ACHIEVING THE BEST

A PRACTICAL GUIDE FOR PARENTS OF CHILDREN

WITH ATTENTION DEFICIT HYPERACTIVITY DISORDER

ADHD

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PREFACE

This guide aims to help parents of children with Attention Deficit Hyperactivity Disorder (ADHD) steer their way through the problems they are likely to meet.

Based on the latest research, the information is described in a simple way and presented in a loose-leaf folder so that it can be easily updated. New or additional pages can then be added when new material becomes available.

The last section is empty so parents can file their child's report or any other information they may want to keep.

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1 AN INTRODUCTION TO ADHD

1.1 What is Attention Deficit Hyperactivity Disorder?

Attention Deficit Hyperactivity Disorder (ADHD) is a term used to describe the condition of children who are inattentive, impulsive, and active at levels higher than expected for their mental and chronological age.

1.2 How is ADHD diagnosed?

The three core symptoms used to diagnose ADHD are:

- **Attention Problems:** Inattention and distractibility, difficulties in sustaining attention and apparently not listening

  Difficulties in organising and following through instructions

  Losing things and forgetfulness

- **Impulsivity:** Difficulties in waiting for his/her turn, often blurting out answers before questions are completed.

  Butting into conversations or games

- **Hyperactivity (restless over activity):** Running about or climbing excessively, always on the go, fidgeting with hands or feet or unable to sit still.

Britain, like most of Europe, uses the International Classification of Disease (ICD). The ICD10 category for the three features above is **HYPERKINETIC DISORDER**. As well as all three features, the condition will have to have been present from an early age and in more than one setting, such as at home and in school. Hyperkinetic Disorder occurs in about one child in 100, and in boys more often than girls.

In North America, using what is called the Diagnostic and Statistical Manual (DSM), only one of the criteria - attention problems or impulsivity / hyperactivity – is necessary to fulfil the diagnosis of **ATTENTION DEFICIT HYPERACTIVITY DISORDER**. This occurs in about 4 – 7 per cent of school-age children.

The North America terminology and the wider diagnostic criteria used for ADHD are now common in this country. It is recognised that a far greater number of children need help than only those with the full set of features indicating hyperkinetic disorder.

It is important to stress that an ADHD **diagnosis** is made on the basis of a **recognisable behaviour pattern**. The cause of the behaviour may be complex. But as this guide will show, children with the condition can be helped through good parenting, good management at school and the controlled use of medication.

Children with ADHD are difficult to raise. They may develop educational, behavioural and conduct problems or emotional difficulties and to suffer from low self-esteem.

1.3 Children with ADHD may also be:

- Charismatic
- Athletic
- Visionary
- Insightful
- Passionate
- Optimistic
- Resilient
- Artistic
- Creative
- Imaginative
- Hard Working
- Adaptable
- Sensitive
- Energetic
- Humorous
- Open minded
- Fun loving

1.4 What is the cause?

In the past, professionals tended to blame parents for the behaviour of a child with ADHD. Others have said the condition was due to additives in the food. However, research has not supported the popular view that ADHD is due to eating food additives, preservatives or sugar. Although the symptoms of some children get worse with certain foodstuffs, this is not the main cause of ADHD.

It is now known that ADHD is associated with a minor difference in the chemical tuning of the brain. It is commonly genetic and many children with ADHD have a parent or close relative with a similar condition.

In rare cases ADHD is associated with pregnancy or birth complications. In a few cases it arises as a direct result of disease or trauma to the central nervous system.

Poor parental management is not thought to be a primary cause of ADHD but can make the symptoms worse.

1.5 What is involved in the assessment?

Parents may be asked to fill in a checklist of symptoms if ADHD is suspected. A similar checklist will also be given to the child's schoolteacher.

In the checklist, parents are asked detailed questions about the child's behaviour in a range of situations. The child will also be observed directly and may undergo tests to clarify ability and attainment.

The evaluation may take time – one to two hours per week over the course of three weeks. This is necessary as a diagnosis in an individual child needs to consider the level of development that the child has reached and rule out other causes, such as deafness or learning disability.

It is also important to find out whether your child has additional problems sometimes found with ADHD. These include learning difficulties, dyspraxia (clumsiness), speech and language problems and autism spectrum problems.

1.6 What is involved in treatment?

Treatment programmes aim to support devolvement in learning and behaviour. The first lines of treatment are through non-medication measures such as in items 1-5, particularly in younger children.

1.7 Behavioural Therapy:

1) Parent Management training

The aim is to modify the child's behaviour. Good behaviour is encouraged by a reward and inappropriate behaviour is ignored or something enjoyable is removed.

Parents are helped to find positive strategies to assist them to manage their child's behaviour more effectively. The aim is to encourage children to develop their own strategies and regulate their symptoms.

NICE guidelines state: parent-training programmes aim to optimise parenting skills to meet the above-average parenting needs of children and young people with ADHD and do NOT necessarily imply bad parenting.

2) Attention Training for Young Children:

The child's ability to attend is gradually developed using structured play activities in a one-to-one situation with an adult, generally the parent.

3) Cognitive Behavioural Therapy:

Includes training in problem-solving and social skills training. For older children who are anxious or whose self-esteem is low, helping children correct their distortions in thinking and developing more positive self-talk can be helpful.

4) Educational Measures:

Children with ADHD have been shown to respond to behavioural programmes at school. They may also have associated problems such as specific learning difficulties or clumsiness which may need special help

5) Special Diets:

These are often well known to parents but are difficult to follow. Their general effectiveness has not been proven in research trials. Occasionally a diet may be tried for a child with known allergies under the supervision of a dietician. A food diary will often clarify the situation. As with all children, a healthy nutritional diet is recommended.

6) Medication:

Using stimulant medication should not be regarded as controversial. There is overwhelming evidence over the years for its effectiveness, most recently supported by a large multi-centre trial in the USA.

A combination of cognitive-behavioural and education methods with medication has been found to be the most successful form of treatment. When behavioural methods are used, the dose of medication can be lower.

1.8 Finally

Children with ADHD are difficult to raise. Even with medication and treatment we cannot cure ADHD. Our aim is to help parents to manage their child's behaviour. This will help the child as well as the parent. Treatment and care can help to improve the child's attention span and encourage his or her enthusiasm to learn and build self-esteem.

1.9 NICE Guidelines

The National Institute for Health and Clinical Excellence (NICE) is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. In September 2008 NICE produced guidance on the diagnosis and management of ADHD in children, young people and adults. More information on these guidelines can be found on the NICE website: www.nice.org.uk

2 MANAGEMENT WITHOUT MEDICATION

Living with a child with ADHD can be very stressful for the whole family: parents, brothers and sisters, and extended family.

Parents often find themselves becoming increasingly negative and angry with their child who does not respond to ordinary parenting. The level of tension within the whole family increases, particularly for the mother.

The first step in reducing the tension is often in realising that the child's problem is **not** YOUR FAULT. It is **not** HIS/HER FAULT either. Due to the difference in chemical tuning of their brain, they have difficulties in listening, following instructions, managing their behaviour etc. and are **unable**, NOT **unwilling**, to behave appropriately.

You may find that members of your family are critical of your parenting…" that child needs a good smack…" but often children with ADHD have been shouted at and smacked for years – has it worked?

Parents can become SUPER PARENTS by learning to use specifically effective parenting techniques with their children. ADHD is **not** caused by poor parent management but problem behaviours can certainly be improved by special management techniques.

For most parents the first methods of coping with children with ADHD is through behavioural management. The techniques of behavioural management are used by professionals and are particularly useful for teachers who come into contact with children with ADHD.

2.1 What is behavioural management?

Behavioural management involves giving children clear rules, consistently enforced in a calm atmosphere. Praise is plentiful, immediate and is supplemented by a clear reward system.

For mild forms of ADHD, behavioural management alone may be sufficient. Even for children who respond extremely well to medication, behavioural strategies can be useful during "medication holidays". When behavioural management is used with medication, the dose of medication needed is usually less.

When children have severe ADHD which is complicated by oppositional behaviour and conduct problems, medication has an effect on the core symptoms of attention problems, impulsivity and hyperactivity. However, reducing oppositional behaviour, conduct problems and anti-social behaviour can **only** be achieved by behavioural management.

Sometimes parents will need intensive help from professionals if problems with oppositional behaviour are very severe.

Some parents will find the following guidance sufficient without additional professional help.

2.2 Teaching your child the behaviour you want

Children will repeat behaviours if they are rewarded for that behaviour. This is called **reinforcing** the wanted behaviour.

The behaviour you want may be sitting or playing quietly, tidying up toys or sharing a game with a sister or brother. We sometimes don't even notice quiet behaviour.

Use WHEN-THEN instructions:

"WHEN you have put your toys away, THEN you can have a story".

Increasing the behaviour you want

2.3 Reinforce the wanted behaviour:

- By praise
- By smiles, hugs and cuddles
- By a favourite activity – reading a story, a special programme on TV, a visit to the park
- By a small present – crayons, stickers
- By points or stars on a chart

2.4 You can also reinforce behaviour in words…

- I am so pleased with you because ……
- That was marvellous when you ……
- I like it when you ……
- You did that all by yourself …… well done ……
- Because you were so helpful we can ……

Sometimes it helps to have SLOGANS.

PRAISE the BEHAVIOUR you want: IGNORE the behaviour you don't want

2.5 Catch a child being good and praise

- Remember – positive reinforcement encourages your child to try harder
- Remember – praising makes parents feel good too

- Nagging or threatening makes parents feel upset and may reinforce unwanted behaviour

2.6 Decreasing the behaviour you don't want

Do not encourage children to repeat unwanted behaviour by rewarding them by giving in.

If you don't want him/her to scream for sweets, ignore the screams and he/she will learn that you mean what you say.

If you give in after 10 or 15 minutes, he/she will learn that if he/she screams for that length of time you will give in.

So you must carry it through – do not give in.

Giving in (even for a quiet life) or shouting at the child is likely to reinforce the unwanted behaviour.

Do not scold but use simple **natural consequences** for everyday situations. For example: if water is splashed out of the bath, the bath ends; or, if the child refuses to eat dinner there will be no ice cream or sweets.

PRAISE the BEHAVIOUR you want: IGNORE the behaviour you don't want

2.7 How do you want your child to behave?

- Decide on the **House Rules** (e.g. bedtime routine, meal time patterns).
  Routine makes a child feel secure. He or she needs to know what is acceptable and what is not. All adults in the household need to **agree** on the rules.

  Giving conflicting instructions confuses the child.

- Give **instructions clearly and consistently**.

  Are you sure your child knows what you want?

  Children with ADHD find listening difficult.

  Make **eye contact** with the child. Give short, clear instructions – wait five seconds for the child to comply - and then praise.

  Use a firm tone of voice and be positive – say "Please clear up after you've finished", not "Don't leave a mess". This may be more demanding and draining for exhausted parents than just saying "don't …", but it is also much more effective in achieving the behaviour you want.

  If your child is in the middle of doing something, rather than abruptly interrupting, give a prompt: "in five minutes it will be bedtime".

Catch your child being good – when your child is doing something you want, it is an opportunity to praise.

- **Model** the behaviour you want at all times. In other words, if you want him/her to be polite, always be polite yourself to him/her, to everyone. If you don't want him/her to get into fights or behave aggressively, avoid using smacks or strong language for discipline.

2.8 Strategies for avoiding trouble

Play: try to improve the relationship with your child by playing with him or her. Instead of giving directions, teaching and asking questions, **attend** to what your child is doing. You can do this by giving a running commentary on what is happening.

Describing your child's play: "you're putting the car into the garage"

Describing his/her desired behaviour: "you're playing quietly by yourself"

Describing his/her likely moods and thoughts: "you're trying really hard to build that model"

You may find this strange or uncomfortable at first but you will find your child beginning to settle and play longer and less aimlessly.

Planning Ahead is an important strategy for avoiding trouble. For example, long phone calls to friends can be made after your child is in bed. Alternatively, practise with your child what he can do to be quiet when the telephone rings during the day.

Another time of trouble may be when feeding the baby. Your older child may need an interesting activity or may be taught to do something to help. Remember to praise them for being helpful.

Problem-Solving: You can develop a problem-solving approach with your child from an early age.

First, **define** the problem; for example, the baby keeps taking their toys.

Secondly, the child is encouraged to think of as **many solutions** as possible to the problems, however silly (for example, hit him, take his toy, run away) and more sensible ones (offer him another toy instead).

Help them look at the **pros** and **cons** of each solution ("if you hit him he may hit you back").

Then choose the best option, try it out and see if it works.

FOR YOUNGER CHILDREN

Summary

Reward immediately the behaviour you want by:

- Praise – tell them why you are pleased
- Smiles, hugs and cuddles
- Favourite activities
- Small presents

Decrease unwanted behaviours by:

- Not giving in
- Ignoring bad behaviour – if behaviour cannot be ignored because it is dangerous or destructive you may have to say no, and restrain and remove him/her.

but avoid shouting, constant criticism, making idle threats, showing you're cross, smacking.

Decide on rules and: Give clear instructions

Teach wanted behaviour by:

- Guiding
- Taking one step at a time
- Learning from others
- Watching your child

Keep trying – nobody's perfect

Look after yourself – find ways of keeping calm

2.9 For older children

The types of problems the child and parents experience are different but the principles of management are the same:

The ABC analysis of behaviour is based on the observation that Behaviour is influenced by Antecedents (what happened before) or Consequences (what happened after) the behaviour.

2.10 Getting the antecedents right

- **Short, clear instructions** delivered in a **positive tone** – make sure you have **eye contact** first.

- **Use helpful prompts –**

  Lists – in the kitchen, in the bathroom

  Checklists of what is needed each day at school inside their school bag.

  Charts – (see example, page 12) listing tasks to be completed.

  Kitchen timers are useful for timing homework, tooth-brushing, television and time out. They can be invaluable in reducing bickering over time-keeping and children love to race them.

- **Identify problem behaviours;** was there any regular antecedent (for example, arguments over lost socks in the morning) which might be changed (by getting clothes ready the night before)?

2.11 Improving the consequences

2.12 Reinforcing the behaviour you want

- Using a **chart** can be very helpful in providing clear visual evidence of the tasks completed.
  You may want to give pocket-money or privileges in response to the tasks completed.

  REMEMBER – start at a very low level (what the child can achieve now) and build up slowly. If you expect too much too quickly you may lose heart.

  Calm, positive persistence wins.

  Always remember to PRAISE as well as reinforce in other ways.

  Children with ADHD need **reinforcement** that is **more frequent, more immediate** and **clear**.

- Using a **token** or **point system** linked to a chart can both highlight the tasks achieved and also be linked to response-cost system (see overleaf) for unwanted behaviours.

- Give praise that is **linked** to the behaviour you are praising. "That's fantastic…all your homework completed tonight" and praise in front of others.

- Try **grandma's rule**: first you work then you play.

  For children who are difficult to reward – use as a reward what the child spends most of his/her free time doing. This could be playing on the computer or even lying in bed.

EXAMPLE: David's Chart

	Mon	*Tues*	*Wed*	*Thurs*	*Fri*	*Sat*	*Sun*
Out of bed by 7.30 am	✓	✓	✓				
Washed, dressed and breakfast by 8.10	✓	✓	✓				
Ready to leave with school bag packed by 8.20 am		✓	✓				
Start homework at 5pm	✓	✓	✓				
Homework completed and checked by 6.30 pm	✓	✓	✓				
Clothes ready, bag packed for next day	✓	✓	✓				
Bath and in bed by 9pm	✓	✓	✓				
Lights out at 9.15 pm	✓	✓	✓				
☆ For all tasks completed		☆	☆				

TARIFF: Star awarded for all tasks ticked
For each star = 25p or small reward
BONUS if 7 stars in a row

The tariff can be varied according to the needs of the child. For example, at first there could be separate stars for mornings and evenings. Sequences of behaviour can gradually be established by starting with a high reward for one day and gradually increasing the consecutive days to earn a reward: One star earns a reward on 3 occasions, then two stars on consecutive days (2 in a row) earns a reward on 3 occasions (repeat 3 times), then 3 stars in a row can be repeated and so on.

2.13 Reducing unwanted behaviour

- **Extinguish** – do not reinforce in any way. Do not tell off, shout, argue or nag.

  For example, answering back can be dealt with very effectively by the parent avoiding responding in any way.

  Unfortunately many parents find this difficult as they think "I can't let him/her get away with this …. I can't let them have the last word".

  Ignoring sounds easy but is a hard skill for parents to manage. Ignoring means no eye contact, not speaking to the child and no physical contact with the child. Ignoring is appropriate for non-dangerous behaviour such as tantrums and answering back. Strategies for dealing with dangerous behaviours are generally dealt with by problem-solving.

- **Use natural consequences whenever possible**
  For example if a child is not ready on time he will miss a treat.

- **Response cost** can be a powerful way of reminding a child of behaviour to avoid – by deducting points or pocket-money.

  Because of their problems, children with ADHD earn fewer rewards than other children. They find it difficult to be motivated by rewards that they think they can never obtain.

  Therefore, the child is given the reward (pocket-money or points) at the beginning and must work to keep the reward.

  For example, to reduce swearing, pocket-money is put in a jar on a shelf visible to the child. While the child does as asked, the money is his/hers. Every time he/she swears a small amount of money is removed from the jar.

- **Time-out** is shorthand for time-out from positive reinforcement. It means removing the child from the fun in the family and all the rewards that were reinforcing the undesirable behaviour, including you telling him/her off. It can be difficult for parents to keep quiet themselves. (It can be helpful to remind yourself by a slogan – zip your mouth or button your lips.)

  It is important that the child knows exactly what behaviour led to time-out. He/she is removed to a place that is unstimulating and boring (the hall or a chair facing a wall and not his/her bedroom) for a previously agreed reason (tantrum, hitting) and not for a minor misdemeanour which is better ignored.

  The time should be short (one minute for each year of age) and the child must be quiet for the last minute and stay for as long as it takes until he/she is quiet for a whole minute. The first few times this may take 40 minutes or more; soon this will reduce to a few minutes only.

Time out gives you a break to calm down. Time-out can be difficult to carry out but is frequently useful in interrupting stressful cycles of conflict. It is important to use it calmly and to welcome the child back when he is behaving reasonably again.

- REMEMBER children with ADHD have good days and bad days. Variable behaviour and mood are typical of ADHD.

- Keep CALM and do not allow the situation to escalate – walk away from trouble.

- Find ways of coping with your own stress. Use the bathroom to escape quickly for a moment. Learn to relax and look after yourself.

2.14 Problem Solving

Many children with ADHD have particular difficulties in managing to pause to problem-solve and may often react in a knee-jerk, panicky style. They can often be helped to go through a problem solving routine.

1. Slow down, what's the problem?
2. What are my choices?
3. What would happen with this choice? How might I feel?
4. Now how do I carry out the best choice?
5. How did that choice work? Should I make another choice next time?

2.15 Social Skills Training

Use every opportunity to teach children how to behave. You may also find that your local school or clinic has groups which help. They are likely to train children in improving their skills with others, in making requests, giving and receiving compliments, making and keeping friends. They are likely to use role plays, video feedback and lots of rehearsal and practice.

You may find that in addition to these strategies your child will need medication.

Often combining medication with behavioural management strategies produces the best outcome overall. Parents frequently find that on medication their child finds it easier to learn to fit in with the family, to get on better with friends and to learn better at school.

FOR OLDER CHILDREN

Summary

- Keep CALM
- Set clear rules and boundaries and stick to them
- Have a routine and plan ahead
- Reinforce frequently, clearly and immediately
- Say WHY you are pleased
- Use natural negative consequences
- Keep CALM
- Listen to your tone of voice and balance praise and criticism
- Manage your child's social life – short visits for friends
- Avoid video games except as a reward
- Look after brothers and sisters
- Look after yourself and your partner
- Keep CALM

Good Luck

3. USING MEDICATION EFFECTIVELY

3.1 Why is medication used in ADHD?

Medication can be the most powerful way of increasing attentiveness and reducing impulsivity and hyperactivity. However, because of the risk of unwanted effects, medication is usually reserved for severely affected children who have failed to benefit from psychological and educational interventions. For those who need it, medication should be used alongside psychological approaches such as attention training and behaviour modification at home and at school.

3.2 What types of drugs are used?

The stimulants **methylphenidate (eg Equasym, Ritalin, Medikinet, Concerta) and dexamphetamine** are the most commonly used, and are safe and effective preparations for the treatment of ADHD. Stimulants are the first choice for medication. The main effect of **Clonidine**, which is a non-stimulant, is on impulsiveness and over-activity. It is usually given in conjunction with stimulants as, by itself, it has little effect on inattentiveness.

3.3 How long have these drugs been available?

The use of stimulant medication for ADHD is not new. They were first shown to be effective in 1937. Though the benefits were recognised then, stimulants were not widely used until the late 1950s when the new preparation methylphenidate was first introduced. After 40 years the safety and effectiveness of methylphenidate have been well researched in scores of trials.

3.4 How do they work?

Stimulants act on the part of the brain which controls attention and impulsivity. Their effect is to increase the child's natural ability to concentrate on tasks and to reduce impulsiveness and restlessness.

When stimulants are successful for a child with established ADHD, parents note that their children are calmer, less restless, less impulsive, less demanding and more reflective.

Teachers note that children are more settled and can complete work without supervision. Children may also be more organised, have neater writing, produce more academic work, be better behaved, be more popular with their peers and socially "in tune".

Stimulants do not cure ADHD – all they do is help children to improve their attention by inhibiting their impulsivity. This helps them to make the best of their abilities with regard to education, relationships and behaviour until some improvement comes with maturity.

3.5 What are the research findings?

The results of numerous trials show that between 60 per cent and 90 per cent of children with ADHD will respond to stimulant medication.

The aim of giving medication to children with ADHD is to maintain or build their confidence, improve family relationships and their will to learn until age brings a natural resolution.

It is said that stimulants are non-specific in their action and that they would be of equal benefit to normal children. Certainly, stimulants have an effect on all people but the degree of response differs. It is possible that those without ADHD might be improved by an imperceptible amount. Children with major problems of attention, impulsivity and hyperactivity show a marked response to this therapy.

3.6 What are the side effects?

The myths

The use of amphetamines raises anxiety about addiction. Though used in children with ADHD for over half a century, there is no evidence that they are addictive or cause increased risk of later substance abuse when used properly.

Adults use tea and coffee to help them focus their attention. Methylphenidate is safer and has fewer side effects than the caffeine in a cup of coffee.

In the past, reduced growth was thought to be a side effect of long term medication because it caused reduced appetite. Recent studies do not support this idea. Growth catches up so that eventually there is no difference in height and weight between children having medication and those not on medication. Although this is of no great concern, measures of weight and height of children receiving medication are still recorded.

3.7 Easily Managed Side Effects

Suppression of appetite

This is not a problem when the drug is taken just before or with a meal, as the food arrives in the stomach before the appetite is lost. Thus children should have a good breakfast. Most children will have a reduced appetite at lunchtime and can catch up on their eating in the evening. “Grazing” is common.

If a child eats too little, stopping the afternoon dose generally allows for catch-up nutrition with a larger and later evening meal. Medication "holidays" at weekends and during school holidays also aid weight gain.

Wakefulness

Wakefulness is rarely a troublesome side effect in the correctly treated child. The untreated child with ADHD finds it hard to settle down to sleep and medication frequently enables the child to calm down before bedtime. Sometimes giving half the normal dose two hours before bed is helpful. If medication makes this worse, this problem can be easily resolved by reducing the last dose of the day and paying particular attention to the behavioural management of bedtime.

3.8 Other Effects

Emotional lability

Some children become withdrawn, over-focused, tearful and miserable. This occurs in one in ten of the children treated and tends to happen at the start of medication or when the dose is increased. It is particularly a problem when medication is introduced in an inflexible, clumsy way and is poorly monitored.

Most emotional problems resolve if the dosage is halved. It is usually possible to decrease very gradually to the previous dose. Remaining problems will disappear within four hours of stopping medication.

Rebound behaviour

This can be a problem when the effects of medication start to wear off, particularly when this coincides with the end of the school day. A behavioural "blow out", can be overcome by adding a small dose at the time the previous dose is wearing off.

The possibility of tics

There is an identified association between ADHD and tic disorders. These are unrelated to the use of methylphenidate medication in most children. If, however, a child already suffers from Tourette's Syndrome, methylphenidate may make tics worse. Other medication can then be used instead. However, quite often tics improve on methylphenidate so that it is certainly worth a trial.

3.9 More details about methylphenidate

This medication should only be prescribed by a specialist such as a child psychiatrist. It is very quick acting, showing an effect within 30 minutes. The effect peaks after about two hours and generally wears off within four hours. Longer acting tablets may last for 8 or 12 hours.

For those children who respond to stimulants, the response is immediate and dramatic. Initially you will be given a prescription which may be adjusted weekly and closely monitored for effectiveness and for side effects (see side effect scale page 22). Your chemist may need warning as it is not a drug regularly kept in stock.

The starting dose for children is 5 mg (which is half a tablet) just before, or with breakfast, followed by 5mg at lunch. The amount given may be increased according to response or it may be given more frequently than twice daily. Older children will need a third dose to cover the longer school day and to sustain their concentration during homework.

Unfortunately, methylphenidate is not available in liquid form. Placing the tablet in a teaspoon of jam or honey can make it easier to swallow. Older children are likely to start on a larger dose which is also carefully monitored.

For children under six years medication dose treatment is not usually offered. Treatment should be supervised in a specialist centre. The starting dose may be 2.5 mg and should be increased very slowly. Young children frequently metabolise the medication very quickly so it may need to be given more frequently.

Children's responses to medication vary. Generally the dose is adjusted according to the individual, monitoring for possible side effects and for the improvement. Side effect charts are completed before the medication is started as some symptoms such as headaches and dizziness are reduced for most children on medication

3.10 How long should my child continue on medication?

Medication is continued for as long as parents see significant benefits. For some, this will take six months, for others two years and for some until school leaving or longer.

Medication "holidays" or breaks can be useful to see if the problem behaviours return. Some parents prefer their children to be medication free during weekends and holiday periods. Parents should not however feel guilty about their children being on medication "full time", the quality of their family life is important. If necessary these medicines can be stopped suddenly without any need to ease off gradually.

Increasingly, some adults are being recognised as suffering from ADHD since childhood and are being prescribed medication

3.11 Summary

Attention Deficit Hyperactivity Disorder is characterised by inattention, poor impulse control and over activity. It is the extreme end of a spectrum of behaviour. Most children come to professional attention in their first few years at school.

Stimulant medication is safe and parents are in charge of its continued prescription. Parents can decide to stop medication at any time if they have concerns about its effectiveness or side effects.

3.12 Side-Effects Rating Scale

Name: …… Date: ……..

Person completing this form: ……

Behaviour	No Problem										Serious Problems
Difficulty getting off to sleep	0	1	2	3	4	5	6	7	8	9	10
Difficulty in staying asleep	0	1	2	3	4	5	6	7	8	9	10
Nightmares	0	1	2	3	4	5	6	7	8	9	10
Loss of appetite	0	1	2	3	4	5	6	7	8	9	10
Stomach aches	0	1	2	3	4	5	6	7	8	9	10
Headaches	0	1	2	3	4	5	6	7	8	9	10
Tics	0	1	2	3	4	5	6	7	8	9	10
Nervous movements	0	1	2	3	4	5	6	7	8	9	10
Feeling dizzy	0	1	2	3	4	5	6	7	8	9	10
Feeling sick	0	1	2	3	4	5	6	7	8	9	10
Feeling drowsy	0	1	2	3	4	5	6	7	8	9	10
Feeling irritable	0	1	2	3	4	5	6	7	8	9	10
Feeing unhappy	0	1	2	3	4	5	6	7	8	9	10
Crying a lot	0	1	2	3	4	5	6	7	8	9	10
Loss of interest in others	0	1	2	3	4	5	6	7	8	9	10
Day dreaming	0	1	2	3	4	5	6	7	8	9	10
How easy is he/she to manage	0	1	2	3	4	5	6	7	8	9	10

Any other different behaviour:

Current Medication: **Medication prescribed:**

4 PARTNERSHIP WITH SCHOOLS

Teachers are now better informed about ADHD but many may be confused by the media stories which blame parents and criticise the role of medication. It will be, therefore, very helpful to share with teachers the information about ADHD that you have been given.

If your child is on medication, find out what the school's arrangements are for medication. You can then negotiate the timing of medication for lunchtime so that it is given with the minimum of fuss and is timed to avoid "rebound". (For methylphenidate this is generally four hours after the previous dose for most children).

It may also be helpful to enquire whether your education authority has published information and guidelines for schools in your area. Many local education authorities have now done this but sometimes the information does not reach all teachers.

Some children with ADHD may have specific learning difficulties which will be apparent in tests. These will be carried out in the school system by an educational psychologist or a Learning Support Advisory Teacher, and in a specialist clinic by a clinical psychologist.

At school (as at home) children with ADHD thrive on consistency, calm and structure:

- They do best in a traditional, closed classroom. Open plan learning provides too many distractions. The child should be seated in the part of the room with the fewest distractions. They do well with sensible seating at the front of the class placed between two calm pupils.

- Clear, warm, positive rules and a planned routine are helpful. Children benefit from having a timetable and knowing what is planned at the beginning of the day.

- Information should be given in short, simple steps remembering that children with ADHD have difficulty in concentrating and taking in the whole of a lengthy instruction.

4.1 Communication with Schools

Talk with your child's teacher about how messages can best be received. A home/school book for messages between parents and teacher may be helpful.

Ask teachers for feedback about your child's behaviour and how much work he or she is producing. This may be helpful in planning the amount of medication and its timing.

Try to meet regularly with your child's teacher. It can be most helpful to work out together a system of merit awards or clear rewards for staying on task. To be effective it needs to measure daily small targets that are achievable.

4.2 At primary school

Help your child by keeping school work enjoyable. Read books together with him/her.

Suggest to your child's teacher that an opportunity to run around and let off steam between times of settled classroom work may be helpful.

4.3 At secondary school

Daily diaries for homework will be essential.

For homework: try to encourage your child to avoid putting off homework. After a short break when home from school, perhaps for a drink and a snack, encourage your child to settle down and get it done. Have a routine with clear timetabling including short breaks for the younger child. Use play, television or a snack as a reward for completing homework.

In exams: The technique to encourage is to plan with headings and lists. If children don't plan, they may ramble on and miss answering the main question.

For revision use highlighter pens, plan and make lists.

If poor writing is a serious problem discuss with your school whether extra time may be allowed or your child may be permitted to use a laptop computer.

5 Information on ADHD for Teachers

5.1 What difficulties do children with ADHD present in the classroom?

Children with ADHD present many difficulties in the classroom:

- They find it difficult to listen and to take in instructions, are rarely ready to start their work and often fail to complete work set.
- They have difficulty concentrating, are easily distracted and are disorganised and forgetful.
- Other behaviours include calling out, interrupting and butting into conversations inappropriately.
- Hyperactivity may be particularly marked in younger children who may have difficulties in staying in their seat. Some wriggle so much they actually fall out of their seats.
- Older children may appear more restless and fidgety, often fiddling dangerously with equipment.
- Children with ADHD are frequently unpopular with other children because of their unpredictable and irritating behaviour.

Children with ADHD are a challenge for the teacher but can be very rewarding if well managed.

All pupils' learning is enhanced by increased attention to task so that the following strategies could well benefit the class as a whole, not just the child with ADHD.

5.2 Classroom organisation

The following TIPS are often found useful:

- Place pupils with ADHD in the least distracting place – not near a window or door
- Seat children near the front and between good role models in a position where good eye contact can be maintained with the teacher
- Working in pairs rather than groups and having a separate desk will be easier for the child with ADHD to manage.
- Write the timetable on the board or have it available daily.

5.3 Routines

- Clearly defined rules which are few in number and frequently rehearsed; help to prompt the child with ADHD.

- Use consistent routines. Model and teach routines, eg turn taking, distributing materials, sharing the equipment,

- Give warnings for beginning and ending of lessons. Children with ADHD have difficulty in re-focusing their attention when changing from one activity to another. Prepare them for the transition.

- Prepare pupils for changes to the timetable if known in advance, eg a change of teacher.

- Place particular emphasis on ensuring that all materials/equipment are readily available.

- Keep classroom interruptions to a minimum.

5.4 Structuring the learning tasks

- Give clear, concise instructions after establishing eye contact. Ask the pupil to repeat directions back to the teacher.

- Break tasks down into small steps – chunking. Tasks should initially be short and when mastered gradually increased in complexity.

- Incorporate short breaks for physical activity into lessons which involve lengthy periods in seat.

- Pair written instructions with oral instructions. Use a multi-sensory approach to learning.

- Give regular feedback as children with ADHD respond to frequent positive reinforcement.

- Provide alternative ways for pupils to present their work including tape, word processor, using teacher or peer as scribe and through diagrams and pictures.

- Aid organisation through the use of lists, daily task sheets, charts and report cards.

- Use highlighter pens to focus attention on key words and instructions.

- Use cooker timers for work completion, changing time on task etc.

5.5 Strategies for managing behaviour

Remember that the behaviour of the child with ADHD is not intended to irritate teachers or peers. They are unable, not unwilling, to work. These pupils need help in managing their behaviour if they are to take advantage of the learning experiences of the classroom.

- Frequent use of praise and rewards. These should be given immediately. Pupils with ADHD respond better to immediate rather than delayed rewards. Reprimands should be brief and given calmly. They should be very specific and involve a reminder of the required task. Avoid sarcasm, anger and arguments.

- Minor disruptions are best ignored.

- Involve the pupil in his/her management plan. He/she will feel empowered and learn to problem-solve.

- Transition times as well as less structured times such as breaks and meal times should be closely monitored. The child with ADHD will find these difficult.

- Identify specific problems, situations and behaviour problems (eg blurts out answers before questions have been completed, wanders around the classroom).

- Teach children to self-monitor. This is effective in reducing unwanted behaviours and is an important skill for children with ADHD to acquire.

- Praise appropriate behaviour at every opportunity.

- Use choices and distractions to avoid confrontations.

- Be alert to opportunities for incidental social skills training eg joining in a conversation, making requests, paying and receiving compliments.

- Use whole class rewards to encourage peer support.

5.6 General

- Teachers and parents need to work closely together. Use a school-home book or daily report card. A daily report card is a list of individual target behaviours that represent a child's most salient areas of impairment. Teachers set daily goals for each child's impairment targets and parents provide rewards at home for attaining goals. Use a homework assignment chart that can be signed daily by parents and supervise writing down of homework assignments.

- Check that the child has no other associated problems such as clumsiness or dyslexia, for which they may need help.

- The school's arrangements for medication should ensure that it is given reliably and with the minimum of fuss. It should be timed to avoid peaks and troughs and "rebound". For methylphenidate (Ritalin/Equasym) this is generally four hours after the previous dose.

- Treat each day as a new beginning. Do not dwell on previous failings.

Many of these suggestions will already be in the repertoire of class teachers but will need to be prominent in the management of children with ADHD.

These strategies may be suitable for inclusion in pupils' Individual Education Plans. More specific advice on behavioural management techniques including contingency management and response cost reinforcement programmes should be available from the local Educational Psychology service or Behaviour Support Team or Early Intervention Team.

5.7 Further reading

Attention Deficit/Hyperactivity Disorder - a practical guide for teachers..
Paul Cooper, Catherine Ideus. £13

ADD Hyperactivity Handbook for Schools
Harvey C Parker £21

Attention Deficit Hyperactivity Disorder - a Multi-Disciplinary Approach.
Holowenko, Henryk. Jessica Kingsley, London. £8.99

Video: Hyperactive children in the Classroom,
University of Southampton Media Services. £32

These are obtainable from

The ADDISS Resource Centre
PO Box 340
Edgware, Middlesex
HA8 9HL

Tel: 020 8952 2800 Fax: 020 8952 2909
Website: www.addiss.co.uk e-mail: info@addiss.co.uk

ADDISS often run conferences which would be helpful to teachers.

6 TYPES OF MEDICATION

6.1 Methylphenidate (MPH)

also known as:	Ritalin	available as 10 mg tablets.
	Equasym	available as 5 mg, 10mg, 20 mg tablets
	Concerta XL	available as 18mg, 27mg, 36mg tablets
	Equasym XL	available as 10mg, 20mg, 30mg capsules

How does it act?

Methylphenidate (MPH) is a central nervous system stimulant with greater effects on mental than motor activities. The effects are thought to be due to cortical stimulation and stimulation of the basal ganglia and other parts of the brain which control attention and impulsiveness.

What is the effect?

Improvement in the core symptoms of ADHD – attention and concentration is improved, restless over-activity and fidgeting is reduced; the child is less impulsive.

What are the possible side effects?

Very common: **reduced appetite:**

a. Ensure the child has a good breakfast
b. Allow for a prolonged evening meal - grazing

Common: **difficulties in settling to sleep**

a. Decide on the cause: if methylphenidate is given too late, reduce the last dose
b. If the child is unsettled, consider adding a small dose two hours before bedtime.

Emotionality: **the child may become subdued, tearful, over focused, have vague nausea and abdominal pain.**

This may happen early in treatment and often disappears spontaneously. Reduce or stop medication; restart and increase very slowly.

Rare Problems **visual accommodation and blurred vision**
See optometrist, consult prescribing doctor

Tics:
MPH may make tics worse in a child with severe tics or

Tourette's syndrome: other medication may be considered.

Epilepsy: MPH reduces the seizure threshold and theoretically may increase the possibility of fits.
Current thinking is that the risk of destabilising epilepsy with MPH has been overstated unless seizure control is unstable.

Very Rare: **Hallucinations**
Clinically significant raised blood pressure or heart rate.
Stop medication, consult prescribing doctor

What is the dosage?

This may vary from child to child. It will be adjusted according to the beneficial effect on the child and any side effects.

Generally for six to nine year olds, we start with 5 mg methylphenidate twice daily (morning and lunch time). We increase at weekly intervals by 5 mg until the desired effect is reached up to 60mg. A third dose may also be added, particularly for children whose problems are worse in the afternoon and for those who need to do homework.

How long does the effect last?

Methylphenidate starts to work after 20-30 minutes, peaks at one and half to two hours and lasts about three to four hours. It has almost entirely "washed out" by five hours.

This means that methylphenidate is very safe and it is easy to adjust the dose, but it also means that timing of the dose is important to avoid ups and downs (rebounds).

Longer acting preparations

Extended release methylphenidale (eg Concerta XL, Equasym XL) slowly releases the MPH during the day. Studies show that in some children effects on concentration may be apparent nine hours later. It is important that the tablet should not be chewed but swallowed whole.

Sometimes there are major difficulties for a child taking medication at school. Extended release preparations may then be helpful if the difficulties cannot be managed by problem-solving and negotiation.

Concerta XL uses an osmotic delivery system to release methylphenidate. It has an overcoat that delivers part of the total dose immediately. The rest of the MPH is released slowly to provide a smooth concentration profile providing efficacy for approximately 12 hours.

Concerta is as effective as standard immediate-release Ritalin and has the same safety profile. Parents generally prefer it.

Drug interactions

Methylphenidate interacts with some anti convulsant drugs, phenyl butazone and tricyclic anti depressants. It is also likely to interact with some herbal preparations, such as St John's Wort. Caffeine-containing drinks such as Coca-Cola and coffee may cause increased nervousness, jitteriness and insomnia.

Other comments

Methylphenidate is the first line medication for most children with ADHD. It is found to be slightly more effective generally than dexamphetamine, but there are some children for whom dexamphetamine works better.

A trial of medication for one month is usually monitored for side effects and for improvement in symptoms.

6.2 Dexamphetamine

Also known as: Dexedrine, available as 5 mg tablets

How does it act?

Dexamphetamine (DEX) is a sympathomimetic amine which has central stimulant and appetite reducing properties.

It has a similar action to methylphenidate.

What is the effect?

Like methylphenidate, dexamphetamine improves the core symptoms of ADHD. Attention and concentration are improved; restless over-activity and fidgeting is reduced, the child is less impulsive.

What are the possible side effects?

As with methylphenidate, most side effects are mild and pass off after a short time.

Dexamphetamine reduces the likelihood of having seizures and is therefore the choice if the child has poorly controlled epilepsy.

What is the dosage?

Dexamphetamine is more potent than methylphenidate. The dosage is half that of MPH, starting with 2.5 mg twice daily.

How long does the effect last?

Dexamphetamine starts to work after 20 minutes and lasts approximately 5 hours. The dose is repeated every four to five hours during the day.

Drug interactions

Sympathomimetic amines interact with a range of drugs including anti depressants, anti convulsants and some anaesthetics.

Caffeine-containing drinks such as Coca-Cola and coffee may lead to increased nervousness, jitteriness and insomnia.

6.3 Clonidine

Also known as: *Catapres* available as 100 and 300 microgram tablets
Also available as liquid.

Dixarit available as 25 microgram tablets

How does it act?

Clonidine is an antihypertensive drug used to treat high blood pressure. It has recently been found to be effective for treating children with ADHD.

It may be used for children with tics.

What is its effect?

Clonidine's main effect is on impulsiveness and over-activity. It is often given with stimulant medication as it has little effect on inattention.

What are the possible side effects?

Some children may be sleepy with it at first and when the dose is increased. They may have a dry mouth and dry eyes (a problem for contact lens wearers).

Rare but serious: Low blood pressure and cardiac arrhythmias may occur. A serious rebound increase in blood pressure may occur if the Clonidine is stopped suddenly. A rebound of tics may also occur.

Other side effects: include headaches, dizziness, constipation, feeling high, nightmares, fluid retention, rashes, feeling sick, slow pulse, hands unusually sensitive to cold.

6.3.6 What is the dosage?

To avoid problems with blood pressure, the dosage is built up gradually over 2-4 weeks and the effect evaluated after 6 weeks of full dosage.

3-5 micrograms/kilo/day divided into 2 doses at breakfast and bed time.

Usually start with 25 micrograms at night increasing by 25 micrograms to 100-200 micrograms if tolerated.

Drug Interactions

Other drugs used to treat hypertension will make dizziness and faintness more likely. Tricyclic antidepressants antagonise effects of the Clonidine so that the dose may need to be increased.

Special Instructions

Clonidine is used as a third line treatment for ADHD particularly when tic disorders are present or there is extreme hyperactivity and emotional swings.

Blood pressure, pulse and ECG should be measured at baseline and for monitoring.

Combination therapy with stimulant medication needs close specialist monitoring.

A trial of Clonidine is usually evaluated after 6 weeks on the full dosage.

6.4 ATOMOXETINE

Also know as: Strattera, available as 10, 18, 25, 40 and 60 mg capsules

How does it act?

Atomoxetine is a selective presynaptic noradrenaline re-uptake inhibitor, especially in the prefrontal cortex of the brain, where it may also elevate dopamine levels.

What is the effect?

Improvement in the core symptoms of ADHD inattention, over-activity, impulsivity. Cognitive effects unclear.

What are the possible side effects in children and adolescents?

Most common (5%) dyspepsia, nausea, vomiting, fatigue, appetite decreased, dizziness and mood swings.

Common (2%) decreased appetite, insomnia, sedation, depression, tremor, early morning awakening, pruritus, mydriasis.

Safety in under 6 years not established. Efficiency beyond 9 weeks and safety beyond 1 year of treatment not systematically evaluated.

What are the reported reasons in clinical trials for early discontinuation?

Aggression, irritability, somnolence, vomiting. Less likely to worsen tics, anxiety or autistic features due to small effect on striatum or nucleus accumbens.

What is the dosage?

(FDA) Food and Drug Authority in USA recommends starting at .5 mg/kg, 1.2 mg/kg and maximum of 1.4 mg/kg.

5-10% are slow metabolisers, thus responding well to smaller doses and prone to early side effects. Enzyme is CYP4502D6.

How long does the effect last?

It starts to work after half an hour reaching maximum plasma level 1-2 hours after dose. The effect lasts for 12-24 hours. Therefore a morning dose is often sufficient. It can be given with or without food.

Drug Interactions

Monamine Oxidase Inhibitors (MAOI): Do not take whilst on MAOI or within two weeks of discontinuing MAOI.

CYP2D6 inhibitors: dosage adjustment necessary e.g. paroxetine, fluoxetine, quinidine. Pressor agents: caution because of possible effects on blood pressure. It can be taken with stimulants.

Contraindicatations

Hypersensitivity, MAOI, Narrow Angle glaucoma.

Precautions

Effects on blood pressure and heart rate: use cautiously with hypertension, tachycardia, cardiovascular or cerebrovascular disease because it can increase blood pressure and heart rate. Therefore, pulse and blood pressure should be recorded at baseline and monitored periodically. Regular weight and height measurements should be recorded.

7 FURTHER READING AND INFORMATION

ADDISS – ADD Information Services provide an excellent source of support and information for parents of children with ADHD. Individuals can visit the office at:

The ADDISS Resource Centre
PO Box 340
Edgware, Middlesex
HA8 9HL

Tel: 020 8952 2800 Fax: 020 8952 2909
Website: www.addiss.co.uk e-mail: info@addiss.co.uk

ADDISS publish an extensive catalogue of books, videos and audio-tapes which can be purchased from them. Of the numerous titles, some of the best are:

Taking Charge of ADHD: The complete authoritative guide for parents
Russell A Barkley 1995 Guilford Press, New York Paperback £12.95

This is a thick American style compendium of a respected American expert and researcher in the ADHD field. It is optimistic in tone – problems are for solving – and very sympathetic to the difficulties experienced by children and parents. It covers a very broad range of topics, challenging many myths, correcting misconceptions and giving useful information on strategies of coping at home and at school.

Hyperactivity – why won't my child pay attention?
Sam Goldstein and Michael Goldstein 1992 £13.99

Well balanced and readable account of ADHD. This has a good section on parent behavioural management but the section of medication is now somewhat dated.

1 – 2 – 3 Magic: Effective discipline for children 2 – 12
Thomas W Phelan 1995 Child Manager Inc. Illinois £11.99

Written in an easy, jokey, colloquial style. This book describes a management system which is clear and makes sense to parents. Not surprising that it is probably the most popular book for parents, presenting behavioural management in an easy to follow format. This is particularly useful for help in managing the oppositional and non-compliant child.

Behaviour Management At Home: #
A token economy program for children and teams.
Harvey C Parker £9.99

Step-by-step, easy to follow instructions for parents to use in behavioural management. Excellent sample of charts for listing appropriate and inappropriate behaviours, rules on how to earn privileges and incentives to motivate children.

Put Yourself in Their Shoes: Understanding teenagers with Attention Deficit Disorder Harvey C Parker £17.99

Sympathetic view of the teenager with ADHD. Useful strategies for improving communications, problem-solving, study and social skills.

The ADHD Handbook – for parents and professionals
Alison Munden & Jon Arcelus.
Jessica Kingsley Publisher, London & Philadelphia £9.99

Easy to read book giving a well-balanced picture of ADHD, the diagnosis, the causes, the effects in adolescents and adult life. It includes helpful information on interagency support from health, education and social services, as well as useful contacts in the UK and abroad. Compared with the books listed above it is low in advice on behavioural management.

How to Talk so Kids will Listen and Listen so Kids will Talk
Adele Faber & Elaine Mazlish 1980
Published by Avon Books, New York £10.99

Not specifically for children with ADHD but an excellent book on improving communication between parents and children. Particularly effective at raising self-esteem and supporting problem-solving.

The Good Child Guide: Putting an end to bad behaviour
Noel Swanson 2000. Published by Aurum Press London £7.99

This is an excellent easy to read, clear and funny book on managing child behavioural problems. It is practical with clear instructions and sensible discussion of a range of techniques and strategies and their use. Although it is not specifically targeted for children with ADHD and focuses on management only, its coverage of useful strategies is outstanding. Its only defect is the lack of an index.

Parenting the ADD Child: Can't do? Won't do
David Pentecost 2000 Published by Jessica Kingsley, London

Sound and readable book on parenting strategies for children with ADHD. Well set out and well presented.

The incredible years: a trouble-shooting guide for parents of children aged 3-8 years.
Carolyn Webster-Stratton 1999 Published by: Umbrella Press. Toronto

Outstandingly good book on helping parents understand and cope with children's problem behaviour. Carolyn Webster-Stratton is the pioneer of using videotape to

train parents in the most effective approaches to parenting. There is excellent advice on how to cope with a range of problematic situations. What is particularly helpful in the attention to detail in describing the suggested strategies, the sound research based from which the book is written and the overall frame of sympathy and understanding for parents

Books for children about ADHD:

Everything a child needs to know about ADHD: for children aged 6 to 12 years
By Dr C R Yemula
Published by ADDISS, 2006

Full of beans, 2nd Edition
By Chris Wever
Published by Shrink-Rap Press, 2006

Jumpin' Johnny get back to work! A child's guide to ADHD/Hyperactivity
By Michael Gordon, Ph.D.
Published by GSI Publications, Inc., 1998

Zak has ADHD
By Jenny Leigh
Published by Red Kite Books, 2005

Videos

1-2-3 Magic Thomas Phelan £32.00

A well illustrated account of the methods described in his book

8 USEFUL CONTACTS

Benefits Enquiry Line **Free phone: 0800 882 200**

This gives advice on the benefit situation for children with disabilities.

The Advisory Centre for Education **Telephone: 020 7354 8321**

They give free telephone advice on issues related to education

Contact a Family **Telephone: 020 7383 3555**

This is a charity which puts parents of children with medical or psychiatric problems in touch with others with similar problems.

WEBSITES

Websites change frequently, some are better maintained than others. Some are frankly fictional and dangerous in their alarmist information. Some useful sites are:

The Royal College of Psychiatrists

Telephone: **020 7235 2351 ext 146** **Fax: 020 7245 1231**
Email: **booksales@repsych.ac.uk**
Book Sales: **17 Belgrave Square, London SW1XC 8PG**

The Royal College of Psychiatrists produces a *Mental Health and Growing Up* series of 36 factsheets on a range of common mental health problems. They can be ordered through Book Sales at above address.

ADDISS

Website: **www.addiss.co.uk**

This site has recently been updated and much improved. The aim is to be accurate and evidence-based. It contains articles by experts and factsheets on ADHD. There are details on conferences, training, support groups and includes the book and video catalogue.

The American Academy of Child and Adolescent Psychiatry

Website: **www.accap.org**

Contains sound research and conference information.
There is also a Facts for Families series.

The brief sheet on
ADHD is accessed on: **www.aacap.org/publications/factsfam/noattent.htm**

CHADD – Children and Adults with Attention Deficit Disorders

Website: **www.chadd.org**

CHADD is an American non-profit organisation representing children and adults with ADHD.

NICE Guidelines

The National Institute for Health and Clinical Excellence (NICE) is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. In September 2008 NICE produced guidance on the diagnosis and management of ADHD in children, young people and adults. More information on these guidelines can be found on the NICE website: www.nice.org.uk

SUPPORT GROUPS

It is often helpful to contact other parents of children with ADHD.

Hounslow CAMHS runs a monthly support group for parents of children with ADHD. Pick up a leaflet at Hounslow CAMHS, 92 Bath Road, Hounslow, TW3 3EL.

ADDISS (ADD Information Services) is a national charity offering information, training, resources and support on ADHD. They will provide support for individuals who are then referred to the nearest support group of the more than 150 support groups across the country with whom they are in contact.

The ADDISS Resource Centre
PO Box 340
Edgware, Middlesex
HA8 9HL

Tel: 020 8952 2800 Fax: 020 8952 2909
Website: www.addiss.co.uk e-mail: info@addiss.co.uk

A list of support groups in England can also be obtained through:

Adders.org
45 Vincent Close,
Broadstairs,
Kent CT10 2ND

Website: www.adders.org e-mail: simon@adders.org