
**Attention Deficit/
Hyperactivity
Disorder (AD/HD):**
*Guidelines and principles
for successful
multi-agency working*



Report of a Working Party of
The British Psychological Society

Attention Deficit/
Hyperactivity
Disorder (AD/HD):
*Guidelines and principles for
successful multi-agency working*

The British Psychological Society
St Andrews House
48 Princess Road East
Leicester LE1 7DR

Contents

1. Introduction	5
1.1 <i>Background</i>	
1.2 <i>Definition of terms used in document</i>	
1.3 <i>The inter-disciplinary meeting</i>	
1.4 <i>Inter-professional working</i>	
1.5 <i>The impact and development of AD/HD</i>	
1.6 <i>Underlying assumptions</i>	
2. Definition	9
2.1 <i>Background</i>	
2.2 <i>Status of the concept of AD/HD</i>	
2.3 <i>Heritability</i>	
3. Identification and assessment practices	12
3.1 <i>Background</i>	
3.2 <i>Participants in process of identification, assessment, diagnosis and intervention for AD/HD</i>	
3.3 <i>Diagnosis</i>	
3.4 <i>Principles in relation to assessment practices</i>	
4. Intervention	15
4.1 <i>Background</i>	
4.2 <i>Principles in relation to intervention</i>	
4.3 <i>Evaluation</i>	
5. Prevention: Improving multi-agency co-operation in working with children with AD/HD	17
5.1 <i>Background</i>	
5.2 <i>Principles in relation to dissemination of information and good practice</i>	
6. References	19
Appendix A: Participants in the multi-disciplinary meetings	21
Appendix B: Parties involved in the consultation exercise	22
Appendix C: Impact and development of AD/HD	24
Appendix D: Roles of participants in the process of identification, assessment, diagnosis and intervention for AD/HD	28
Appendix E: WHO and APA diagnostic criteria	33

Section 1: INTRODUCTION

1.1 BACKGROUND

Many different agencies, professions and disciplines will be involved in identification and management of Attention Deficit/Hyperactivity Disorder (AD/HD). It is, therefore, essential that clear principles are developed to enable the complex interactions that will inevitably occur between agencies, groups and individuals. Among the recommendations of the British Psychological Society (BPS) report on AD/HD was the expressed need for multi-disciplinary guidelines for those working with children and young people with the disorder.¹ In response to this the Society funded a meeting of invited key professionals in the area, chaired and facilitated by Dr Pam Maras of the University of Greenwich, and Dr. Paul Cooper, of the University of Cambridge. Twenty invited professionals met initially for two days to establish draft principles for inter-agency working based on combined expert knowledge, experience and evidence. A further meeting was held and the group corresponded throughout the process of preparing this document. Calls for evidence and comment were also placed in *The Psychologist*, made at the Boards of the Society and to member organisations of the Joint National Forum and other relevant organisations and parties.

1.2 DEFINITION OF TERMS USED IN DOCUMENT

In this document three terms are used to describe professional working. To ensure common understanding they are defined below.

AGENCY

The administrative structure within which various professionals and other workers function. Usually has responsibility for funding and policy decisions.

PROFESSIONAL

Refers to individuals with specific expertise recognised through formal accreditation based on nationally approved training.

DISCIPLINE

The specific knowledge base underpinning different professionals' expertise.

1.3 THE INTER-DISCIPLINARY MEETING

The meeting identified and addressed three areas which were believed to be essential to effective inter-disciplinary working. These are: definition of the AD/HD concept; appropriate identification of and assessment practices for AD/HD; how methods of intervention with, and prevention of, AD/HD might be enhanced by improved multi-agency co-operation. The main

¹ The term disorder is used throughout this document, as it is the one commonly associated with AD/HD. Where relevant to the text other terms may be used. We would however, wish to dis-associate ourselves from any value judgments implied by terminology used.

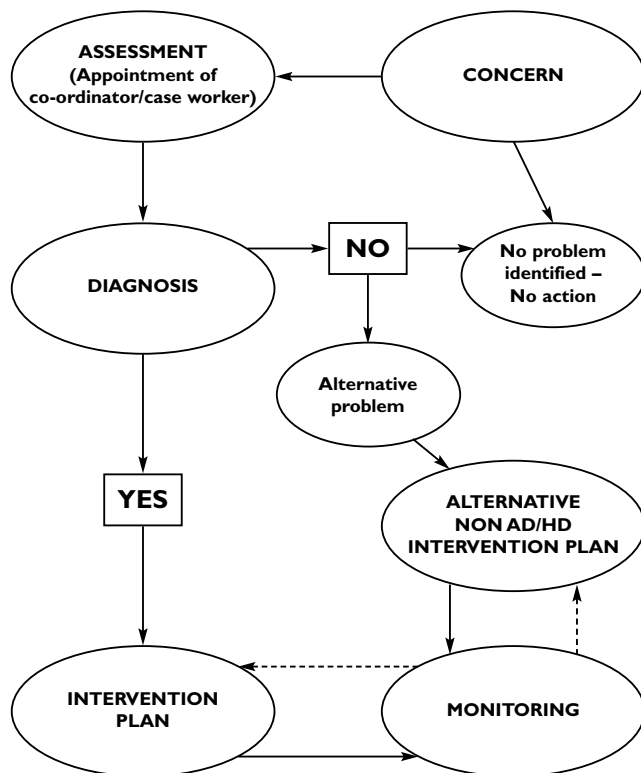
To make reading easier the person with AD/HD is referred to as child(ren), however, this should be seen as young person or adult where relevant.

aims were to establish basic principles, rather than rules that would help to facilitate positive interaction between professions for the ultimate benefit of children. These guidelines are intended to be accessible to parents and professionals from a range of disciplines who might first identify, or have concerns about, problems that may or may not result in an AD/HD diagnosis. Their first efforts are likely to be of a broadly psychosocial nature (i.e. behavioural/cognitive and educational interventions). Currently different professionals use different terminology to describe the phenomenon of AD/HD (e.g. hyperkinetic disorder, behaviour problems). The use of different terms is not helpful to professionals, children or their families, therefore, an attempt has been made in this document to be consistent in the use of terms that have been selected for their clarity and acceptability to a wide range of professionals. In this document we outline guidelines that are sanctioned through multi-disciplinary consensus. The document is intentionally short. The objectives were to identify principles that are:

1. Acceptable to a range of professions, disciplines and agencies as well as to children and young people with AD/HD and their families
2. Flexible enough to be utilised within existing organisational structures.

This approach is most likely to promote change and the further development of good practice. To this end, a model of the process for inter-agency working is given to illustrate how the principles can be applied (see Figure 1).

Figure 1: *Process of identification, assessment, intervention and monitoring AD/HD.*



1.4 INTER-PROFESSIONAL WORKING

There are significant differences, sometimes of an ideological nature between and within different professional groups (Cooper, 1997; Hughes, 1999; Maras & Redmayne, 1997). These differences can be exaggerated through training and practice and are often reflected in different professional perceptions and views of AD/HD. Differences can sometimes result in confusion, misunderstandings and conflict and may have an adverse influence on the effectiveness of multi-disciplinary/agency working. However, there is also much common ground among professionals, especially in terms of sought after outcomes of intervention. AD/HD by its very nature demands a multi-agency response, and provides an opportunity for medical, educational, psychological, social work and other professionals to work together. It is essential, therefore, that a set of common assumptions and a definition are agreed and used by all groups, and that these reflect the multi-faceted nature of AD/HD. The involvement of a full multi-disciplinary team in each case of AD/HD, though ideal, is likely to be constrained by resource, practical and logistical factors. When a multi-professional team is not available, those who are involved need to be well versed in the roles and practice of professionals not represented. Consultation between agencies, disciplines and professionals should take place in order to disseminate information on the roles and practices of the different groups. Shared knowledge and understanding of each others practice and roles is essential to understanding the complex nature of AD/HD as a medical, psychological and social phenomena.

Primary carers (such as parents and guardians) and their children (and their advocates) should have a formal involvement in multi-professional discussion. Where there are disputes or interagency disagreements, the team should try to come to agreement. However where consensus cannot be reached consideration should be given to the involvement of an independent appropriately qualified professional to assist in the decision making process. The over-riding concern in such discussions should always be the best interests of the child. Current legislation on children's rights and policy on child protection should inform decision making (e.g. The Children Act, 1989).

1.5 THE IMPACT AND DEVELOPMENT OF AD/HD

When considering assessment and intervention it is essential that a developmental perspective be taken. A brief account of some of features typical in the course of AD/HD and its common impact on the individual and significant others is given in Appendix C. The surface behaviours associated with AD/HD, as outlined in diagnostic criteria, have to be viewed within the context of an individual's current social, psychological, neurological and developmental status. It should be stressed that by no means do all children with AD/HD conform to this pattern. Individual differences as well as variations in environmental circumstances will influence the severity of the problem the child experiences. In addition, the common co-occurrence of AD/HD with other difficulties can create patterns of interaction which lead to widely different behavioural manifestations. The intention of the account in Appendix C is to illustrate the cumulative development of AD/HD rather than to provide a definitive description of its developmental course.

1.6 UNDERLYING ASSUMPTIONS

1. It is important that AD/HD is seen within the broad context of a wide range of social, emotional and behavioural problems that affect an individual's ability to function in a range of settings such as school and home.

-
2. From a practical perspective, AD/HD is part of a broader category of social, emotional and behavioural difficulties that may be grouped under the umbrella term of emotional and behavioural difficulties (EBDs) (Cooper, 1996; Maras & Kutnick, 1999).
 3. A decision to apply the AD/HD diagnosis should be made on the basis of an holistic assessment that goes far beyond the interpretation of surface behavioural symptoms. AD/HD is developmental and this should underlie all considerations of children's behaviour and its impact.
 4. Different professionals may represent different emphases in terms of understanding of, and interventions with, AD/HD. It is essential that professionals work towards ways of harmonising and emphasising the complementary nature of their different perspectives in order to serve the best interests of children and their families.
 5. At an individual level, AD/HD often occurs with other problems such as oppositional defiant disorder (ODD), conduct disorder, anxiety, depression and a range of learning difficulties.
 6. Similarly, AD/HD may only be one label that may be considered in assessment, others such as ODD may also be considered.
 7. Boys diagnosed with AD/HD outnumber girls and have been described as presenting differently, boys' behaviour being seen in some cases to impinge on others more than that of girls (Maras & Cooper, 1999).
 8. Current research and evidence from clinical practice indicate that both within-person and contextual factors influence the development and presentation/severity of AD/HD and must be taken into account at all stages from assessment to intervention (Cooper, 1997).
 9. Different professions have something to offer, and where appropriate should be involved in identification, assessment and interventions for children with AD/HD.
 10. Assessment and intervention should be informed by best, most current, research evidence from all appropriate sources (e.g. neuro-science, medicine, psychology, education, etc.).

Section 2: DEFINITION

2.1 BACKGROUND

The AD/HD diagnosis refers to a social phenomenon of large-scale proportions with international estimates of prevalence ranging from 1 to 6 per cent of the child population (Tannock, 1998). It has received widespread public attention and continues to be the subject of a great deal of controversy. Much of this has focused on aetiology and the diagnosis of AD/HD as a distinct clinical category. This is despite the fact that there is a powerful body of research evidence to support the validity of the condition.

Attention Deficit/Hyperactivity Disorder is a term used rather precisely by most clinical child psychologists and child and adolescent psychiatrists to describe behaviour in children that fulfils certain criteria. The term derives from an American classification system (American Psychiatric Association (APA), 1994). The criteria bear many close similarities with those used to define Hyperkinetic Disorder, the terms used in the International Classification of Diseases (ICD-10) World Health Organisation (WHO, 1990). These similarities are, however, offset by a small number of significant differences, the result of which are to render the APA diagnosis more inclusive than the WHO version, and, therefore, leading to its being associated with much higher prevalence rates (copies of the APA and WHO diagnostic criteria are appended Appendix E).

2.2 STATUS OF THE CONCEPT OF AD/HD

AD/HD is a term in widespread use. Many teachers, social workers, child psychotherapists and indeed some psychologists and physicians find it unhelpful to attach labels to children's behaviour and prefer not to use them. It may nevertheless be helpful for them to know how the term is used by clinicians who, while accepting the label has limited value, believe it has validity and find it helpful in managing the problem, in communication with parents and in research.

2.3 HERITABILITY

There is a growing body of research evidence supporting the view that heredity can play an important role in the development of AD/HD. Tannock (1998) identifies the following findings which support this view:

- AD/HD is more common in the biological relatives of children with AD/HD than their non-biological relatives;
- Studies which compare the incidence of AD/HD among children and parents who are biologically related with that of children and parents where the child is adopted, have found the biological link to be predictive of the presence of AD/HD in both parents and children;
- Twin and adoption studies have repeatedly shown a much greater incidence of AD/HD among identical (i.e. monozygotic) twins than among non-identical (dizygotic) twins;

-
- Molecular genetic research has identified genetic abnormalities in the dopamine system (*Ibid*). Dopamine is a neurotransmitter which is found in systems of the brain concerned with, among other things, the regulation of movement (Thompson, 1993).

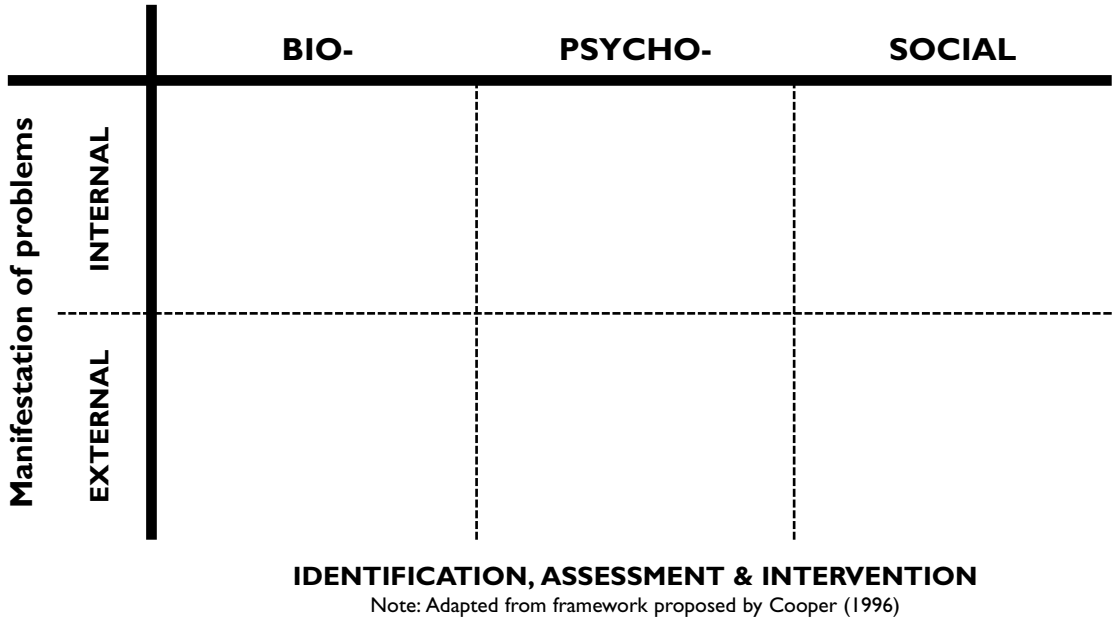
As is noted elsewhere in this report, the presence of a biological influence in the development of AD/HD should not be taken to mean that AD/HD is biologically determined, and that there is a 'gene for AD/HD', the presence of which will predict the development of the disorder. Rather the genetic evidence points to the important insight that individuals who share particular elements of their forebears' biological make up are at greater risk of developing the disorder than those relatives who do not share the specific elements, and those who are not biologically related. It is widely understood that the final state (e.g. whether or an individual develops AD/HD or not) is the product of an interaction between biological influences and environmental experience (Johnson, 1997). This helps to explain why it is that some individuals who possess the biological predisposition for the disorder never actually develop the disorder.

By five to seven years, when the condition is first diagnosed, children with AD/HD show marked inattention, overactivity and impulsiveness. Their problems are evident and cause social impairment in at least two settings (usually home and school) and are persistent over time. They show a characteristic development (see Appendix C). A significant number show other disorders, especially conduct disorder, characterised by intractable disobedience and more serious forms of anti-social behaviour. Such associated problems may be referred to as 'comorbid' disorders.

AD/HD if present in moderate or severe form is widely regarded as a reliable and valid diagnosis. In its less severe form it merges into 'normality'. At the borderline, in common with many educational difficulties, social disadvantage and medical diagnoses, the judgement whether AD/HD is present or not is more difficult to make. The degree to which a diagnosis is reliable in such circumstances depends on the rigour of the assessment process that has been employed. The diagnosis depends on the presence of behaviour, which is confirmed by observers with knowledge of normal developmental variations in behaviour and temperament. Some parents and teachers may view normal variations in behaviour as problematic and this means that, although their concerns always need to be taken seriously, some confirmation of their observations is necessary if the diagnosis according to agreed criteria is to be made.

A full understanding of AD/HD in a particular child requires consideration of biological factors (especially genetic influences and brain function), psychological factors (especially cognitive and emotional processes and the child's internal world) and social factors (especially parental child rearing practices and classroom management) (see Figure 2 overleaf). It is important that the child's strengths as well as the child's difficulties are considered.

Figure 2: A bio-psycho-social framework for AD/HD.



Section 3: IDENTIFICATION AND ASSESSMENT PRACTICES

3.1 BACKGROUND

Assessment should always reflect the multi-faceted nature of AD/HD taking into account the biological, social, emotional and psychological features of the phenomenon. These may differ in their prevalence for individual children and each has implications for different disciplines and multi-disciplinary working. Thus assessment should be multi-modal and involve professionals from a range of disciplines. As a general rule, where there is existing involvement of a service with a child or child's family, this service should be represented through membership of the assessment team. Where this is not possible, services should be consulted and asked to provide written evidence detailing any information that is deemed to be relevant to the child's current situation and future development. The core team should ideally include teacher, health visitor, psychologist and physician (including psychiatrist). Carer(s) and child should be part of this team and should be treated as such. If a named person has been identified in the local authority or through statutory assessment, it would be appropriate to invite that person to participate. Representatives from social and other services such as youth justice and youth and community services, child psychotherapy, occupational therapy, paediatric nursing, speech and language therapy and voluntary agencies may also be involved. Multi-agency working has obvious implications for funding. Agreement on policy for this should be reached in the early stages of working with children with AD/HD as a matter of priority. As noted earlier, there is a strong need for different groups to have know-ledge of each other's roles and working practices. This need is particularly important in cases where, because of practical constraints, multi-agency teams are not available.

Effective inter-disciplinary working will be characterised by clear channels of communication between members of the assessment team (including the child and carers). As noted in the conclusions of the BPS Working Party Report:

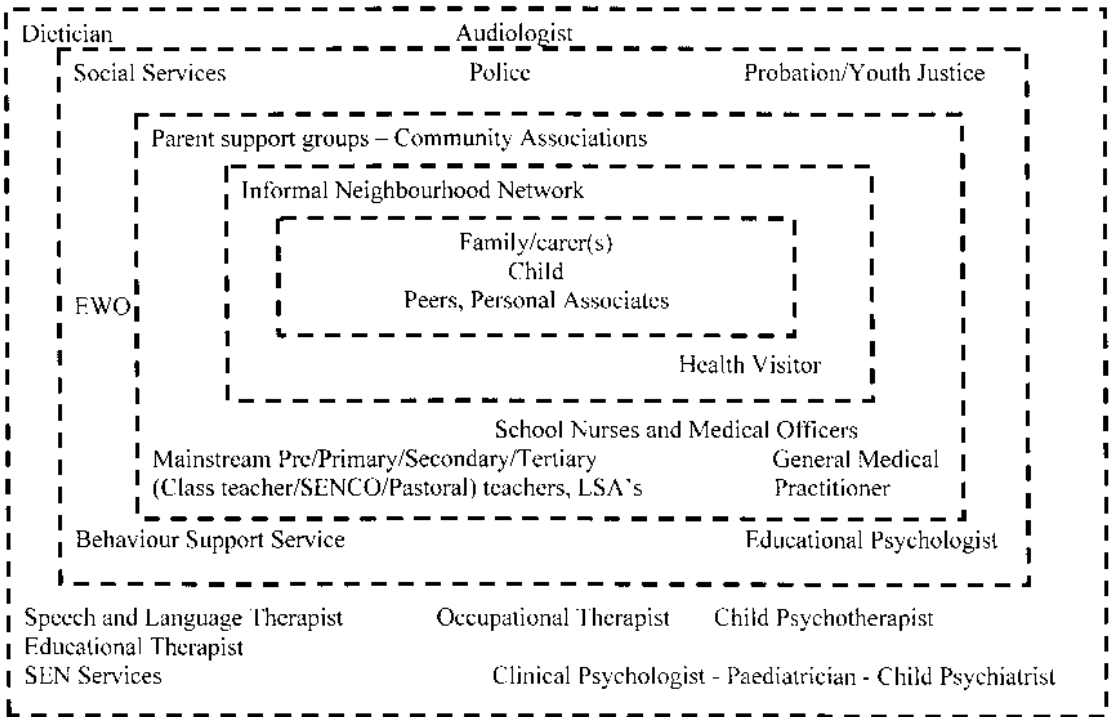
'Assessment for the purposes of clinical or educational practice aims to obtain as comprehensive a picture as possible of the many factors that influence the child across contexts' (BPS, 1997, p.63).

The development of a non-technical vocabulary that is understood and accessible to children and non-professionals is essential for the fulfilment of this endeavour. Such developments must be undertaken with full multi-professional and client co-operation and discussion. Appropriate intervention may occur at any stage of the assessment process (e.g. adjustment of teaching practice, behaviour management approaches). Assessment should, therefore, be diagnostic and formative, and take full account of cultural factors in order to ensure that procedures do not discriminate against minority sub-groups (BPS, 1987).

3.2 PARTICIPANTS IN THE PROCESSES OF IDENTIFICATION, ASSESSMENT, DIAGNOSIS AND INTERVENTION FOR AD/HD.

A range of individuals and groups may be involved in the processes of identification, assessment and intervention for AD/HD. Involvement may be formal and informal and may vary across situations, between times and individuals. Roles and responsibilities of different individuals, groups and services in relation to the assessment of and intervention with AD/HD is outlined in Appendix D. This account is not exhaustive, it is meant to illustrate roles and responsibilities at various times. A scheme of individuals and groups involved at points relative to each other is also given in Figure 3 below.

Figure 3: *Individuals and groups involved in identification, assessment and interventions for AD/HD.*



3.3 DIAGNOSIS

This document is concerned with processes preceding and following diagnosis rather than diagnosis *per se*. The concept of AD/HD is multi-faceted, therefore no individual discipline is likely to be competent to identify, assess and intervene alone. As such diagnosis becomes a mechanical feature in an holistic process involving a range of professionals.

Although medication is by no means always necessary in interventions for AD/HD, it is clear that medication has to be considered as an option within an intervention plan. For this reason it is important that at the present time diagnosis remains within the province of the medical profession. It is recognised that the issue of who is competent to make medical diagnoses in certain situations is currently under debate. At a future time it may be necessary for this recommendation to be reviewed. However, we are fully supportive of the current practice where-

by clinical psychologists use APA and WHO criteria to inform their practice and judgement about children and where they work in conjunction with, and advise child psychiatrists and/or paediatricians in the process of diagnosis.

As such a child psychiatrist or paediatrician should normally make the formal diagnosis. However, a diagnosis can only be considered valid if it is made on the basis of evidence from multi-modal assessment. It should be recognised that all possible agencies cannot be involved in all cases, however, where there is evidence that a particular agency is pertinent, that agency should be involved as appropriate. Medical practitioners also have a significant role to play in diagnosis and assessment in order to rule out physical factors which may lead to the symptoms similar to those of AD/HD (e.g. mineral deficiencies, dietary problems, hearing and other sensory impairment and allergies).

3.4 PRINCIPLES IN RELATION TO ASSESSMENT PRACTICES

1. The needs and best interests of the child are paramount.
2. The child and carer(s) should be involved and fully consulted at all stages.
3. Systemic influences (e.g. in the family, peer group, school, interactions between family and school) should be considered in relation to the presentation of 'symptoms'.
4. Diagnosis should not be applied to a child primarily in order to meet the needs of others [e.g. carer(s), teacher(s), etc.].
5. When a child is presented for formal assessment, the assessment process should inquire into the psychosocial background to the problem.
6. It should be recognised that a positive response to medication is not an effective or appropriate assessment tool and does not justify abandonment of ongoing assessment, intervention, support and monitoring.
7. It is unlikely that a single clinician and/or a single consultation will constitute an effective assessment procedure.
8. It should be emphasised that the symptoms and other presenting problems that make up a diagnosis of AD/HD can be mimicked as a result of a wide range of physical, social and psychological conditions and circumstances.
9. Diagnosis of AD/HD should only be made after other possible explanations for the existence of the problem are fully considered.
10. Cultural factors should be considered at all stages of identification, assessment and intervention.

Section 4: INTERVENTION

4.1 BACKGROUND

A crucial aspect of intervention is that children, carer(s) and other involved parties come to develop understanding of the nature of AD/HD and its management. It is important that professionals show a united front in portraying AD/HD in terms that provide the child and others with a sense of empowerment in relation to the condition. Singly determined causes of AD/HD must be actively discouraged in favour of an interactive account. Such an account should emphasise the importance of volition, motivation, emotion, relationships and perseverance in dealing with AD/HD and ways of framing aspects of AD/HD as individual differences, which, in certain circumstances, may be assets (Cooper & Ideus, 1996). Medication is sometimes a necessary intervention for AD/HD though it is rarely sufficient alone. In some instances of acute problems medication may be appropriate as a first line of treatment, as a general rule medication should be used as part of a multi-modal intervention programme, which will usually include educational, behavioural and other psychological approaches.

There is evidence that in some circumstances non-pharmacological approaches can be successful without the aid of medication. There is also evidence to show that psychosocial interventions are associated with reductions in levels of medication in some cases (Hinshaw *et al.*, 1998). Environmental/psycho-social interventions (e.g. behaviour management strategies) should normally be applied prior to the prescription of medication. Such interventions (especially when applied in home and school) should begin at the earliest stages that AD/HD is suspected. An understanding of the nature of AD/HD can be used by a teacher to make adaptations to a child's learning environment, thus preventing difficulties interfering with educational progress (Cooper & Ideus, 1996). Where medication is applied school staff, carer(s) and children should be informed of its nature and intended effects (and side effects). They should be fully trained to record and monitor actual effects in order that the prescribing physician can ensure the optimum dose. Once a programme of medication is embarked upon, opportunities for assessing the child's performance when not on medication should be investigated (i.e. during regular medication 'holidays'). Such assessment should include means of monitoring a child's perceptions of what it is like for that child to be taking and not taking medication.

4.2 PRINCIPLES IN RELATION TO INTERVENTION

1. A principle of minimal invasiveness should normally apply (i.e. attention to aspects such as behavioural management and educational practice should precede efforts to 'change' a child. Ecological and systemic interventions, social competence training, behavioural and cognitive interventions should precede, and continue during medication).
2. A clear programme should be developed that matches the precise nature of the needs identified. Cases similarly diagnosed may not necessarily require the same interventions.
3. Interventions should be designed with a clear and explicitly stated rationale against which effectiveness can be assessed.

-
4. A programme of regular reviews should be arranged at the beginning of intervention. Interventions should be continually monitored and outcomes should be based on evidence such as measured change.
 5. Objectives of intervention should be clearly stated in terms of measurable outcomes expressed in terms of the child's positive development (e.g. educational, social and behavioural/personal psychological traits).
 6. A programme of short, medium and long term interventions and assessments should be specified at the outset of treatment.
 7. Evidence is likely to come in two forms: (1) empirical research, including clinical trials , and (2) from practice and experience. Whilst both types of evidence are valid, in instances where empirical evidence is not available it should be sought.
 8. Evidence has to be seen as contingent on different perceptions of effectiveness. For example, the extinction of 'unwanted' behaviour(s) may be seen as a successful outcome by one or more individuals involved in intervention; others may emphasise the development of pro-social behaviour and the acquisition of particular skills. In determining the effectiveness of treatment the child's needs and best interest should be paramount.
 9. Most professional groups work within a remit that respects the confidentiality of information in relation to their clients and patients. Professional ethical guidelines should guide professional judgement on this. However, parents and/or children are able to give consent for information about their cases to be shared. While they should not be pressured to do this, in many instances it will be in the best interest of a child for this to happen. In these cases professionals can advice parents/children to consent to information being shared. For example, as a general rule no child should be on medication without the knowledge of relevant school employees. Such judgements should be made within the constraints of current legislation and best practice guidance on the rights of children and young people and with parental consent.
 10. A co-ordinating person should hold a record of the child's progress. This person may differ in different areas, but should be identified at the outset. This record of progress should be disseminated to all team members at regular intervals, regardless of whether medication is part of intervention or not.

4.3 EVALUATION

Evaluation of intervention is essential. The desired outcomes of any intervention should be clearly defined and stated in order of priority. In addition:

1. Individual agencies should include multi-agency work as a strand within their existing service evaluation practices.
2. Co-ordinating agencies or individuals should action evaluation specific to different localities.
3. National external inter-agency evaluation systems should be developed.

Section 5: IMPROVING MULTI-AGENCY CO-OPERATION IN WORKING WITH CHILDREN WITH AD/HD

5.1 BACKGROUND

Workers with children (of all ages) and carer(s) should be educated about the nature of AD/HD and the types of psychosocial interventions that will avoid exacerbating the problem as well as ways of exploiting positive aspects of children's behaviour. Key professionals who should be targeted for such awareness raising include general practitioners, health visitors, education professionals (including teachers, Learning Support Assistants [LSAs], educational psychologists, and education welfare officers), social workers, speech and language therapists, occupational therapists, audiologists, child psychotherapists and dieticians. In-service training and other forms of continuing professional development should be utilised to address issues arising out of inter-agency working generally and AD/HD specifically.

There is a need to instigate early identification and intervention schemes that enable 'at risk' children and their carers to be given support aimed at prevention. Of particular concern here is the need for carer(s) for young children to be given access to effective child rearing skills including positive behaviour management. Effective multi-modal intervention programmes commonly include such parental training. It seems sensible, therefore, to provide such support before problems occur. The growing evidence base for genetic/familial dimensions of AD/HD suggest that such support might be targeted at clearly identifiable 'at risk' families. Health visitors and paediatric health services have a role here.

Whilst guided by the principles outlined within this document, patterns of specific implementation of multi-disciplinary work are likely to vary across different geographical areas. It is, therefore, necessary for services in different areas to develop clear policies detailing the range of professionals and agencies involved in each multi-agency team as well as the means of resourcing effective implementation. These policies should be formally agreed. A figure showing the process of identification, diagnosis, intervention and monitoring to which the principles in this document can be applied is given in Figure 1 earlier.

Where patterns of provision are incomplete, professionals concerned with AD/HD will need to investigate local conditions, as improvisation may be necessary. At the same time new structures for the long term should be developed (including, where appropriate, policy changes). The education/health interface, typified in the Special Educational Needs (SEN) Code of Practice and the Health Service tiering system are crucial, though it has to be recognised that these are sometimes competing structures. It is, therefore, essential for the purposes of successful inter-agency working that there is harmonisation in this area. Bio-psycho-social explanations, which place appropriate emphasis on multi-modal forms of intervention, are likely to result in the most effective outcome. As noted earlier evaluation is crucial for effective multi-agency working. This may entail instigating new systems for monitoring and evaluation; existing agencies and professional associations would have an important role in instigating and designing such systems.

Responsible bodies, such as Professional Associations, need to consider whether diagnosis should continue to be mainly the province of particular members of the medical profession such as psychiatrists and some paediatricians including school doctors. School doctors and nurses have a vital and often under-used role as sources of information and guidance to schools in many areas including AD/HD. However, they are likely to be most effective if they have direct access to specialist knowledge from, for example, paediatricians. Where paediatricians are based in the community, rather than hospitals, this process is better facilitated. In some cases action at health authority level is necessary to facilitate these links. In the case of pre-school children health visitors should have this role, bearing in mind the need for caution in relation to early intervention referred to earlier. Whilst it is acknowledged in Appendix C on Impact and Section 2 above that AD/HD is difficult to identify in early years, the general signs of a child being at risk of a developmental disorder may be evident and should be picked up. There is a need for training for health visitors in early recognition along with a need to examine the home-health interface in terms of the provision of knowledge, support and communication.

5.2 PRINCIPLES IN RELATION TO DISSEMINATION OF INFORMATION AND GOOD PRACTICE

1. Knowledgeable professionals should make it a priority to disseminate information about AD/HD to key professional and client groups [particularly teachers and carer(s)].
2. Professionals from different disciplines should share different views of AD/HD within multi-disciplinary fora.
3. Evidence on AD/HD should be disseminated between professional groups. It is important that the evidence base is shared.
4. Parental and school-based strategies should be promoted to remove family/school stressors that can exacerbate attentional and activity problems for all children.
5. AD/HD is a multi-faceted condition. Ill-informed and unhelpful ways of portraying AD/HD, for example, as a disorder determined solely by either biology or environment should be challenged; biological, psychological, social and cultural aspects should be considered in all cases.
6. Government agencies (e.g. Department of Health, Department for Education and Employment) must adopt coherent, consistent and preferably joint policies for AD/HD.
7. There is a need for more research on AD/HD, which takes a multi-disciplinary multi-agency approach, thus reflecting the true bio-psycho-social nature of the problem.

Section 6: REFERENCES AND BACKGROUND READING

REFERENCES

- American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: APA.
- Barkley, R. (1990). *AD/HD: A handbook for diagnosis and treatment*. New York: Guilford.
- Barkley (1997). *AD/HD and the nature of self control*. New York: Guilford.
- Blau, B. (1996). Oppositional defiant disorder. In G. Blau & T. Gullotta (Eds.) *Adolescent dysfunctional behaviour*. Thousand Oaks, CA: Sage.
- British Psychological Society (1997). *Attention Deficit Hyperactivity Disorder (AD/HD): A psychological response to an evolving concept*. Leicester: British Psychological Society.
- Children Act* (1989). London: HMSO.
- Cooper, P. (1996). Giving it a name: the value of descriptive categories in educational approaches to emotional and behavioural difficulties. *Support for Learning*, 11, 4, 146–150.
- Cooper, P. (1997). Biology behaviour and education: AD/HD and the bio-psychosocial perspective. *Educational and Child Psychology*, 14, 1, 31–38.
- Cooper, P. (1999). Making sense of AD/HD. In P. Cooper & K. Bilton, *AD/HD: Research, opinion and practice*. London: Whurr.
- Cooper, P. & Ideus, K. (1996). *AD/HD: A practical guide for teachers*. London: Fulton.
- Focus (1999). The use of stimulants in children with Attention Deficit Hyperactivity Disorder. *Focus evidence-based briefing*. London: Royal College of Psychiatrists.
- Goldstein, S. & Goldstein, M. (1999). *Managing attention disorders in children*. Chichester: Wiley.
- Hinshaw, S. (1994). *Attention deficits and hyperactivity in children*. Thousand Oaks, CA: Sage.
- Hinshaw, S., Klein, R. & Abikoff, H. (1998). Childhood AD/HD: Non-pharmacological and combination treatments. In P. Nathan & M. Gorman (Eds.), *A guide to treatments that work*. Oxford: Oxford University Press.
- Hughes, L. (1999). Professionals perspectives on AD/HD. In P. Cooper & K. Bilton, *AD/HD: Research, opinion and practice*. London: Whurr.
- Johnson, M. (1997). *Developmental cognitive neuroscience*. Oxford, Blackwell.
- Maras, P. (1996). 'I'd rather have dyslexia': Perceptions of EBDs. *Educational and Child Psychology*, 13, 1, 32–43.
- Maras, P. & Cooper, P. (1999). Sex differences, gender issues and EBDs. In P. Cooper (Ed.), *Understanding and supporting children with emotional and behavioural difficulties*. London: Jessica Kingsley.
- Maras, P. & Kutnick, P. (1999). Emotional and behavioural difficulties in schools: Consideration of relationships between theory and practice. *Social Psychology of Education*, 3, 3, 135–143.
- Maras, P., Redmayne, T., Hall, C., Braithwaite, D. & Prior, P. (1997). 'Helicopter children' and 'butterfly brains'. AD/HD: Perceptions, issues and implications. *Educational and Child Psychology*, 14, 1, 39–50.

-
- MTA Co-operative Group (1999). A 14-Month randomised clinical trial of treatment strategies for Attention Deficit/Hyperactivity Disorder. *Arch. Gen. Psychiatry*, 56, 1073–1086.
- MTA Co-operative Group (1999). Moderators and mediators of treatment response for Attention Deficit/Hyperactivity Disorder: The multi-modal treatment study of children with Attention Deficit/Hyperactivity Disorder. *Arch. Gen. Psychiatry*, 56, 1988–1096.
- Pelham, W.E. (1999). The NIMH Multi-modal Treatment Study for Attention-Deficit Hyperactivity Disorder: Just Say Yes to Drugs Alone? *Canadian Journal of Psychiatry*, 44, 981–990, December 1999.
- Scottish Intercollegiate Guideline Network (SIGN) (2000). AD/HD in Children. <http://www.show.scot.nhs.uk/sign/home.htm>
- Taylor, E. (1994). Disorders of attention and activity. In M. Rutter, E. Taylor & L. Hersov (Eds.), *Child and adolescent psychiatry: Modern approaches* (3rd ed.). Oxford: Blackwell.
- Taylor, E. (1999). Commentary: development of clinical services for Deficit/Hyperactivity Disorder. *Arch. Gen. Psychiatry*, 56, 1097–1099.
- Tannock, R. (1998). AD/HD: Advances in cognitive, neurobiological and genetic research. *Journal of Child Psychology and Psychiatry*, 39, 1, 65–99.
- Thompson, R. (1993). *The brain: A neuroscience primer* (2nd ed.). New York: Freeman.
- Weiss, G. & Hechtman, L. (1993). *Hyperactive children grown up* (2nd ed.). New York: Guilford.
- World Health Organisation (1990). *International classification of diseases* (10th ed.). Geneva: World Health Organisation.

Appendix A: PARTICIPANTS IN THE MULTI-DISCIPLINARY MEETINGS

Convenors and Joint Chair: Pam Maras, University of Greenwich and Paul Cooper, University of Cambridge.

PARTICIPANTS

Dr Ken Aitken, Clinical Neuropsychologist, Edinburgh.

Sharon Bingham, Research Associate (Emotional and Behavioural Difficulties), University of Greenwich (Meeting Administrator).

Jean Charlesworth, Social Worker, Children & Families, Gloucester Area Team.

Dr Paul Cooper, Lecturer in Education (Emotional and Behavioural Difficulties), School of Education, University of Cambridge.

Kate Diesfeld (J.D.), Kent Law Clinic (Mental Health and Learning Disabilities), Law Department, University of Kent.

Raymond Evans, Head of Service Education Access, City of Coventry.

Corinne Garvie, Speech & Language Therapist, Cambridge.

Professor Philip Graham, Child Psychiatrist, London.

Gerry Lewis, General Inspector Special Education Needs, EQUIPS, Education Services, Walsall, Metropolitan Borough.

Dr Pam Maras, Reader in Social & Educational Psychology, University of Greenwich.

Kevin Martin, Senior Youth Worker, Link Project, London Borough of Sutton.

Dr Diane Melvin, Committee Member SIG (Children and Young People) and Consultant Clinical Child Psychologist, Great Ormond Street Hospital, NHS Trust and St Mary's Hospital Brent, Kensington, Chelsea and Westminster NHS Trust.

Professor Brahm Norwich, Professor of Educational Psychology, School of Education, University of Exeter.

Eileen Orford, Child & Adolescent Psychotherapist, Child Psychotherapy Trust.

Sue Panter, Senior Teacher & Learning support Co-ordinator.

Professor Anthony Pellegrini, Professor of Educational Psychology, University of Minnesota.

Dr Rashmin Tamhne, Consultant Paediatrician, Leicester and Rutland Healthcare Trust, Leicester.

Professor Eric Taylor, Child Psychiatrist, Institute of Psychiatry.

Appendix B: PARTIES INVOLVED IN THE CONSULTATION EXERCISE

The Association of Directors of Social Services.
The Association of Educational Psychologists.
The Association for Health Visitors and Community Nursing Practitioners.
The Association of Workers for Children with Emotional and Behavioural Difficulties.
Professor John Bench (School of Communication Sciences, La Trobe University, Australia).
Lisa Blakemore (Chartered Psychologist).
The British Association for Community Child Health.
The British Association of Social Workers.
The British Dietetic Association (Paediatric Group).
The British Paediatric Association.
The British Dyslexia Association.
The British Psychological Society (Members of the Professional Affairs Board).
Kathy Bull (Department for Education and Employment).
Susan Chandler (British Association for Psychopharmacology).
CIBA Pharmaceuticals (Dr David Lott).
College of Occupational Therapists.
College of Speech and Language Therapists.
Dr Mike Connor (Surrey Educational Psychology Service).
Department for Education and Employment.
Gill Evans (Principal Educational Psychologist, Educational Psychology Service, Weston-Super-Mare).
Department of Health.
The Health Advisory Service.
Dr Doug Heller (Consultant Community Paediatrician, North Somerset).
Dr Cyril Hellier.
Professor Peter Hill.
Dr Gareth Hughes.
Lesley Hughes (Lecturer in Multi-Professional Education, University of Bradford).
Allan Magregor (County Educational Psychologist, Kent).
Pete Maguire (Child and Adolescent Mental Health Services).
Dr Judith Middleton.
David Moore (OFSTED).
Carolyn Morley (Partnership with Parents, Maidstone).
Philip Prior (Principal Educational Psychologists, Medway).
Professor Peter Pumfrey.

Ashok Rehal (Principal Educational Psychologist, Hackney).
Stephanie Robinson (Social worker, Families team, Cambridge).
The Royal College of General Practitioners.
The Royal College of Nursing.
The Royal College of Paediatricians.
The Royal College of Physicians of Edinburgh.
The Royal College of Psychiatrists.
The Royal College of Psychiatrists (Faculty of Child and Adolescent Psychiatry).
Scottish Inter-collegiate Guidelines Network.
Terry Redmayne (Assistant Director of Education, Luton).
Dr Sonia Sharp (Principal Educational Psychologist).
Dr Ros Shute (School of Psychology, Flinders University of South Australia).
David Spellman (Head of Child and Family Clinical Psychology, Burnley).
Professor Edmund Sonuga-Barke.
Thanet ADDers (Parent Support Group).
Phil Thompson (Headteacher, Hawksmoor Comprehensive School, Herts).
Dr Geoffrey Thorley.
Tornado (Family support in Kent for AD/HD).
Gillian Tutt (Clinical Psychologist, West Dorset General Hospital).
United Kingdom Central Council for Nursing, Midwifery and Health Visiting.

Appendix C: IMPACT AND DEVELOPMENT OF AD/HD

It is difficult to provide a single, definitive account of the personal and social impact of the developmental course of AD/HD, partly because the condition manifests itself in a wide variety of ways, and partly because the way it is experienced and perceived may vary. Important factors here are temperamental differences among children with the condition and among parents and other family members. Also, the high level of co-morbidity between AD/HD and other disorders and conditions is a further complicating factor. For example, Goldstein and Goldstein (1999) review research indicating that between 16 and 50 per cent of school age children with AD/HD experience comorbid Oppositional Defiant Disorder and Conduct Disorder, whilst 30 to 50 per cent of adolescents with AD/HD experience depressive disorders and anxiety symptoms. Barkley (1990) reviews research indicating a 5 per cent suicide rate among adolescent AD/HD sufferers, compared with 12.3 per 100,000 suicides in the general population of the same age group (Blau, 1996). Substance abuse and autistic spectrum disorders are, proportionately, also more likely to occur with AD/HD than in the general population (Goldstein & Goldstein, 1999). Specific medical conditions found to be co-morbid with AD/HD have included (Taylor, 1994):

- Foetal alcohol syndrome;
- Fragile-X chromosome disorder;
- Williams syndrome;
- Hearing impairment;
- Thyroid dysfunction;
- Developmental language and motor co-ordination disorders;
- Epilepsy.

In addition AD/HD is associated with a wide range of educational problems, such as dyslexia and dysgraphia, which are not necessarily a direct result of AD/HD.

This section¹ restricts itself to the contribution that AD/HD may make to an individual's developmental progress and the impact of this on his or her environment and social and interpersonal relationships. It must, however, be borne in mind that in many cases AD/HD will be present and interact with other problems, such as those referred to above. In many cases additional, comorbid problems (such as conduct disorder and anxiety disorders) may develop as a consequence of the way in which the social environment reacts to the core problems of AD/HD.

EARLY CHILDHOOD

AD/HD is not normally diagnosed with confidence before the age of four years. With hindsight children are often described retrospectively as having been unusually active from the time they could first walk. Other problems are often present from early development, but can also be encountered in other developmental disorders. They include apparent difficulties of temperament characterised by a tendency to respond aversively to external stimuli. Young

¹ Key sources for this section include Barkley (1990), Hinshaw (1994), Goldstein & Goldstein (1999) and Taylor (1994).

children may appear uninterested in or resistant to interaction with parents and siblings. They may appear to be unusually fractious and difficult to pacify to the extent that routine care-taking activities, such as feeding, bathing and changing are marked by difficulties for both child and parent. In such situations the child may be distressed, extremely overactive and resistant to the caretaker's efforts. Furthermore, changes in routine may produce a greater intensity of distress and conflict. The stress, which the parent may experience as a result of this situation may in turn, influence the quality of child-parent/carer relationship.

THE PRE-SCHOOL STAGE

It is during this phase that the child's tendency towards non-compliance with parental rules and demands and extreme overactivity may first be noticed. By contrast, the child with the mainly inattentive variety of AD/HD will often seem overly passive and far less responsive to external stimuli than other children of the same age. These children will tend to show little interest in play activities, or become easily distracted from such activities. However, the tendency for these behavioural patterns to present in an unpredictable and erratic manner may make it difficult to distinguish, at this stage, between the occasional vigorous presentation of age appropriate behaviour and the indication of a serious delay in development. There are also complicating factors such as the tendency of children with AD/HD, as they grow older, to exhibit the most extreme examples of their non-compliant behaviour in group situations, whilst being relatively compliant in the one-to-one situation.

It is also more common at this stage for children with AD/HD to have exhibited problems in their acquisition and development of speech and language skills when compared with the general population of their same age peers. Children with AD/HD tend to have difficulties in communicating with others as well as difficulties in the area of self-talk. The former can lead to problems in responding appropriately in social situations, and difficulties in forming social relationships. The latter range of problems is hypothesised to be related to difficulties of impulse control and non-compliance (Barkley, 1997).

Problems of impulse control may lead to the child being attracted to dangerous situations and circumstances in which he or she may cause damage or otherwise interfere with the property of others. Respectively, these tendencies will often lead to the child becoming accident prone, as well as developing a reputation for selfish and intrusive behaviour. An overarching feature here is the child's failure to respond to or comply with the behavioural boundaries to which children of this age are usually subject.

It is at this stage that the parents and other relatives of the child may begin to experience social stigma through the reactions of persons outside the immediate family who may respond negatively to the child's apparently unpredictable and uncontrollable behaviour. The parents may also be blamed for their perceived failure to manage the child effectively. As a result, the child and other family members may become ostracised from their wider family, and acquaintances, or may choose to withdraw from social contact through fear of embarrassment. These difficulties may in turn put further strain on relationships within the family, particularly in interpersonal relationships with the child.

EARLY SCHOOL YEARS

Prior to the advent of compulsory schooling for the child with AD/HD it may be possible for

carer/parents and others to insulate the child from the full social and personal effects of his or her difficulties with concentration, impulsiveness and overactivity. This may be achieved by keeping the child away from situations where these problems are most exposed. The fact that overactive and impulsive children tend to be socially disruptive and passive, and inattentive children unrewarding, may also mean that others do not invite the child with AD/HD into situations (such as group play situations, home visits, children's parties) where their dysfunctional behaviour will be exacerbated. The school, however, severely reduces the opportunities for avoidance of situations where children's social and behavioural difficulties are publicly exposed.

It is usually quite early in his or her school career that the individual with AD/HD experiences difficulty. From the outset the child with AD/HD may be identified as persistently failing to conform. In the classroom situation the child may appear to be distractible and unable to persist with learning and play tasks. Short term memory problems will begin to be academically debilitating towards the end of the primary school phase. He or she will display a lack of social skills, be unable to engage in group work or co-operative play, or simply show a lack of interest in social interaction. A major result of these problems is likely to be academic under performance, whereby the child repeatedly fails to perform in accordance with his or her assessed ability.

This failure to sustain attention and/or tendency to display a lack of social skills may also manifest itself in behaviours that contravene school or classroom rules, leading to disciplinary measures being brought against the child. Such measures, however, are seldom effective, especially when they are based on the assumption that the child simply is not trying hard enough to conform. This can lead to inappropriate pressure being placed on the child and on the child's carers, with further negative consequences for the social relationships within the family.

In these early school years the child is likely to become aware of the concerns of those around him or her, particularly adults, and their general sense of disappointment at the child's social and academic performance. Furthermore, the child is likely to experience difficulty in making friends, either as a result of social rejection or neglect by peers. This means that the early school years will often initiate a pattern of negativity that will lead to school being seen as an aversive experience by the child. In the absence of appropriate intervention this pattern often continues for the duration of the child's schooling, peaking, in terms of its negative intensity, in the adolescent years.

THE ADOLESCENT YEARS

The academic careers of the vast majority of children with AD/HD tend to be marked by failure, owing to their inattentiveness and tendency to have difficulty in conforming to rules. As the child makes the transition from primary to secondary schooling these problems are compounded by the increased emphasis that is placed on children's abilities to be self organising and autonomous, both in their learning and social behaviour. Secondary school students' failure to meet these expectations are often interpreted as reflecting an uncaring and oppositional attitude, rather than an absence of competence. As a result problems in producing homework, in bringing the correct equipment and books to lessons, and in organising their work schedules are often met with a disciplinary rather than a supportive remedial response. Similarly, evidence of average to above average abilities coupled with problems of

presentation, organisation and sequencing of academic assignments may be interpreted as indicating the student's lack of interest in or motivation for academic study. Some children with AD/HD will show an aptitude for kinaesthetic learning activities, most, however, will fail to thrive in tasks which rely on abstract conceptualisation and analytical thinking. This means that many children with AD/HD are disadvantaged by the educational approaches increasingly favoured in schools throughout the developed world. Therefore, the narrowing of the curriculum in the secondary school towards an emphasis on abstract and analytical learning activities makes schooling an increasingly aversive experience for many children with AD/HD. In addition the common alternative route to social success and recognition, in the form of sporting achievement, is unlikely to benefit the child with AD/HD, since organised games tend to rely on rules, the ability to sustain attention and effort, and co-operative interaction. It is not uncommon for children with AD/HD to be perceived as posing a health and safety risk in school activities which involve the use of potentially dangerous equipment, such as sporting equipment, science apparatus and tools and machinery involved in technical subjects.

It is during the adolescent years that the personal consequences of AD/HD become most acute. The individual with AD/HD is likely to be portrayed as being immature, lazy, anti- or a-social and an academic failure. As a result the adolescent with AD/HD is prone to low self esteem, a lack of self confidence in many areas of life and depression. These problems may in turn give rise to a lack of motivation to improve achievement levels and develop social skills, and, in some cases, lead to the development of oppositionality, conduct disorder or delinquency.

Without appropriate intervention, adolescents with AD/HD are likely to leave school with few or no formal qualifications. Their social profile is likely to indicate unreliability, a lack of motivation and/or a tendency towards oppositionality

The core problems of AD/HD which create social and academic problems in the school are likely to be associated with concomitant problems in the home setting, with predictable consequences for the quality of relationships.

ADULTHOOD

Estimates vary that between 50 and 70 per cent of individuals with AD/HD in childhood cease to qualify for the diagnosis by the time they leave school and reach adulthood. For those in whom the condition persists, in the absence of appropriate intervention, the possibilities of a wide range of social and psychological problems are greater than they are for the general population. These problems include: difficulties in obtaining and sustaining employment; relationship difficulties; depressive illness; drug and substance abuse; and criminality (Weiss & Hecthman, 1993).

Appendix D: ROLES OF PARTICIPANTS IN THE PROCESS OF IDENTIFICATION, ASSESSMENT, DIAGNOSIS AND INTERVENTION FOR AD/HD

PRIMARY UNIT

These include: The child, parent(s), carer(s), siblings, peers, extended family and other personal associates.

The child, his or her carer(s) and family members (referred to here as the primary unit) are at the heart of the assessment and treatment processes. Not only are they likely to be initiators of the referral process and vital sources of essential information on which accurate assessment depends, they are also key people in the intervention process. Their motivation to participate in and support intervention strategies may well be critical to the outcomes of the intervention programme. It is essential, therefore, that they be seen as, and made to feel like members of the assessment/intervention team, who are kept informed, consulted at all stages in assessment and intervention, and encouraged to contribute to the formulation of intervention plans.

The professional members of the team should each take responsibility for promoting understanding of their roles to member of the primary unit. This should include providing members with an accurate understanding of the nature of AD/HD. A relationship of trust and openness, between primary unit members and professionals will need to be fostered to facilitate this. Whilst members of the primary unit should not be used as a channel through which different professionals communicate with one another, primary unit members may support the process of inter-professional communication.

At the intervention stage the carer(s) knowledge of the child is invaluable. Their knowledge will be complemented by that of the school to create a composite picture of the circumstances which are, on the one hand, most aversive and stressful for the child, and, on the other, most conducive to the child's positive functioning. Where medication is prescribed, carers will play a key role in monitoring its effects. In the early stages this will enable the prescribing doctor to adjust the dosage if necessary. In time the carer(s) will also be able to give accounts of how the child responds to 'medication holidays', where these are prescribed. Carer(s) will also be important sources of information about changes in the child's behaviour over time, and thus indicate the effectiveness of intervention, or indicate that a new assessment or evaluation of the child's condition should be undertaken.

In many of these matters the child him or herself is also an important and valuable informant. In addition to providing information about the above issues, the child may also be able to give an account of his or her own inner states, in terms of developing thoughts and feeling about the condition and its treatment. This is particularly the case as the child moves into the adolescent years and may begin to experience a sense of stigma related to the diagnosis and

its associated treatment. This may provide clinicians with an indication that the child requires psychotherapeutic support, and/or the opportunity to share concerns with sympathetic, supportive and informed adults or peers.

It is also important to recognise that difficulties surrounding a child with AD/HD may become entwined with conflicts between carer(s), and members of the extended family. Professionals should, therefore, give thought to how best the carer(s) and child might communicate with extended family members about the issue of AD/HD, in order to create a more sympathetic and understanding approach to the problem. Handled well this effort might lead to members of the extended family taking an active role in intervention, or at least help them to engage in behaviour that is supportive of intervention.

The precise make up of the primary unit should be self determined by its members, and may, in some circumstances include members of the extended family or individuals who might be regarded as close associates of the child's carers. In some cases family members or associates may be recruited as 'mentors' for the child.

INFORMAL NEIGHBOURHOOD NETWORK

As with the extended family the informal neighbourhood network of the child with AD/HD and his or her carer(s) can play a significant role, which has either a positive or negative effect on the situation. An informed lay understanding of the nature of AD/HD in some circumstances can be a source of support to struggling families, and, in addition to providing moral support, may lead to an identification of concern by which the assessment process is triggered.

It may be the case that neighbourhood reactions are negative and exacerbate the situation. As with the extended family, the carer(s) and the child with AD/HD need to be supported by being given access to understandings and approaches designed to influence neighbours in positive ways. The intention here is to elicit their understanding, and ideally, their co-operation with the intervention programme.

HEALTH VISITOR

Health visitors play a major role in supporting mothers (and other carer(s)) and young children from early infancy. They may well be the first professional to perceive that a child exhibits problem behaviours. Health visitors may advise parents on child care and management strategies. They may form a link between isolated carer(s) and local community organisations, or refer parents to other specialist agencies. They may also initiate an assessment process via the child's General Medical Practitioner.

PARENT AND FAMILY SUPPORT GROUPS

There are many of these groups in the UK at the present time, concerned principally with the problem of childhood AD/HD. Their function is to provide carers and their families with information about AD/HD and relevant support services, as well social support, through meetings, newsletters and other communal activities. For many carers it is the support group, which provides them with their initial knowledge and understanding of AD/HD, and information about how to initiate an assessment procedure.

COMMUNITY ORGANISATIONS

Voluntary, local community action groups are often concerned with youth issues, such as violence and delinquency. Where there is concern about individual youngsters, these groups can play a useful role in bringing about local awareness of the problem of AD/HD as a possible option when seeking explanations for behavioural problems in young people. This can trigger an assessment process. Similarly such groups can support intervention plans by liaising with youth, carers and schools and creating community based opportunities for all children and young people to be engaged in constructive and rewarding activities.

EDUCATION PROFESSIONALS

These include: pre-school, primary, and secondary teachers, including class teachers; SENCOs; Learning Support Assistants (LSAs); pastoral staff and senior managers; tertiary tutors and lecturers

School personnel play a vital role in the assessment of and intervention with AD/HD, at all phases of education. Teachers, particularly at the pre-secondary stages, are often second only to primary carers in terms of their level of knowledge of and contact with a child. School personnel may independently suspect that a child may have AD/HD, or do so in concert with carers. Either way, the relationship between the carers, the school staff and the child is of central importance. As in other cases already mentioned this relationship needs to be positive and characterised by a shared commitment to meeting the needs of the child through a co-operative approach. Every school should have ready access to an educational professional who is conversant with the concept AD/HD, be able to identify aspects of the school setting which may exacerbate the child's difficulties, and be prepared to make appropriate changes and accommodations where necessary.

Where assessment is concerned, school staff will play a vital role, in some respects mirroring that of the parents, by providing detailed information about the child's current and previously observed educational and behavioural functioning.

It is essential that Learning Support Assistants (LSAs) and other educational support staff (such as lunchtime supervisors) are given full access to knowledge about AD/HD and the ways in which it affects children's behaviour, as well as their role in supporting children with such difficulties.

At the intervention stage the knowledge that school personnel have of circumstances in which the child functions effectively may be even more valuable than knowledge of his or her deficits, as a basis for selecting intervention strategies. If the child has a statutory statement of special educational need relating to the problems of AD/HD then this may be a source of further support for the total intervention package. Where medication is prescribed school personnel will play a key role in monitoring its effects. This will enable the prescribing doctor to adjust the dosage if necessary. Similarly, school staff will be important sources of information about changes in the child's behaviour in school over time. They will thus indicate the effectiveness of intervention, or that a new assessment or evaluation process be undertaken.

The school can also be a site where the child can begin to learn more about the nature of AD/HD, and how to overcome its potentially debilitating consequences. Included in this process should be structured opportunities to learn appropriate ways of interacting with peers.

SCHOOL NURSES AND MEDICAL OFFICERS

School nurses and medical officers are often well placed to work closely with school personnel and carers in relation to AD/HD. Their expert medical knowledge will enable them to offer early advice on referral routes and to provide support for intervention programmes, through existing direct routine liaison with educational psychologists, school staff and consultant paediatricians and child psychiatric services.

GENERAL MEDICAL PRACTITIONERS

The family General Practitioner may be the first professional who carer(s) actively seek out when they believe that they have a child who has a serious behavioural problem. In these circumstances the GP has to determine whether there is a case for referral to a specialist clinician (such as a clinical psychologist, psychiatrist or paediatrician) or whether the core problem is more likely located elsewhere, such as in the dynamics of the family, in some aspect(s) of the carer's perceptions or personal make up, in the school or some other aspect of the child's physical or psychological make up. Again, the quality of the GPs relationship with the family/primary unit is an essential requirement to the creation of a setting in which these different areas of experience are opened up in a none-judgmental and honest manner. Once again, the role of the GP as educator about the nature of AD/HD is important, since the client may well come to the surgery with inaccurate understandings AD/HD or unrealistic expectations about its treatment.

LEA BEHAVIOUR SUPPORT SERVICE

The precise make up of behaviour support services will vary from one LEA to another. Although usually under the auspices of the Local Education Authority they are often composed of professionals from a range of agencies. The role of behaviour support services is to provide support for children with or at risk of developing emotional and behavioural difficulties in schools. Services operate in many different settings, from providing staff to work alongside mainstream staff in schools, to special schools and units for children who are excluded from school. Members work directly with children and sometimes in an advisory capacity with teachers. They can assist in the assessment process. They can also provide advice on intervention strategies, which may either preclude the need for further assessment, or be incorporated into an AD/HD treatment plan.

CONSULTING HEALTH PROFESSIONALS

These include: child psychiatrist, clinical child psychologist, and paediatrician.

One of these health professionals is likely, at present, to take a leading role in the assessment and treatment of individuals with AD/HD. They will work in conjunction with other professionals already mentioned, these professionals will contribute medical and psychological aspects of the assessment process, and ultimately make the decision on the basis of information derived from these sources, whether a diagnosis of AD/HD is warranted or not. They will also play a central role in the design and implementation of the treatment/intervention plan. The psychiatrist and the paediatrician alone are able to prescribe medication at present. Between them, these professionals will offer medical intervention, as well as psychological and social support, such as individual, group or family therapies to clients and their carers. Clinical child psychologists will provide a developmental framework within which to view a child's difficulties and can act as an interface between health, education and community services. Their direct role could include parental and family support as well as early interventions and behavioural management concerns of the child.

EDUCATIONAL PSYCHOLOGIST

Educational psychologists can serve important functions at almost any stage of the assessment and intervention processes. Specialist educational psychologists may work with particular age groups or focus on specific issues. They also provide advice to LEAs as part of the statutory assessment process (1996 Education Act) which could lead to a Statement of Special Educational Needs. This is a major pre-requisite for accessing resources beyond those readily available in most schools for the support of an individual child. It is essential, therefore, that educational psychologists work co-operatively with clients and other professionals to ensure the most appropriate and effective deployment of resources. It is also important that educational psychologists maintain an up-to-date and accurate understanding of AD/HD.

SOCIAL SERVICES

Social services are very wide ranging in the breadth of their provision. They can provide services to individuals, families and communities, and are relevant to both assessment and intervention stages in relation to AD/HD. A major contribution that they can make to assessment is an evaluation of family functioning in relation to a suspected case of AD/HD. Also the presence of relevant information relating to child protection issues will be accessible to social workers and may have considerable bearing on a child's behavioural patterns. Social workers also engage in a range of intervention activities, including family therapy and providing social support to children and young people in community settings.

EDUCATIONAL WELFARE OFFICERS

Education welfare officers have a particular contribution to make to assessment and monitoring of children's status and progress, particularly in terms of the child's relationship with, attitude towards and attendance at school.

OTHER SPECIALIST SERVICES

These include: special educational needs services and provision; speech and language therapist; occupational therapist; child psychotherapist; audiologist; dietician.

These services are likely to be most active at the post initial-assessment phase, though they may also provide assessment information. Their main role is to provide services that are targeted to a child's specifically identified need.

POLICE, PROBATION AND YOUTH JUSTICE SERVICES

Knowledge of AD/HD and close association between members of these services and the other professional services already mentioned will help broaden the range of response options available to legal services when dealing with young offenders. In some cases this involves combining a youth justice intervention with a therapeutic intervention.

PROFESSIONALS NOT DIRECTLY INVOLVED

Though not directly relevant to the brief for this document, it is also important to note that information on children with AD/HD should be available to other professionals (such as dentists) who may come into contact with them.

Appendix E: WHO AND APA DIAGNOSTIC CRITERIA

In these guidelines we refer to diagnostic criteria for AD/HD. As noted, AD/HD is a diagnostic category of the APA. However, we also noted there is overlap between this and the World Health Organisation (WHO) criteria for hyperkinetic disorder. On the following pages, for information, are tables showing the American Psychological (APA) and WHO diagnostic criteria for AD/HD and hyperkinetic syndrome.

Table 1: Criteria for hyperkinetic disorder in the *International Classification of Diseases*, 10th edition (the ICD-10 criteria). Geneva: World Health Organisation, 1990. (Permission to reproduce applied for.)

F90. Hyperkinetic disorders

Note: The research diagnosis of hyperkinetic disorder requires the definite presence of abnormal levels of inattention, hyperactivity and restlessness that are pervasive across situations and persistent over time and that are not caused by other disorders such as autism or affective disorders.

- G1. *Inattention.* At least six of the following symptoms of inattention have persisted for at least six months, to a degree that is maladaptive and inconsistent with the development level of the child:
- (1) often fails to give close attention to details, or makes careless errors in schoolwork, work or other activities;
 - (2) often fails to sustain attention in tasks of play activities;
 - (3) often appears not to listen to what is being said to him or her;
 - (4) often fails to follow through on instructions or to finish schoolwork, chores or duties in the workplace (not because of oppositional behaviour or failure to understand instructions);
 - (5) is often impaired in organising tasks and activities;
 - (6) often avoids or strongly dislikes tasks, such as homework, that require sustained mental effort;
 - (7) often loses things necessary for certain tasks or activities, such as school assignments, pencils, books, toys or tools;
 - (8) is often easily distracted by external stimuli;
 - (9) is often forgetful in the course of daily activities.
- G2. *Hyperactivity.* At least three of the following symptoms of hyperactivity have persisted for at least six months, to a degree that is maladaptive and inconsistent with the developmental level of the child:
- (1) often fidgets with hands or feet or squirms on seat;
 - (2) leaves seat in classroom or in other situations in which remaining seated is expected;
 - (3) often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, only feelings of restlessness may be present);
 - (4) is often unduly noisy in playing or has difficulty in engaging quietly in leisure activities;
 - (5) exhibits a persistent pattern of excessive motor activity that is not substantially modified by social context or demands.

- G3. *Impulsivity.* At least one of the following symptoms of impulsivity has persisted for at least six months, to a degree that is maladaptive and inconsistent with the developmental level of the child:
- (1) often blurts out answers before questions have been completed;
 - (2) often fails to wait in lines or await turns in games or group situations;
 - (3) often interrupts or intrudes on others (e.g. butts into others' conversations or games);
 - (4) often talks excessively without appropriate response to social constraints.
- G4. Onset of the disorder is no later than the age of 7 years.
- G5. *Pervasiveness.* The criteria should be met for more than a single situation, e.g. the combination of inattention and hyperactivity should be present both at home and at school, or at both school and another setting where children are observed, such as a clinic. (Evidence for cross-situationality will ordinarily require information from more than one course; parental reports about classroom behaviour, for instance, are unlikely to be sufficient.)
- G6. The symptoms in G1–G3 cause clinically significant distress or impairment in social, academic or occupational functioning.
- G7. The disorder does not meet the criteria for pervasive developmental disorders (F84), manic episode (F30.–), depressive episode (F32.–) or anxiety disorders (F41.–).

Comment

Many authorities also recognise conditions that are sub-threshold for hyperkinetic disorder. Children who meet criteria in other ways but do not show abnormalities of hyperactivity/impulsiveness may be recognised as showing *attention deficit*; conversely, children who fall short of criteria for attention problems but meet criteria in other respects may be recognised as showing *activity disorder*. In the same way, children who meet criteria for only one situation (e.g. only the home or only the classroom) may be regarded as showing a *home-specific* or *classroom-specific disorder*. These conditions are not yet included in the main classification because of insufficient empirical predictive validation, and because many children with sub-threshold disorders show other syndromes (such as oppositional defiant disorder, F91.3) and should be classified in the appropriate category.

F90.0 Disturbance of activity and attention

The general criteria for hyperkinetic disorder (F90) must be met, but not those for conduct disorders (F91.–).

F90.1 Hyperkinetic conduct disorder

The general criteria for both hyperkinetic disorder (F90) and conduct disorders (F91.–) must be met.

F90.8 Other hyperkinetic disorders

F90.0 Hyperkinetic disorder, unspecified

This residual category is not recommended and should be used only when there is a lack of differentiation between F90.0 and F90.1 but the overall criteria for F90.– are fulfilled.

Table 2: AD/HD criteria from the *Diagnostic and Statistical Manual of Mental Disorders* (the DSM IV criteria). American Psychiatric Association, 1994.
(Permission to reproduce applied for.)

A	EITHER (1) OR (2)
(1)	<p>Six (or more) of the following symptoms of inattention have persisted for at least six months to a degree that is maladaptive and inconsistent with developmental level:</p> <p>INATTENTION</p> <ul style="list-style-type: none"> a. Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities. b. Often has difficulty sustaining attention in tasks or play activities. c. Often does not seem to listen when spoken to directly. d. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behaviour or failure to understand instructions). e. Often has difficulty organising tasks and activities. f. Often avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort (such as school work or homework). g. Often loses things necessary for tasks and activities (e.g. toys, school assignments, pencils, books or tools). h. Is often easily distracted by extraneous stimuli. i. Is often forgetful in daily activities.
(2)	<p>Six (or more) of the following symptoms of hyperactivity-impulsiveness have persisted for at least six months to a degree that is maladaptive and inconsistent with developmental level:</p> <p>HYPERACTIVITY</p> <ul style="list-style-type: none"> a. Often fidgets with hands or feet or squirms in seat. b. Often leaves seat in classroom or in other situations in which remaining seated is expected. c. Often runs about or climbs excessively in situations in which it is inappropriate. (In adolescent or adulthood may be limited to subjective feelings of restlessness.) d. Often has difficulty in playing or engaging in leisure activities quietly. e. Is often 'on the go' or often acts as if 'driven by a motor'. f. Often talks excessively. <p>IMPULSIVENESS</p> <ul style="list-style-type: none"> g. Often blurts out answers before questions have been completed. h. Often has difficulty awaiting turn. i. Often interrupts or intrudes on others (e.g. butts into conversations or games).
B.	Some hyperactive-impulsiveness or inattentive symptoms that caused impairment were present before the age of seven years.
C.	Some impairment is present in two or more settings.
D.	There must be clinically significant impairment in social, academic or occupational functioning.
E.	The symptoms do not occur exclusively during the course of a pervasive development disorder, schizophrenia or other psychotic disorder, and are not better accounted for by another mental disorder.

The British Psychological Society
St Andrews House
48 Princess Road East
Leicester LE1 7DR

Tel: 0116 254 9568 E-mail: mail@bps.org.uk

£5 (BPS members) £10 (non-members)