is described as the most common behaviour disorder in children which is increasing by 3% annually as National data states that up to 11% of 4–17-year-olds are diagnosed with ADHD (Felt, *et al.* 2014). The ADHD Centre (2024b) points out that significantly more boys are diagnosed with ADHD than girls with a ratio of 4 boys to every 1 girl. ADHD is described as a lifelong disorder that often continues into adulthood (Wolraich, *et al.* 2019 and Hammerness, 2009). The exact cause of ADHD is unknown, but it has been shown to run in families (NHS, 2021a), therefore, ADHD UK (no date) states that a mix of genetic and environmental factors are considered during a diagnosis, with genetic factors being responsible for 70-80% of the probability of the cause. However, Wolraich, *et al.* (2019) points out that it is difficult to identify genes linked to ADHD and therefore, difficult to determine any hereditary links.

Diagnosis

A diagnosis of ADHD is considered in children over 4 years of age who are displaying numerous symptoms of inattention, hyperactivity or impulsivity that are abnormally high for their age, occur in multiple settings and impact on the child's day-to-day life (The ADHD Centre, 2023 and Welsh Government, 2019). Diagnosing ADHD relies on a strict set of symptoms outlined within three sections of inattention, hyperactivity, and impulsivity. These sections contain statements that describe behaviours and symptoms of ADHD. Children must have at least 6 symptoms of inattention and/or 6 symptoms of hyperactivity and impulsivity that have been occurring in more than 1 setting over a period of 6 months to gain an ADHD diagnosis (Adler, Spencer and Wilens, 2015 and NHS 2021b). NICE (2019) states that diagnosis of ADHD should only be made by paediatricians, psychiatrists and specialist clinicians who have sufficient training and expertise in ADHD. However, NHS (2021a), ADHD UK (no date) and Hire, *et al.* (2015) point out that most children are diagnosed by their GP as they work with the parents to gain an insight into the child's behaviour across multiple settings.

Barriers

A child diagnosed with ADHD or displaying symptoms of ADHD and their families will face many barriers throughout their life including structural and attitudinal barriers (Baweja, Soutullo and Waxmonsky, 2019) which is why early intervention is essential in providing support and strategies as soon as possible to eliminate some of these barriers for the child and their family (Dr Curran, 2020). The medical model of disability focuses on the impairment of a child with ADHD including what is 'wrong' with them and considers ways to treat or cure the problem or make adaptations to restore 'normal functioning' for that child (Albert, 2004 and Disability Wales, 2017). However, the social model of disability separates the impairment from the disability and focuses on removing barriers or making adaptations to cater for everybody's needs, regardless of their diagnosis (Disability Wales, 2017).

One barrier for parents of children with ADHD is the negative stigma surrounding the symptoms and behaviours displayed. Children with ADHD are often labelled as 'naughty' children with bad behaviour, which causes parents to feel embarrassed and responsible for their child's behaviour (Sayal, Goodman and Ford, 2005). Parents often feel ashamed and embarrassed about their child's behaviour and believe that they have caused their child to receive a diagnosis of ADHD due to poor parenting or lack of discipline (Mikami, *et al.* 2015). DosReis, *et al.* (2010) found that parents of children with ADHD often feel extremely isolated and rejected as other parents seem to avoid them and not invite the child to birthday parties or play events.

Another barrier present for a child with ADHD and their parents is the concern of accessing the right form of education to best support the child and their needs. Research has shown that children with an ADHD diagnosis or those with probable ADHD can struggle in education settings as ADHD symptoms can affect a child's learning and development, therefore, affecting their academic performance and social experience in a school setting (Kendall, 2016 and The ADHD Centre, 2024a). The Education Act 1981 describes the responsibility of a local authority to provide all children with a suitable education, whether that is in a mainstream school or a specialist provision school. Parents and professionals around the child are tasked with the decision of deciding which provision would be best to meet the needs of a child with ADHD as each child is different and will require different levels of support and intervention (Kendall, 2016).

Strategy

Page (2023) states that children with ADHD require a clear routine and need to understand what is happening around them. One strategy used to support this is visual strategies which is a positive intervention that has a significant effect on a child with ADHD in a classroom environment (Thomas and Karuppali, 2022). Using visual strategies in a classroom is regarded as inclusive practice as the teacher is adapting the environment to meet the needs of every child, rather than attempting to change the child to 'fit in' the classroom (Cardiff Council, 2021 and Welsh Government, 2019). Visual aids can include pictures, photographs or drawings that are used in a sequence to explain to children what is happening now and next (Chmiliar, 2020). The visual cues support children with ADHD in understanding the routine and what is expected of them (The ADHD Centre, 2023), reduces anxiety levels (Chmiliar, 2020) and reduces temper tantrums or meltdowns during transition periods as children are clear about what is happening (Flynn, 2022 and Thomas and Karuppali, 2022).

Conclusion

To conclude, ADHD is the most common behavioural condition in children (Wolraich, *et al.* 2019) and can present in a variety of ways with differing levels of severity (ADHD UK, no date), therefore, making it difficult to diagnose effectively (NHS, 2021a). It is evident that further training is required for parents of children receiving an ADHD diagnosis (The ADHD Centre, 2024a) and for school staff working to support children on their educational journey (Page, 2023). By being proactive and implementing specific strategies to support children with ADHD, society can adapt their attitudes and understanding to enable children and adults with ADHD to feel accepted and included in their environment (Albert, 2004 and Smith, 2023).

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Introduction

I chose to research ADHD for this webinar as I have worked in Early Years for over 20 years and do not believe that I have worked with a child displaying symptoms of ADHD. This may be because most children are diagnosed with ADHD between the ages 7-9 years (Hire, et al. 2015) and Felt, et al. (2014) states that ADHD cannot be reliably diagnosed in children under 4 years of age. However, I am currently working with a child aged 2 years who I believe is displaying signs and symptoms of ADHD which has prompted me to research and find out more about the condition.

Attention Deficit Hyperactivity Disorder, more commonly known as ADHD, is a neurological disorder that contains three core symptoms – hyperactivity, impulsivity, and inattention (Hire, et al. 2015). NHS (2021a) describes hyperactivity and impulsiveness as being unable to sit still, constantly fidgeting and having excessive physical movement and describes inattention as being easily distracted, constantly changing activities and being unable to carry out instructions. ADHD is described as the most common behaviour disorder in children which is increasing by 3% annually as National data states that up to 11% of 4–17-year-olds are diagnosed with ADHD (Felt, et al. 2014). The ADHD Centre (2024b) points out that significantly more boys are diagnosed with ADHD than girls with a ratio of 4 boys to every 1 girl. There can be many reasons for this as Oakes (2019) discusses that boys symptoms of ADHD appear to be far more extreme and consist of hyperactivity and impulsivity, whereas, NHS (2021a) points out that girls are less likely to be diagnosed due to the lower level of hyperactivity that they display. Mowlem, et al. (2019) are concerned for girls being undiagnosed with ADHD due to ‘masking’ symptoms, therefore, not being referred and supported as required.

ADHD is described as a lifelong disorder that often continues into adulthood (Wolraich, et al. 2019 and Hammerness, 2009). The exact cause of ADHD is unknown, but it has been shown to run in families (NHS, 2021a), therefore, ADHD UK (no date) states that a mix of genetic and environmental factors are considered during a diagnosis, with genetic factors being responsible for 70-80% of the probability of the cause. However, Wolraich, et al. (2019) points out that it is difficult to identify genes linked to ADHD and therefore, difficult to determine any hereditary links.

Diagnosis

A diagnosis of ADHD is considered in children over 4 years of age who are displaying numerous symptoms of inattention, hyperactivity or impulsivity that are abnormally high for their age, occur in multiple settings and impact on the child’s day-to-day life (The ADHD Centre, 2023 and Welsh Government, 2019). Diagnosing ADHD relies on a strict set of symptoms outlined within three sections of inattention, hyperactivity, and impulsivity. These sections contain statements that describe behaviours and symptoms of ADHD. Children must have at least 6 symptoms of inattention and/or 6 symptoms of hyperactivity and impulsivity that have been occurring in more than 1 setting over a period of 6

months to gain an ADHD diagnosis (Adler, Spencer and Wilens, 2015 and NHS 2021b).

NICE (2019) states that diagnosis of ADHD should only be made by paediatricians, psychiatrists and specialist clinicians who have sufficient training and expertise in ADHD.

However, NHS (2021a), ADHD UK (no date) and Hire, et al. (2015) point out that most children are diagnosed by their GP as they work with the parents to gain an insight into the child's behaviour across multiple settings. French, Sayal, and Daley (2019) discuss delays in referrals of ADHD in children due to the low knowledge of health professionals which often leads to a misdiagnosis. This can be stressful for the child and family as early identification and intervention are essential in helping and supporting children and their families with ADHD symptoms (May, et al. 2020). Receiving a late or incorrect diagnosis can have a detrimental effect on a child's life, particularly socially and academically (Smith, 2023) as Moore, et al. (2017) emphasises the positive impact that an early diagnosis can have on children's school life and academic achievements. French, Sayal, and Daley (2019) state that more training regarding ADHD symptoms and treatment is required for health professionals to improve diagnosis and give families the support needed.

ADHD treatments are symptomatic and individual to each person and are not curable treatments but ways to help the child or person to live with their disorder more comfortably (Wolraich, et al. 2019). ADHD symptoms can be managed using stimulant medication alongside behavioural interventions (NHS, 2021a and Felt, et al. 2014). Hammerness (2009) points out that 75% of children with ADHD will respond to stimulant medication and see specific improvements in symptoms and behaviours displayed. However, DosReis, et al. (2010) states that parents are hesitant to use medication as a form of treatment as they feel that doctors are too quick to prescribe medication to treat ADHD and feel that behavioural interventions are beneficial in supporting the child and their needs. Smith (2023) agrees with DosReis, et al. (2010) as they also found that parents have strong concerns about medication used to treat ADHD, in particular, the side effects of medication which can cause appetite loss, moodiness, and sleep issues (Watson, 2023).

Behavioural interventions used to support a child with ADHD include parent training, family therapy and school-based interventions (ADHD UK, no date). These interventions can only be successful if all professionals and parents work closely together to ensure that the child is getting the same messages and support from everyone around them (The ADHD Centre, 2023 and Hire, et al. 2015). The Additional Learning Needs and Education Tribunal (Wales) Act 2018 emphasises the need to always consider the rights of the child when considering and discussing plans for treatment of any additional learning need by including the child (where possible) and their parents in any decision making. The ADHD Centre (2024a) also focuses on the importance of collaborative working between parents, health professionals and education staff as this can have a positive impact on the child's development and education process.

Barriers

A child diagnosed with ADHD or displaying symptoms of ADHD and their families will face many barriers throughout their life including structural and attitudinal barriers (Baweja, Soutullo and Waxmonsky, 2019) which is why early intervention is essential in providing support and strategies as soon as possible to eliminate some of these barriers for the child

and their family (Dr Curran, 2020). The medical model of disability focuses on the impairment of a child with ADHD including what is ‘wrong’ with them and considers ways to treat or cure the problem or make adaptations to restore ‘normal functioning’ for that child (Albert, 2004 and Disability Wales, 2017). The medical model of disability can be beneficial for a child with an ADHD diagnosis as they will be prescribed medication to support their condition (Owens, 2020). However, the social model of disability separates the impairment from the disability and focuses on removing barriers or making adaptations to cater for everybody’s needs, regardless of their diagnosis (Disability Wales, 2017).

Welsh Government (2023b) states that institutional barriers can include policies and procedures that cause barriers to equality. The social model of disability impacts any policies and procedures to include adaptations to support every individual, however, the medical model of disability does not consider these changes which leads to people with additional needs being socially isolated and excluded (Albert, 2004). More recent legislation has impacted inclusive practice for anyone with additional needs as they promote a society that enables people to fulfil their potential regardless of their needs and states that providers are required to make any changes to ensure a fully accessible provision, avoiding any disadvantages for those with disabilities (The Equality Act, 2010 and Wellbeing of Future Generations (Wales) Act 2015).

One barrier for parents of children with ADHD is the negative stigma surrounding the symptoms and behaviours displayed. Children with ADHD are often labelled as ‘naughty’ children with bad behaviour, which causes parents to feel embarrassed and responsible for their child’s behaviour (Sayal, Goodman and Ford, 2005). Smith (2023) points out that parents automatically blame themselves for their child’s hyperactive behaviour and outbursts without considering the brain chemistry or genetic and environmental factors that cause ADHD in children. Parents often feel ashamed and embarrassed about their child’s behaviour and believe that they have caused their child to receive a diagnosis of ADHD due to poor parenting or lack of discipline (Mikami, et al. 2015). DosReis, et al. (2010) found that parents of children with ADHD often feel extremely isolated and rejected as other parents seem to avoid them and not invite the child to birthday parties or play events. These link to the attitudinal barriers discussed in the social model of disability as people’s attitudes towards a child with ADHD and the language and terminology used can have a negative impact on the child and their family, including negative effects on their confidence and wellbeing (Disability Wales, 2017 and Welsh Government, 2023b). Mikami, et al. (2015) worries that children may be misdiagnosed and not receive the treatment and support needed due to parents concerns around the stigma of receiving a diagnosis.

Another barrier present for a child with ADHD and their parents is the concern of accessing the right form of education to best support the child and their needs. Research has shown that children with an ADHD diagnosis or those with probable ADHD can struggle in education settings as ADHD symptoms can affect a child’s learning and development, therefore, affecting their academic performance and social experience in a school setting (Kendall, 2016 and The ADHD Centre, 2024a). The Education Act 1981 describes the responsibility of a local authority to provide all children with a suitable education, whether that is in a mainstream school or a specialist provision school. Parents and professionals around the child are tasked with the decision of deciding which provision would be best to meet the needs of a child with ADHD as each child is different and will require different levels of support and intervention (Kendall, 2016).

There is clear evidence that further training is required in schools for staff supporting children with ADHD (Toye, Wilson and Wardle, 2019). Greenway and Rees-Edwards (2021) found that there is a lack of knowledge and understanding of ADHD amongst teaching assistants in schools which causes poor attitudes and barriers for working with those children. Kendall (2016) also discusses the lack of training and understanding of teachers having an impact on children's education as children with ADHD can be challenging for a teacher within a mainstream classroom, therefore, teachers need to understand the child and use positive strategies to support that child.

The Additional Learning Needs and Education Tribunal (Wales) Act 2018 places a duty on the local authority to favour education in mainstream schools for children with ALN when possible. However, Page (2023) states that a child with ADHD needs to be in a school where teachers understand and support their needs. The Warnock Report 1978 describes the variety of options to support a child with an additional need in their education setting which could be specialist provision for some and for others it could be attending mainstream school whilst accessing additional support. The report states that provision should be flexible and reviewed regularly to reflect the changing needs of the individual. Moore, *et al.* (2017) emphasises the importance of interventions at school having a positive impact on a child's academic journey and prospects in later life and discusses labelling as receiving a label of being diagnosed can lead to negative stigmatisation, however, having that label could help staff to understand ADHD and provide the support needed for the child. The ADHD Centre (2024a) states that a child diagnosed with ADHD can attend a mainstream school with reasonable adjustments being made to meet their needs. Moore, *et al.* (2017) agrees as they say that having staff with a high level of understanding of ADHD and the use of inclusive strategies can ensure a successful placement for a child in a mainstream classroom. Page (2023) points out concerns regarding a child accessing specialist school provision as they worry about the level of education the child would receive and the social aspect of making friends and having role models to influence their levels of development.

Strategy

May, *et al.* (2020) discusses the urgent need to develop strategies to support children with ALN in schools as early intervention can impact children's academic achievements and future life chances. Moreover, McDougal, *et al.* (2022) states that specific strategies for ADHD are lacking as school staff tend to deal with behaviour as it happens rather than being proactive and putting strategies in place to prevent disruptive behaviours.

Page (2023) states that children with ADHD require a clear routine and need to understand what is happening around them. One strategy used to support this is visual strategies which is a positive intervention that has a significant effect on a child with ADHD in a classroom environment (Thomas and Karuppali, 2022). Using visual strategies in a classroom is regarded as inclusive practice as the teacher is adapting the environment to meet the needs of every child, rather than attempting to change the child to 'fit in' the classroom (Cardiff Council, 2021 and Welsh Government, 2019). Visual aids can include pictures, photographs or drawings that are used in a sequence to explain to children what is happening now and next (Chmiliar, 2020). The visual cues support children with ADHD in understanding the routine and what is expected of them (The ADHD Centre, 2023),

reduces anxiety levels (Chmiliar, 2020) and reduces temper tantrums or meltdowns during transition periods as children are clear about what is happening (Flynn, 2022 and Thomas and Karuppali, 2022).

Visual strategies can be used with every child in the class or individually for specific children but need to be used consistently and effectively by staff to be successful in supporting children with ADHD (Flynn, 2022). However, Zimmerman, Leford and Barton (2017) point out that further training is required for staff to use visual strategies appropriately and successfully as often there is a lack of involvement from all staff members and lack of time in mainstream schools due to the teacher: child ratio. Macdonald, et al. (2018) agrees as they found that many teachers had received training on using visual strategies in the classroom but failed to use them everyday which is not beneficial for the children as consistency is key when working with children with ADHD (The ADHD Centre, 2023).

Conclusion

To conclude, ADHD is the most common behavioural condition in children (Wolraich, et al. 2019) and can present in a variety of ways with differing levels of severity (ADHD UK, no date), therefore, making it difficult to diagnose effectively (NHS, 2021a). It is evident that further training is required for parents of children receiving an ADHD diagnosis (The ADHD Centre, 2024a) and for school staff working to support children on their educational journey (Page, 2023). By being proactive and implementing specific strategies to support children with ADHD, society can adapt their attitudes and understanding to enable children and adults with ADHD to feel accepted and included in their environment (Albert, 2004 and Smith, 2023).

Completing this research has significantly developed my knowledge and understanding of ADHD, particularly the varying symptoms and the diagnosis process. I am keen to use some of the strategies I have discovered to help the child that I am currently working with whom I suspect is displaying symptoms of ADHD.