

**ATTENTION DEFICIT
HYPERACTIVITY DISORDER**

ADHD

**INFORMATION AND GUIDELINES
FOR SCHOOLS**

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PREFACE

Inattention, impulsivity and overactivity; these are the three defining characteristics of Attention Deficit Hyperactivity Disorder, or ADHD. These difficulties are not new and ADHD is not a diagnosis which gives an easy explanation of difficulties some children have in education. There is, however, a new awareness that when these characteristics occur in combination and in a severe to moderate form, they can represent a hidden handicap for many pupils.

The ADHD Family Support Group (Malta) has issued this document (based on the one drawn up by the Hampshire County Council, UK) in consultation with colleagues from the health and education service with the aim of providing up-to-date practical information for teachers and parents about how to identify and manage the difficulties of pupils who might be described as having ADHD. There is also a section about managing these difficulties at home.

Media interest has focused on the uses and abuses of drugs in the treatment of behaviour. “ADHD Information and Guidelines for Schools” clearly shows that there is a wide range of alternatives to drugs that can and should be used, even if medication is involved for a small minority of pupils. Above all, this publication emphasises that no single professional group has the answers to children’s complex problems. As in many areas, to understand children and get things right for them within the groups they learn and play in, we have to work together.



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INFORMATION AND GUIDELINES FOR SCHOOLS REGARDING ATTENTION DEFICIT HYPERACTIVITY DISORDER

INTRODUCTION

The purpose of this booklet is to provide information for staff working in all schools in Malta about pupils who are inattentive, impulsive and/or overactive. The guidelines have been produced by a group of educational psychologists in consultation with child psychiatrists, paediatricians and child therapists. Guidance is offered about the identification, assessment and management of the needs of these students.

DESCRIPTIONS AND DEFINITIONS

The concept of attention deficit hyperactivity disorder, ADHD, is rather a contentious one. The arguments are summarised in Appendix A. ADHD is a title used to describe people who exhibit long-term difficulties that include inattention, hyperactivity and impulsivity.

Attentional difficulties are manifested by children being easily distracted both in tasks and in play activities. They often find it very difficult to settle down to school tasks, 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 shown by children having a tendency to interrupt conversations, talk out of turn, having difficulties in waiting for their turn and saying and doing things without a regard for consequences.

For the label to be correctly used in the case of children, such behaviours need to last for longer than six months, to have been present before the age of seven, and to be evident in more than one setting; for example at home and at school. Only if these three conditions are met, can the ADHD label be used correctly. In the case of adults, clinicians look back to see if symptoms were present around the age of twelve.

Distinctions are made between children who show difficulties in attention and impulsivity, and those who in addition show high levels of motor restlessness. The former are described as having ADHD mainly Inattentive Type, those who exhibit only the Impulsive and Hyperactive symptoms are ADHD Impulsive & Hyperactive and those who exhibit all three sets of symptoms, as having ADHD Combined Type. In this document the expression ADHD is used to encompass all types. Other expressions sometimes used are hyperkinetic disorder and overactive.

The complete list of criteria for ADHD from the Diagnostic and Statistical Manual (APA) is shown in Appendix B.

ATTENTION DEFICIT HYPERACTIVITY DISORDER AS A SPECIAL EDUCATIONAL NEED

The National Minimum Curriculum reflects the idea that pupils with emotional and behavioural difficulties are seen as having special educational needs, rather than being seen as naughty or ill. Some pupils do find it very difficult to learn academically and socially for emotional and behavioural reasons. They can also disrupt the learning of other pupils and cause stress to teachers in ways that are not typically true of other areas of special educational needs.

The behaviours and emotions shown by children with ADHD can be seen as a subset of emotional and behavioural difficulties. The biological component may be more obvious for these particular difficulties than for other kinds of difficult behaviour that teachers encounter. The behaviour of as many as 70% of children with attention difficulties and overactivity improves following the administration of a drug called Methylphenidate. This has led to a greater awareness of the interactions between neurological processes and children's difficult behaviours.

The child's behaviour can be very stressful to parents in the more extreme cases of ADHD. Difficult behaviour in turn influences the behaviour of parents, who may become confused, helpless, inconsistent and punitive. Such parental behaviours simply compound the problem and a vicious spiral of negativity, on both sides, can result. Ideas about managing a child with ADHD at home are given in Appendix G.

ADHD does present serious challenges, but the typical features of the ADHD process are not all disabling, as can be seen in the table below.

STRENGTHS	WEAKNESSES
Verbal expression Quick applications of skills Ability to see the big picture Long term memory Intense emotions Enthusiastic, curious Active Generalisation of ideas Creative	Listening Poor organisation Visual detail Short term memory Impulsive Bored easily Impatient Written expression of ideas Cluttered

MANAGEMENT STRATEGIES

As with all learning and behaviour difficulties, intervention needs to be considered at three levels; whole school, classroom and individual.

WHOLE SCHOOL STRUCTURES AND SYSTEMS

Schools have a duty to identify pupils who are experiencing difficulties in learning and behaviour and to attempt to help children with such difficulties, whatever the cause.

Children who do not show the hyperactivity component of ADHD tend to be overly passive, lethargic, prone to daydreaming and sometimes anxious. As children with such behaviour frequently go unnoticed in comparison with other more disruptive behaviours, it is important that schools are vigilant to ensure that their needs are recognised and catered for.

Early identification is important for all children with learning difficulties including those with ADHD.

It is the degree of severity of a pupil's behavioural and emotional problems and their impact on learning that determines the appropriateness, or not, of the method of proceeding. This is more important than whether or not someone has given a label or made a diagnosis. ADHD is like most other emotional and behavioural conditions in that the difficulties range from very mild to very severe.

Schools should follow the Directorate for Educational Services guidelines on the administration of Medicines in Schools for any child prescribed medication for ADHD.

Medical practitioners should give clear instructions when to administer medication in school. It is good practice for the school to provide information about

the pupil's learning and behaviour within school to medical practitioners. This will help to establish the right diagnosis. Checklists for schools to provide such information are given in Appendix C.

In certain cases it may be prudent and beneficial for schools to consult the School Psychological Services of the Education Psycho-social Services within the Directorate for Educational Services. The College educational psychologist should also be involved and s/he working collaboratively with other college team professionals such as psychotherapists and counsellors may liaise usefully between school, home and medical colleagues at any stage.

CLASSROOM MANAGEMENT STRATEGIES

The needs of students with ADHD-type behaviours and experiences are best met with good teaching and classroom management techniques that have relevance to all pupils. Clare Jones, who is recognised as one of the foremost educational authorities in the USA regarding ADHD, writes as follows:

“Just as there is no magic pill to cure attention deficit disorder, there is also no magical strategy that will cure this child's life forever. Rather it is a cluster of good strong teaching techniques that balance theory and practical application that will make the difference. What I have compiled in this book are a variety of strong teaching interventions and strategies that seem particularly appealing to the child with attention deficit disorder but, in fact, will work with all children. They are simply good teaching skills and principles... The answer to serving the child with attention disorders in the classroom is the answer to serving any child in the classroom.”

ATTENTION DEFICIT HYPERACTIVITY DISORDER: STRATEGIES FOR SCHOOL-AGE CHILDREN

Pupils with ADHD-type behaviours 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:

- hook and get the students attention before discussing or making a point
- use non-verbal as well as verbal means of communication to secure child's interest
- use voice effectively, avoid loudness or high pitch
- use movement and distance from child effectively, approaching and moving away from child as necessary to maintain contact and keep interest.
- maintain eye contact during verbal instructions without staring down a student.
- keep instructions short, clear and concise; break up long explanations and instructions into short and manageable elements
- check that students have listened and that they know what to do
- repeat instructions in a calm, positive manner if required.

More detailed advice and guidance for classroom management of ADHD behaviours is to be found in Appendix D.

MANAGEMENT OF THE INDIVIDUAL CHILD WITH ADHD

Behavioural approaches seem to be the most effective. It is recommended that schools and teachers consult the School Psychological Service to ensure that behavioural principles are being applied correctly. Many of the interventions to be described in Appendix D are derived from behavioural approaches.

Most children respond very well to a very positive approach to behaviour that uses rewards and praise for good behaviour. Adults' noticing and acknowledging even small aspects of positive effort and behaviour and then telling children what they saw and heard is very important immediate feedback that builds the children's positive sense of themselves. This is also true of children with attentional difficulties and overactivity. For them, however, it appears that it may be also important to couple this with a response cost management

strategy. For example, this may involve pupils losing tokens for specific undesirable behaviours.

Children must learn the negative effects of wrong doing and the cost to themselves along with the positive effects of doing the right thing with the related rewards. This feedback system needs to be put in place with immediate effect, using a negative consequence that is proportionate to the wrong doing. This system does work if applied firmly, calmly and consistently referring to class rules as necessary guidelines for living and working together. Although some children might show disdain for reward systems and downplay their satisfaction when rewarded, the system needs to be sustained as it helps them mentally connect action with consequence. Reward systems will need to be varied creatively from time to time depending on individual interests of the child.

Behavioural interventions need to be grounded in robust relational approaches. Teachers need to acknowledge, appreciate and take the time to know the students as persons, so that students feel well connected with their teacher and peers and thus much more likely to accept the behaviour guidelines aimed at helping to keep their behaviour on track.

Educational interventions, particularly the matching of the curriculum to the abilities and skills of the pupil, are considered extremely important. The secondary effects of attention difficulties and overactivity are frequently very poor peer relationships, low academic attainments and a very poor self-image.

Counselling and individual therapy can be used to help children understand their emotions and behaviours and build a sturdier sense of themselves so they may feel more in charge of themselves when feeling restless or bored.

Some children may respond better in peer group situations such as the circle of friends approach used by psychologists, psychotherapists and counsellors. This system facilitates relational learning and group problem-solving whilst also creating and consolidating friendship among students – a powerful motivator for developing helpful behaviour in all children and specifically those with ADHD.

In-situ therapy in the classroom is being implemented in our classrooms with good effect – with hands on behavioural learning for the child and his/her impact on the group he belongs in and support for the teacher and LSA.

Filial therapy and Family therapy may be useful to address the cycle of negative interactions within the family.

Diet has been thought to be relevant, but the evidence is inconclusive. Many different substances are thought to have an effect on ADHD, particularly on hyperactivity. Food additives, artificial colourings and sugar have been implicated. It is difficult to prove these claims scientifically.

Medication has been used to treat ADHD. Research suggests that three classes of behaviour-modifying drugs are useful in the management of attention disorders: stimulants, anti-depressants and anti-hypertensive clonidine.

The most likely medication that teachers will come across in Maltese schools is Ritalin. The technical name of this stimulant is methylphenidate hydrochloride. It might seem strange that drugs classified as stimulants are found to be effective in reducing impulsive and overactive behaviour. There is some evidence that children with ADHD lack sufficient neurotransmitters to control their responses. Stimulants such as Ritalin seem to make more of these available and so lead to a greater degree of self-control.

Appendix E lists the names of the most common medications and their possible effects that may sometimes be seen in school.

Experience indicates that after a child with serious attention difficulties has started to take Ritalin, teachers will often notice improvements such as better self-control, concentration, less hostility and provocation to peers, fewer behaviour problems, more co-operation and more on-task behaviour. However, Ritalin does not lead directly to any major improvements in academic attainments, social and interpersonal behaviour. Moreover, the administration of Ritalin does carry risk of some negative side-effects and for this reason teachers are asked to help monitor the child.

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

There are major concerns about the use of medication without the introduction of a carefully structured teaching intervention. For this reason, it is imperative that there is close co-operation between teachers, the family, medical personnel, psychologists and therapists. These guidelines are designed to ensure that, at least as far as schools are concerned, children's needs are met ethically as well as effectively.

It is also important for teachers to be aware of, and so look out for, possible side-effects of medication. If the dosage level is not adjusted correctly, then the child may

- appear lethargic, disorientated and clumsy.
- may increase the child's activity level and so appear to make the problem worse.
- children report feeling as if they are racing and find it almost impossible to settle.
- The most common side-effect, however, seems to be a mild insomnia, which is reported in about 70% of cases. This may be shown by unusual tiredness in the classroom.
- There is sometimes a lessening of appetite.
- There have also been concerns about slight growth reduction in a minority of cases.
- Children who exhibit tics or twitches are particularly vulnerable to stimulant medication which may exacerbate those problems.

THE IMPORTANCE OF MULTI-AGENCY WORKING

Children with attentional or hyperactivity problems are likely to be identified either because their difficulties come to light initially at school, or because of concern about behaviour at home. The referral route may be different depending on the circumstances. Experience suggests that for the most severe cases no single agency has all the answers. These guidelines indicate courses of action for each referral route, which demand multi-agency co-operation.

WHEN EMOTIONAL AND BEHAVIOUR PROBLEMS ARE ISSUES WITHIN SCHOOL

If the problem is predominantly Learning Difficulties, these should initially be referred to the School Psychological Services of the Department for Student services within the Directorate of Educational Services.

If a learning support assistant is to be considered, an initial application (signed by parents/guardians and school authorities) should be made to the Statementing Moderating Panel, who will in turn, ask for an assessment from the Child Development Assessment Unit (see below), the Child Guidance Clinic, School Psychological Services, SPS or a Psychologist in private practice.

N.B. THE SCHOOL NEEDS A PSYCHOLOGIST'S REPORT AS WELL AS THE PARENT'S/GUARDIAN'S SIGNED CONSENT IN ORDER TO MAKE THE APPLICATION TO THE STATEMENTING MODERATING PANEL.

For a multidisciplinary team assessment to take place at either the Child Development Assessment Unit (C.D.A.U.) or Child Guidance Clinic (C.G.C.) a TICKET OF REFERRAL is needed from any of the following:-

- a) the family doctor
- b) School Medical Officer
- c) Any G.P./Health Centre Doctor

Where the child is referred to depends on the predominant nature of the problem. Learning problems are usually assessed at C.D.A.U. However, if the problems are behavioural and/or emotional these are assessed at the C.G.C and SPS.

The Alternative to intervention and referral to the School Psychological Services of the Department for Student Services is the hiring of a private psychologist, contact us for a list of numbers of reliable practitioners.

APPENDIX A

EDUCATIONAL AND MEDICAL PERSPECTIVES ON ADHD

ADHD: A CONTENTIOUS ISSUE?

There has been a shift away from the categorising and labelling of pupils and preferred reference being made to children's difficulties in terms of special educational needs. A special educational need is seen as a challenge one rises up to. The challenge is to reduce the discrepancy between what the child is currently attaining and what adults should be able to expect from a child at that age. There is a wider debate about whether or not it is helpful to describe children's performance in comparison with age-norms.

Clearly categories or labels are of educational significance only if they have implications for what needs to be taught and how best to do it. Special educational needs are difficulties to be overcome, rather than disorders to be diagnosed.

Mental health professionals, on the other hand, are much more at home with the idea of disorders. They tend to focus on classifying problems into syndromes (clusters of symptoms that seem to hang together). Sometimes there is a need, particularly in the USA, to have a label for the disorder in order to secure funding or placement. Usually, this is not the case in Malta (although, once a label is used, it catches on).

These two very different approaches, one focusing on effective teaching (psycho-educational) and the other focusing on classification (medical) can cause difficulties of understanding when different professionals communicate about a child with lay people.

There is one particular fact that makes the management of ADHD prone to conflict. For over 50 years it has been found that sometimes difficult behaviours in attention and hyperactivity could be quite profoundly and suddenly changed by the administration of methylphenidate (more commonly called Ritalin).

There are very different views about the use of behaviour-modification drugs. The topic of ADHD raises strong emotions, particularly when schools are asked to become involved in the administration of medication.

There is also confusion because ADHD overlaps with a range of other difficulties, particularly specific learning difficulties, communication disorders, dyspraxia etc.

CAUSES AND EXPLANATIONS

Research evidence regarding the causes of ADHD remains somewhat inconclusive. This is in part due to the lack of agreement about reliable criteria that can be used to diagnose ADHD correctly. Nevertheless there is a growing consensus that some kind of altered biochemistry is one of the factors. The frontal lobes of the brain seem to be involved in regulating attention, emotional responses and activity levels. The rate at which the brain uses glucose in this area of the brain appears slower in children showing hyperactivity. Neurotransmitters certainly play a part in controlling behaviour, concentration and impulsivity.

There are a number of hypotheses to account for these variations in brain functioning. They range from prenatal and perinatal difficulties, genetic factors, diet and increasing lead poisoning, through to social aspects such as styles of parenting, sometimes internal brain/head injuries from sports such as football have been implicated.

It is highly unlikely that there is one single cause that will account for the susceptibility of some children to be more dreamy, disorganised, overactive and impulsive. Above all, it is important to recognise that biological factors only predispose children to behave in certain ways.

An integrative psychotherapeutic approach, in fact emphasises that the attentional processes and the movement within the person from awareness of a need or goal to satisfaction and completion, involve the complex interaction of a number of processes, each of them with its own neurochemical dimensions and each of them interacting not just with each other but with other subjective organizational dynamics and relational context and history. Any and all of these boundaries will mediate and co-structure

the child's experience and thus his or her success or failure at forming and actualising goals. These same boundaries are the points where intervention and support may be useful.

Most behavioural and emotional difficulties can be addressed by increasing the child's awareness and self-support so that he or she learns and practises techniques of self-monitoring and self-management and also increasing environmental support: caring, contactful teachers and a specifically structured learning environment.

Children with ADHD need the adults around them to like them and believe in them..although they find it hard to keep their behaviour on the mark. They are so more than the difficult behaviours they engage in from time to time. It is also useful to remember that they have particular strengths as well as their more obvious weaknesses.

APPENDIX B

DSM V: DIAGNOSTIC CRITERIA FOR ATTENTION DEFICIT HYPERACTIVITY DISORDER

- A. Inclusion: Requires a pattern of behaviour, with onset before age twelve years, that is present in multiple settings and gives rise to social, educational, or work performance difficulties. The symptoms must be persistently present for at least six months to a degree inconsistent with developmental level. The disorder is manifested by at least six of the following symptoms of *inattention*.**
- i. Overlooks details: *Over at least the last six months, have other people told you that you often overlook or miss details, or that you made careless mistakes in your work?*
 - ii. Task inattention: *Do you often have difficulty staying focused on a task or activity, such as reading a lengthy writing or listening to a lecture or conversation?*
 - iii. Appears not to listen: *Do other people tell you that when they speak to you, your mind often seems to be elsewhere or that it seems like you are not listening?*
 - iv. Fails to finish tasks: *Do you often struggle to finish schoolwork, chores, or work assignments because you lose focus or are easily sidetracked?*
 - v. Difficulty organising tasks: *Do you often find it difficult to organise tasks or activities? Do you struggle with time management or fail to meet deadlines?*
 - vi. Avoids tasks requiring sustained mental activity: *Do you often avoid tasks that require sustained mental effort?*
 - vii. Often loses things necessary for tasks: *Do you often lose things that are essential for tasks or activities, such as school materials, books, tools, wallets, keys, paper-work, eyeglasses, or your phone?*
 - viii. Easily distracted: *Do you find that you are often easily distracted by things or thoughts unrelated to the activity or task you are supposed to be doing?*
 - ix. Often forgetful: *Do you find, or do other people find, that you are often forgetful in your daily activities?*
- B. Inclusion: Alternatively, requires the presence of at least six of the following manifestations of *hyperactivity* and *impulsivity* over the same course.**
- i. Fidgets: *Over the last six months, have you often found yourself fidgeting with your hands or feet? Do you find it hard to sit without squirming?*
 - ii. Leaves seat: *When you are in a situation where you are expected to sit, do you often leave your seat?*
 - iii. Runs or climbs: *Do you often find yourself running around or climbing in a situation where doing so is inappropriate?*
 - iv. Unable to maintain quiet: *Do you often find yourself unable to play or engage in leisure activity quietly?*
 - v. Hyperactivity: *Do you often feel as if you are, or do other people describe you as always being, on the go or acting as if you were “driven by a motor”? Do you find it uncomfortable to sit still for an extended time?*
 - vi. Talks excessively: *Do you often talk excessively?*
 - vii. Blurts answers: *Do you often struggle to wait your turn in a conversation? Do you often complete other people’s sentences or blurt out an answer before a question has been completed?*
 - viii. Struggles to take turns: *Do you often have difficulty waiting your turn or waiting in line?*
 - ix. Interrupts or intrudes: *Do you often butt into other peoples’s activities, conversations, or games? Do you often start using other people’s things without permission?*

C. Exclusion: If the criteria are not met in two or more settings, or there is no evidence that the symptoms interfere with functioning, the symptoms occur only in the context of a psychotic disorder, or the symptoms are better explained by another mental disorder, do *not* make the diagnosis.

D. Modifiers:

i. Specifiers

- Combined presentation: If both inattention and hyperactivity-impulsivity criteria are met for the past six months
- Predominantly inattentive presentation: If inattention criteria are met but hyperactivity-impulsivity criteria have not been met for the past 6 months.
- Predominantly hyperactive / impulsive presentation: If hyperactivity-impulsivity criteria are met and inattention criteria have not been met for the past 6 months.

ii. Specifiers

- In partial remission

iii. Severity

Mild: Few, if any, symptoms in excess of those required to make the diagnosis are present, and symptoms result in no more than minor impairments in social or occupational functioning.

Moderate: Symptoms or functional impairment between “mild” and “severe” is present.

Severe: Many symptoms in excess of those required to make the diagnosis, or several symptoms that are particularly severe, are present, or the symptoms result in marked impairment in social or occupational functioning.

E. Alternatives:

If a person is experiencing a subthreshold symptoms or you have not yet had sufficient opportunity to verify all criteria, consider other specified or unspecified attention-deficit/hyperactivity disorder. The symptoms must be associated with impairment and do not occur exclusively during the course of schizophrenia or another psychotic disorder and are not better explained by another mental disorder.

APPENDIX C

SCHOOL ASSESSMENT OF CHILDREN WITH ADHD

There are several instruments available. Schools may photocopy the ADHD rating scale on this page. No attempt has been made to standardise this measure. Schools are encouraged to contact the School Psychological Services, SPS of the Student Services Department, DES who may liaise with the C.D.A.U. or C.G.C. for a comprehensive understanding of the presenting issues.

ADHD RATING SCALE

Name..... This form completed by

Today's date/...../..... Age Year group male/female (*please circle*)

Circle the number in the appropriate column which best describes the child's behaviour

	not at all	just a little	quite often	often
Often fidgets or squirms in seat	0	1	2	3
Has difficulty remaining in seat	0	1	2	3
Is easily distracted	0	1	2	3
Has difficulty waiting for turn in groups	0	1	2	3
Often blurts out answers to questions	0	1	2	3
Has difficulty following instructions	0	1	2	3
Has difficulty sustaining attention to tasks	0	1	2	3
Often shifts from one uncompleted activity to another	0	1	2	3
Has difficulty playing quietly	0	1	2	3
Often talks excessively	0	1	2	3
Often interrupts or intrudes on others	0	1	2	3
Often loses things necessary for tasks	0	1	2	3
Often engages in physically dangerous activities without considering consequences	0	1	2	3

APPENDIX D

i CLASSROOM MANAGEMENT STRATEGIES FOR STUDENTS WITH ADHD

1 PHYSICAL ARRANGEMENT OF THE CLASSROOM

- Use rows for tasks which do not require interpersonal contact. Avoid the use of tables with groups of pupils, as this maximises interpersonal distractions for the student with ADHD.
- Ideally a classroom should provide flexibility of seating, with several tables for group work and rows for independent work.
- Keep the room free of 'obvious' visual distractions, take a seat at one of the pupil's desks and observe what would catch your eye first, is it the teacher or one of the posters?
- Arranging desks in a horseshoe shape has been found to promote discussion without impeding independent work.
- Lighting should be adequate, with enough brightness to stimulate visual learning.
- Sit distractible students near the teacher – as close as possible without being perceived as punitive.
- Locate the more distractible students away from windows and corridors to minimise visual and auditory distractions.
- Keep a part of the room free from obvious visual and auditory distracters.
- Seat peer models with good study skills next to children showing attentional difficulties and overactivity.

2 LESSON ORGANISATION

- Provide an outline, key concepts and essential vocabulary prior to lesson or topic presentation.
- Vary the pace of lesson presentation, especially the vocal tone and pitch.
- Include a variety of activities during each lesson
- When appropriate, intersperse in-seat tasks with more physical activities.
- Use multi-sensory presentation, but make sure that interesting pictures and sounds relate directly to the material to be learned.
- Set short achievable targets and reward task completion promptly. Allow a short break before the next target is set.
- Musical Rhythm and Sound during reading or while doing specific tasks, reinforces learning with an auditory element provided the music is soft and enhances concentration.
- Actively involve students in lesson preparation.
- Encourage students to develop mental images of the concepts or information being presented. Ask them about their images to be sure they are visualising the key material to be learned.
- Use co-operative learning activities, particularly those that assign each child in a group a specific role or piece of information that is needed to complete the group task.
- Ask Students to make connections about the material being taught by asking thought provoking questions, linking ideas and explanations together.

3 GENERAL ORGANISATION

- If sports activities can be done at the start of the day it will help in expending excessive energy and get blood flowing in the brain early in the day, enhancing the learning process.
- Establish a daily classroom schedule and ensure that routines are known and practised, particularly for beginnings, endings and transitions.
- Give five minute warning before ending of a session for the completion of the task and putting away equipment, etc.
- Use individual assignment charts or home-school book to go home with the pupil and be signed daily by the parent if necessary.
- Be clear about when pupil movement is permitted, when it is not allowed and when it is discouraged.
- Use a timing device, (eg. kitchen timer) to indicate special periods of intense independent work and reinforce the class for appropriate behaviour during this period. Start with briefer periods (5-10 minutes) and gradually increase the length of time as the class develops success.

4 BEHAVIOUR

- Keep classroom rules simple and clear, with examples of keeping and breaking the rule modelled and role-played.
- Allow use of stress balls to divert fidgety behavior into harmless actions.
- Chewing gum may be allowed to increase blood flow to head reduce fidgety behaviour provided that it's also instructed to dispose in the bin rather stuck underneath the table.
- Actively reinforce desired classroom behaviours.
- Praise specific behaviour in a relational way by using 'I' and 'you' statements. For example: "I like how you correctly wrote down all the things you have to do" rather than "Well done!"
- Frequently, move about the room so that you can maximise your degree of proximity control.
- Set short measurable goals for behaviour with lesson by lesson reinforcement.
- Tackle only one target behaviour at a time.

ii STRATEGIES TO ADDRESS SPECIFIC BEHAVIOURAL ISSUES

1 INATTENTION

- Provide frequent, immediate and consistent feedback on behaviour and redirection back to task.
- Seat pupil in a quiet area.
- Seat pupil near a good role model.
- Increase distance between desks.
- Seat pupil away from distracting stimuli.
- Give assignments one at a time.
- Gear assignments to attention span e.g.: 10 minutes, 15, minutes, 20 minutes, 30 minutes.
- Break long assignments into smaller parts.
- Include a variety of activities during each lesson.
- Assist pupil in setting short term goals.
- Restrict homework to that which is essential.
- Give clear, concise instructions.
- Provide written outline of lesson.
- Cue pupil to stay on task, eg, using a private signal.
- Let pupil share recently learned concepts, etc, with a peer still having difficulty with them.
- Pay careful attention to design of worksheets and tests.
- Use large type and provide only one or two activities per page.
- Keep page format simple.
- Avoid extraneous pictures or visual distracters that are not specifically and directly related to the task.
- Have white space on each page.

- Use dark black print and avoid hand-written worksheets or tests if possible.
- Write clear, simple directions.
- Provide alternative environments with fewer distractions for taking tests.
- Allow pupil to use tape recorder sometimes rather than always requiring written work.
- Shorten assignments. If the pupil can demonstrate adequate skill mastery in 10 or 20 questions, don't require completion of 30-40 items.

2 EXCESSIVE MOTOR ACTIVITY

- Choose the ADHD pupil to be the one who writes keywords or ideas on the board, etc.
- Allow opportunities for pupil to move around the room or use of a stress ball.
- Provide short break between assignments.
- Remind pupil to check work if performances is rushed or careless.
- Plan ahead for transitions, establish rules and supervise closely.

3 POOR ORGANISATION AND PLANNING

- Establish a daily classroom routine and schedule.
- Help students in writing down a plan of activity before hand.
- Organise desks and folders daily. Check for neatness.
- Persuade parents to use organiser trays at home marked with the day of the week so that books and work required at school that day are all together.
- A personal visual timetable may be helpful in view of the difficulty with time concepts.

- Fasten a checklist to the pupil's desk, or put one in each subject folder/exercise book to outline the steps to be taken in following directions or checking to ensure that a task is correctly completed.
- Give notes to the pupil about key elements in the lesson.
- Use individual homework assignment charts that can go home to be signed daily by parents.
- Provide rules for getting organised.
- Give assignments one at a time.
- Supervise recording of homework assignments.
- Check homework daily.
- Assist pupil in short-term goals in completing assignments.

4 IMPULSIVENESS

- Keep classroom rules clear and simple.
- Ignore minor inappropriate behavior.
- Increase immediate rewards and consequences.
- Use careful reprimands for misbehaviour (criticise the behaviour not the child).
- Attend to positive behaviour with compliments.
- Seat pupil near a good role model or near teacher.
- Encourage the pupil to verbalise what must be done; aloud to the teacher in a one to one setting at first, then whispering quietly to self and finally saying silently to self.
- Teach verbal mediation skills to reduce impulsive behaviour by modelling. Practise a structured routine of stop/listen, look/think, answer/do.

5 NON-COMPLIANCE

- Praise co-operative behaviour.
- Provide immediate feedback about acceptable and unacceptable behaviour.
- Use teacher attention to reinforce positive behaviour.

6 DIFFICULTIES WITH PEERS

- Praise appropriate social behaviour.
- Organise social skills training to teach concepts of communication, participation and co-operation.
- Define social behaviour goals with pupil and implement a reward programme.
- Encourage co-operative learning tasks with other pupils.
- Praise pupil frequently to increase esteem within the classroom.
- Assign special responsibilities to pupil in presence of peer group so others observe pupil in a positive light.

7 POOR SELF-ESTEEM

- Provide reassurance and encouragement.
- Frequently compliment positive behaviour.
- Focus on pupil's talents and accomplishments.
- Reinforce frequently when signs of frustration are noticed.

APPENDIX E

COMMONLY PRESCRIBED MEDICATIONS FOR ADHD AND THEIR EFFECTS

Drug Class	Common name	Technical name	Effects	negative
Stimulants	Ritalin	Methylphenidate hydrochloride	<p>Increasing attention Controls impulsiveness</p> <p>Reduces task- irrelevant activity</p> <p>May increase compliance May improve writing</p>	<p>May:- restrict range of emotional responses result in mild insomnia cause loss of appetite</p> <p>may lower seizure threshold</p> <p>may exacerbate tics, licking of lips, finger picking. Pemoline may have adverse effects on the liver.</p>
	Concerta	Methylphenidate hydrochloride (slow release)		
	Dexedrine	Dextro-amphetamine Amphetamine salt combination		
	Adderal	Pemoline		
	Cylert			
Anti-depressants	Tofranil	Imipramine	<p>Increasing attending behaviour</p> <p>Increasing verbal/gestural communication</p> <p>Decreases depression/anxiety</p> <p>Decreases disruptive behaviour</p>	<p>Some effects on cardiovascular System (except for Bupropion) Dry mouth (except for Bupropion)</p> <p>Constipation (except for Bupropion)</p> <p>Bupropion may lower seizure threshold</p>
	Norpramin	Desipramine hydrochloride		
	Wellbutrin	Bupropion		
	Trypizol	Amitriptyline		
Anti-hypertensives	Catapres	Clonidine hydrochloride	<p>Reduces hyperactivity</p> <p>Reduces impulsivity</p> <p>Decreases aggressive behaviour</p>	<p>Less effective than stimulants in increasing attention</p> <p>May trigger delirium or hallucination</p>
Nor-epinephrine Re-uptake inhibitor	Strattera	Atomoxetine	<p>Increases attention, reduces impulsivity and hyperactivity.</p>	<p>Upset stomach, decreased appetite, fatigue, dizziness, mood swings reducesv</p>
	Anti-Psychotic	Risperdal / Risperdone	<p>Used for autistic irritability</p> <p>Decrease aggressive behaviour</p>	<p>Heart and blood pressure need to be monitored</p>

APPENDIX F

MONITORING THE EFFECTS OF MEDICATION FOR

Name.....This form completed by

Today's date/...../.....Age Year group male/female (please circle)

Please indicate by placing a tick in the appropriate column any changes you have noticed in the pupil's behaviour as described below:

Main effects seen in behaviour	worse	no difference	improved a little	improved a lot
attention to task				
finished assigned work				
impulsivity				
calling out in class				
organising work				
overactivity				
restlessness, fidgety				
talkative				
aggressive				
peer interaction				

Tick any side-effects which you have noticed or which the pupil has mentioned.

appetite loss	stares into space a lot	sadness
insomnia	irritability	withdrawn
headaches	excessive crying	motor or vocal tic
nervousness		

Any other comments:

APPENDIX G

MANAGING A CHILD'S ADHD BEHAVIOURS AT HOME

Basically, children with ADHD find it difficult to look to the future and to control their behaviour based on that foresight. Outside, they rush headlong into hazardous situations. At school, their progress can be a worry. At home, their incessant talking can be tiring. In short, it is seriously hard work to parent a child who is impulsive and has difficulty concentrating; even more so if he or she is also overactive. Children with ADHD need more supervision, more support and a greater level of tolerance than do most children. If you are the parent of such a child, then stress is inevitable, but it does not have to destroy you. This section offers guidelines to parents about managing children with ADHD.

One small child with ADHD can have a big impact on a family. Problems start early. When pre-school children with ADHD are around, more things just seem to get broken, food just seems to get spread about, and other children just seem to end up in tears.

Patterns of family life in Malta are changing, but it is still true that mothers are the main carers of children. Research suggests that ADHD children behave better when they are with their fathers (it's probably being the fact that 5 out of 7 children diagnosed with ADHD are boys, and fathers are role models for boys). It is not uncommon therefore for parents of ADHD children to experience conflict with each other. The father blames the mother for not keeping the child under control. The mother explains that nothing she does works. Fathers then react in a variety of ways; avoiding going home until the child is asleep, for example, or taking sides with the child in conflicts against the mother.

Mothers also react. They see other women raising their families with apparent ease. This adds to maternal self-doubt, anxiety and depression. In turn, these feelings are communicated to the child and the situation deteriorates further. Some parents become social isolates; demoralised, despairing and tyrannised by their offspring. In extreme cases, the family may break up.

Many families seek professional help and discover that their child is recognised by professionals as having a developmental difficulty. Although the process of deciding to seek an assessment can

be traumatic, many parents find that diagnosis is a relief. This is because it enables them to offer an account, particularly to critical onlookers, of why their child's behaviour is what it is. Application of a diagnostic label can help parents to realise that their child's weaknesses are not their fault. This realisation can be the start of a long-term process of better-informed advocacy for the child.

Diagnosis is controversial. It can be helpful as indicated above. One of the most powerful reasons for avoiding diagnostic labels, however, is that they do tend to limit expectations and thus create artificial ceilings for children. For example, if no one expects an ADHD child to concentrate, there is a danger that no one will ever try seriously to get him or her to do so. In this way a diagnosis can create a handicap.

It does not have to be like this. Russell Barkley in this book "Taking charge of AD/HD", (1995) advises parents to work out for themselves their philosophy of child-rearing. "If you view your parental responsibility as resting on a tripod, the first leg is the principle-centred approach. Add executive parenthood and scientific thinking, and your strategy for raising a well-adjusted child will have a firm and balanced base". These three elements are summarised below:

BEING A PRINCIPLE-CENTRED PARENT

Principles are useful because "when we see the why, we are more likely to do the how". In other words, we are more likely to manage children's behaviour effectively when we understand what techniques we are using and the reasons for choosing them. Having a set of principles gives us the chance to stop and think before reacting. Helpful principles include:

1 BEING PROACTIVE, NOT JUST REACTING

We can take the initiative to change what we do not like in the way we react to children. We have the ability to subordinate our impulses to our values. We can choose our actions.

2 BEGINNING WITH THE END IN MIND

If we don't know where we are going, we are sure to end up somewhere else. When faced with a problem, we can try to imagine how we would like it to turn out. With a clear goal in mind we are more likely to be able to design steps towards that goal.

3 PUTTING FIRST THINGS FIRST

Ask what really matters? For example, is it more important for my child to arrive at school calm and cheerful, or to tidy his room before leaving the house?

It is helpful to distinguish between tasks that are:

- urgent and important
- important but not urgent
- not important and not urgent

We can then decide what needs doing now, and what can wait.

4 LOOKING FOR BETTER-FOR-BOTH SOLUTIONS

No one wants to be remembered as a nagging parent. It is much better to aim to be seen as respectful and assertive negotiators. In many situations it is possible for us and our children to get the outcomes we both want, but we need to think creatively.

5 SEEKING FIRST TO UNDERSTAND, THEN TO BE UNDERSTOOD

This principle is about understanding a child's point of view. We need to realise how things are from a child's perspective. All children and particularly ADHD children live in the here and now. Next time we feel angry, we cannot expect them to reflect on all the things we have done for them in the past and realise how much we love them. They will respond to how we are right now. How we talk to our children will influence their reactions dramatically. It involves attending to the little things, like smiling, being courteous and making expectations clear. Taking on board a child's perspective involves ethically challenging issues such as keeping our promises and apologising for our own mistakes.

6 TAKING CARE OF YOURSELF

At a basic level, taking care of yourself means getting proper nutrition, exercise and rest. In addition, we all need emotional support, social contacts, intellectual stimulation and spiritual well being. If you are not doing these things, it doesn't mean you are hopeless; it probably means you're exhausted.

BEING AN EXECUTIVE PARENT

Professionals have their useful contributions, but you know your child best. Professionals change and they have different priorities at different times. For you, your child will always be a high priority. It may be right to respect expertise, but don't feel intimidated by professional titles. Ask for advice about your child, but then take the decision yourself about what should happen to him or her. This appendix is called Managing a child's ADHD behaviours at home. That describes exactly what needs to be done. Parents are managers, leaders of the family.

BEING A SCIENTIFIC PARENT

Scientists admit their uncertainty about something and then seek as much information as they can. They question, remain open to new information, and are sceptical of opinions unsupported by facts. Finally, they experiment with new ways of doing things and revise their plans based on the results. The idea is that truth is gradually pieced together, not revealed in a flash.

As a parent, it is healthy to admit uncertainty. A recent research paper described ADHD as "an evolving concept originating in America". Although a lot of research has been done, much remains unknown.

The more knowledge parents seek, the less likely they are to make the same mistakes as others. They need to read what they can and to question what they read. It is a good idea to talk with professionals about what one has read and to maintain an open mind. If they don't support a course of action, probably they will have their reasons. Parents should find out what they are. Parents can then decide if those reasons are convincing.

Experimenting and revising are never-ending processes. If something works once, try it again. If a course of action does not seem to work, then use what you have learnt to try to help the child in a different way.

In addition to the general ideas above, there are some practical strategies which parents have found to be valuable in managing children with ADHD:

1 GIVE YOUR CHILD FREQUENT FEEDBACK

Children with ADHD are often unaware of whether or not they are doing the right thing. You need to believe all children want to do the right thing in their heart of hearts. Use reminders to yourself to give your child feedback on how he or she is getting on. Remarks like: "Its good to see you on track" "Looks like you're doing well right now", "Keep at it, its a hard job and you're managing well", "Glad to see you're getting along with your sister, friend" are useful and encouraging. Reminders to give feedback could include use of the kitchen timer, post-it notes on the corners of mirrors, or a note on the door of the fridge.

2 GIVE YOUR CHILD IMMEDIATE FEEDBACK AND CONSEQUENCES

ADHD children live for now, not the future. Positive feedback rewards a child for doing something well. The child will be more likely to behave in that way in future. Make sure you say specifically what it is that he or she has done right. The more **immediately** you can provide this feedback, the more effective it is likely to be. Imagine, for example, an ADHD child who has problems playing with a younger brother or sister. You should be alert to any examples of co-operation, sharing or politeness by the older child and give praise when you spot the child behaving in that way. Similarly, the child should receive negative consequences for any instances of bullying, or damage to toys. Stop and think before you speak. Stay calm. Tell the child exactly what has been done wrong; don't just yell, even if you feel like it.

You may need to remove a privilege or some other punishment to fit the wrong-doing. There is no point going over-the-top and making a big fuss about a relatively minor misdemeanour. Similarly, there is no point setting long term consequences. Consequences need to be very short term. Consequences will be more useful than a long talk about the problem. A lengthy telling-off is likely to lead to aggravation, not respect, or compliance. Aim to be firm but fair.

3 USE REWARDS RATHER THAN PUNISHMENT

It is common for parents to resort to punishment when a child misbehaves. Unfortunately, punishment leads to resentment and hostility, especially if the child has been genuinely unable to control his or her behaviour.

A more effective and less stressful way to change undesirable behaviour is to use incentives and rewards, rather than punishments. Remember that rewards are not bribes. Rewards are deserved and legitimate positive consequences. Bribery only refers to promoting dishonesty or some other anti-social behaviour.

Firstly, decide what the positive alternative is to the behaviour you want to change. Then you can praise the child for it when it occurs naturally. If this fails, after about a week, then try introducing mild negative consequences. Options include loss of an immediate privilege, or perhaps time out, which is, isolating the child for a few minutes in a safe place. Make sure that you criticise the behaviour, not the child.

4 AIM TO BE CONSISTENT

Consistency means managing the child in the same way every time. Having decided upon a course of action, it is important not to give up too soon. Consistency also means ensuring that all the adults in a child's situation respond in the same way. Most difficult of all, it involves managing children the same way in public and in private situations.

5 PLAN AHEAD TO MANAGE PROBLEM SITUATIONS

If you know that a potentially stressful event is approaching, you can use a problem solving strategy to find an alternative way of managing it. Everyone has problems sometimes, so it is worth having a strategy for finding solutions, such as:

- **identify the problem and set a goal**
define the problem clearly; say what you want the outcome to be.
- **generate alternative solutions: brainstorm**
think of as many ideas as you can; don't criticise any ideas at this stage borrow other people's ideas and build on them.

- **consider the consequences**
choose an idea that you think will work.
- **make an action plan**
write down a step by step plan; practise each step.
- **implement the plan**
put each step into action.
- **evaluate**
ask yourself did it work? If not – why not?

6 PRACTISE FORGIVENESS

Try reviewing the day and letting go of any anger and resentment towards your child that may have arisen during the day. Forgiving children at the end of each day does not mean that they avoid all responsibility for their actions, but this is one way of maintaining a positive relationship with your child. It may even help them to get to sleep.

Sometimes we may need to forgive other adults for the way they have misunderstood our children (by seeing them as mad, bad, or whatever). We may need to continue to advocate assertively for our children, but it is not going to help if we feel in turmoil because of what someone else has said.

Finally, you may need to forgive yourself for the mistakes you've made. None of us is perfect. When we do make mistakes we can maintain an experimental perspective and try to learn from them.

APPENDIX H

GENERAL STATISTICS REGARDING

ADHD

- ADHD affects 6-7% of children according to DSM-IV criteria and 1-2% according to ICD-10 criteria.
- ADHD affects boys 3 to 7 times more than girls, due to inherent brain differences between boys and girls during development.
- ADHD continues into adulthood in about 30-50% of children.
- 2 to 5% of Adults have ADHD.
- The Condition is 75% likely to be genetically inherited from a parent or grandparent.
- At least 30% of cases of children with traumatic brain injury develop ADHD.
- Around 5% of cases of ADHD are due to brain damage, especially sports.
- With ADHD it is 50% likely to have a co-morbidity such as anxiety, depression or dyslexia.

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