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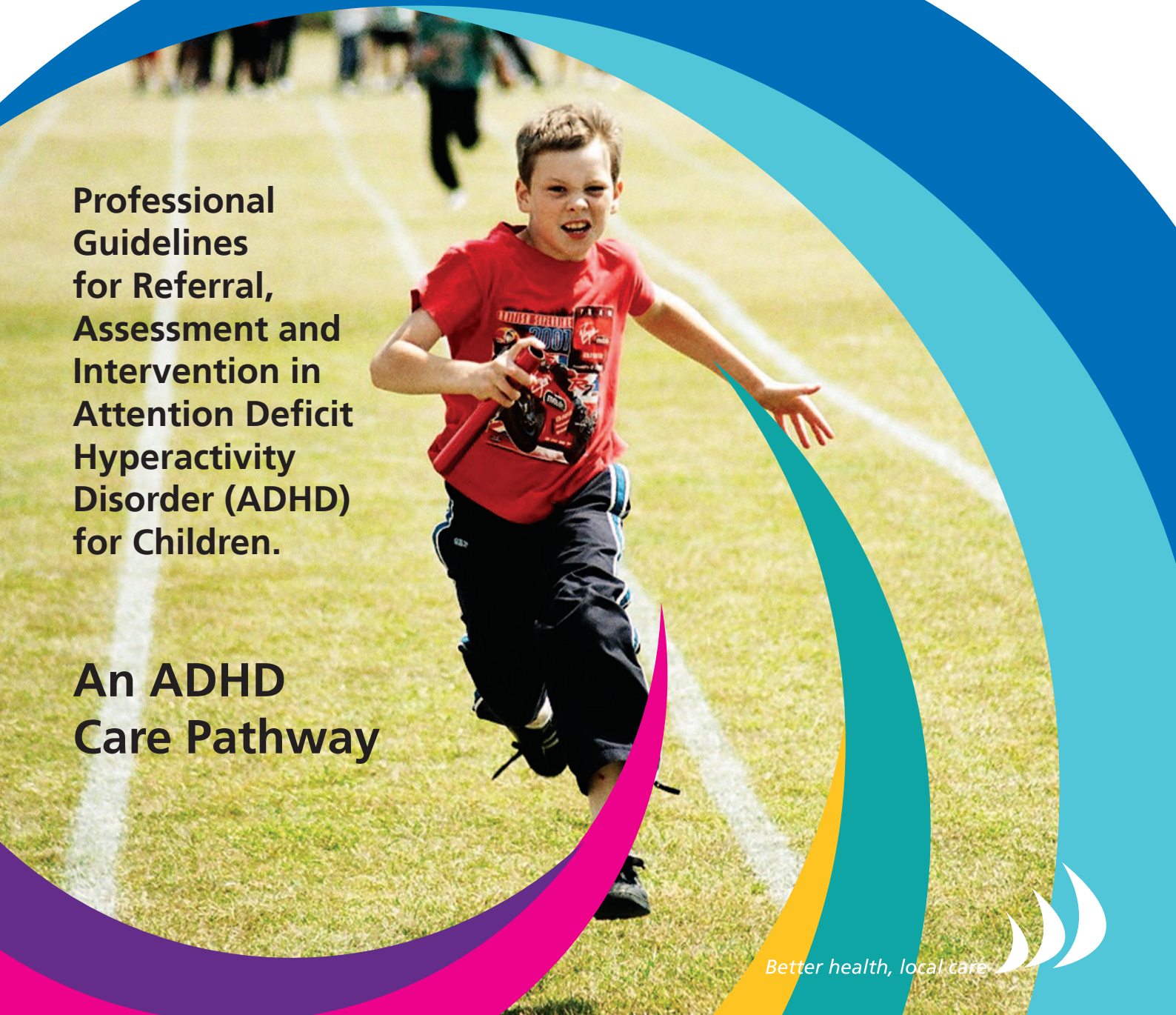

Professional Guidelines for Referral, Assessment and Intervention in Attention Deficit Hyperactivity Disorder (ADHD) for Children.

An ADHD Care Pathway

Better health, local care

ADHD is a term that most people are familiar with, but this familiarity can be a mixed blessing: so much information about this condition is available that it can be very difficult for professionals, let alone parents and young people, to find out 'the facts'.

Subject and Version of Document:	Professional Guidelines for Referral, Assessment and Intervention in Attention Deficit Hyperactivity Disorder (ADHD) for Children An ADHD 'Care Pathway'
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Date agreed:	24th June 2010
By whom agreed:	As above consultation committee
Date reviewed and by whom:	June 2013, Zam Bhatti and above group
Date of next review	June 2016
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Distribution:	All schools, GP practice managers, Educational Psychologists, Community Paediatricians, CAFÉ/ Social Care, members of the group
Date document issued:	October 2013
Responsibility for dissemination to new staff:	Service managers/ADHD Champions in schools

Contents

Foreword

ADHD is a term that most people are familiar with, but this familiarity can be a mixed blessing: so much information about this condition is available that it can be very difficult for professionals, let alone parents and young people, to find out 'the facts'.

This document has been written to provide information about ADHD for professionals who may be working with a child or young person with behaviour difficulties, or perhaps a diagnosis of ADHD, and their family. It is intended to ensure that children, young people and their parents receive well-informed, accurate and consistent advice from the range of different professionals they are likely to meet when concerns about a child's behaviour are raised.

Some of the information is general and true for many children and families across the country but the heart of this document is a description of local policy and procedures that are specific to the Solent NHS Trust – Portsmouth CAMHS.

Reference to, and use of, this document should improve the quality of services offered to children, young people and parents in Portsmouth by making the processes of information collection, assessment, diagnosis, treatment and management of ADHD more transparent and more easily understood.

List of acronyms and abbreviations

List of acronyms and abbreviations used in this document and/or commonly encountered in other documents and discussions about children and young people's behaviour:

ADD Attention Deficit Disorder

ADHD Attention Deficit Hyperactivity Disorder

ASD Autism Spectrum Disorder

BESD Behavioural, Emotional and Social Difficulties (also SEBD and EBD)

CAF Common Assessment Framework

CAMHS Child and Adolescent Mental Health Services (also CAMHS-LD the Learning Disability Team)

CBT Cognitive Behavioural Therapy

CFL Children, Families and Learning

DFE Department for Education

DSM IV The Diagnostic and Statistical Manual of Mental Disorders 4th edition, American Psychiatric Association, 1994

ECM Every Child Matters

EP Educational Psychologist (also Ed Psych)

EPS Educational Psychology Service

EWO Education Welfare Officer

EWS Education Welfare Service

EYP Early Years Panel

GP General Practitioner

IBP Individual Behaviour Plan

ICD 10 The International Classification of Mental and Behavioural Disorders 10th edition, World Health Organisation, 1994

IEP Individual Education Plan

ISP Inclusion Support Panel

LA Local Authority

LD Learning Disability

MABSS Multi Agency Behaviour Support Service

NICE National Institute for Health and Care Excellence

PMHW Primary Mental Health Worker

PSP Pastoral Support Programme/Plan

SALT Speech and Language Therapist/Therapy

SEN Special Educational Needs

SENCO Special Educational Needs Co-ordinator (also Inclusion Manager)

SLD Severe Learning Disability

TA Teaching Assistant (also LSA - Learning Support Assistant)

Tier 1 Universal services provided by Non Specialists CAMHS Staff

Tier 2 Targeted services provided by the Specialist CAMHS

Tier 3 Specialist Multi-disciplinary CAMHS team

Summary

This document is a description of what should happen before, during and after an assessment for ADHD by the local CAMHS team. It has been written to provide guidance and information for professionals in order to ensure that clear and consistent messages and expectations can be given to children, young people and their families.

Not all children who show difficult behaviour are found to have ADHD but it is very important that all children who are referred for an ADHD assessment have experienced the same level and quality of early intervention that any child with behaviour difficulties can expect. A diagnosis of ADHD requires very clear evidence that a child's behaviour difficulties have persisted over a significant period of time and have had negative effects in at least two areas of their life, such as home and school, preschool or any other area of the community. Without evidence of what has been put into place for a child before they are referred to CAMHS, the professionals in that team are unable to carry out a complete assessment. The appropriate response to that child's difficulties may then be delayed.

This document should help professionals to be clear about what needs to be done when concerns about a child's behaviour are first expressed, so that if a referral to CAMHS is later felt to be appropriate it can proceed without unnecessary delays. It also clarifies the information that is needed as part of a CAMHS assessment for ADHD and who will be involved in the assessment process. If a diagnosis is made, a plan will be put into place to support and monitor that child or young person's progress at home and at school. This document therefore also describes the form that this support and monitoring should take.

It is recognised that professionals using this document will come to it with different needs. Readers looking for quick answers to specific questions about ADHD are likely to find them in the Frequently Asked Questions section. Information principally about the discussions and decisions that could lead to a child being referred for an ADHD assessment are covered in section 2 What should happen when concern is expressed about a child's behaviour? An explanation of what takes place for the child and his/her family once such a referral has been made is covered in section 3 The assessment and management of ADHD.

These guidelines are the written outcomes of consultation between a wide range of professionals and parent representatives who have been able to attend the city's ADHD Strategy Group (see Appendix 7). They reflect the best practice advice on the assessment, diagnosis and management of ADHD published by NICE in 2008 and the principles and practice of the DCSF's Think Family agenda.

Throughout this document the term 'parent/s' is used in its widest sense to include all adults who are the main carers for children.

ADHD: frequently asked questions

What does ADHD stand for?

It stands for Attention Deficit Hyperactivity Disorder.

What exactly is ADHD?

It is a common neuro-behavioural developmental disorder which arises as a result of an imbalance of certain chemicals in the brain, which means that ADHD is a physiological problem and not an emotional problem. It affects many school-aged children and young people. It usually starts in early childhood, the diagnostic guidelines used by professionals' state that at least some symptoms must have been present before the age of 7 years. It has 3 main symptoms:

Inattention - The child is unable to listen and concentrate for reasonable periods or finish a task, they may often lose things and may be easily distracted, forgetful or disorganised.
Over activity – The child is unable to sit still, and may be fidgety and restless. Children with ADHD may be running and climbing much of the time, talking constantly and have difficulty in carrying out 'quiet' activities
Impulsivity – The child may be unable to wait or take his or her turn, they may speak without thinking about the consequences and interrupt other people

In addition the behaviours must be judged to be inappropriate to the child's age and development; they must be persistent and pervasive across different settings; and most importantly, the behaviour must have a significant negative impact on the child's daily life including their social friendships, family relationships and school learning.

Are there different types of ADHD?

Many terms are used to describe these difficulties, for example: hyperactivity, hyperkinesis, ADHD, AD (H) D or ADD and Hyperkinetic Disorder (HD). To some extent the terminology varies according to whether diagnostic criteria from the ICD 10 or the DSM IV are being used (see List of Acronyms on page 5 and Appendix 1)

Why have I heard that it is difficult to diagnose ADHD?

The problem arises because not all people with symptoms similar to ADHD necessarily have ADHD. Anyone can be inattentive, hyperactive or impulsive some of the time - particularly children. But a person with ADHD has the relevant symptoms most of the time and they will be seriously affecting their daily life, their learning, their capacity to make friends and socialise and work productively. It is also sometimes difficult to diagnose ADHD because there are conditions that can cause similar behaviours, such as Conduct Disorder (anti social behaviour), Mood Disorder e.g. Bipolar disorder, Autism Spectrum Disorder (ASD) and Learning Disability (LD). The person concerned may also have other conditions such as Anxiety Disorder or learning difficulties as well as ADHD.

...it is a common neuro-behavioural developmental disorder which arises as a result of an imbalance of certain chemicals in the brain...

What causes ADHD?

No single cause has been identified yet and therefore the exact cause remains unknown. However, it does seem clear that ADHD tends to run in families and hence there is likely to be an increased genetic vulnerability in some people. Other reported causes link it to brain insult to the unborn baby arising from maternal alcohol use, some illnesses e.g. meningitis, head injury, epilepsy, diet, lead exposure and psycho-social adversities in early life. Poor parenting, a chaotic home life, divorce or school stresses don't cause ADHD but may affect how a parent may manage their child's behaviour.

How common is ADHD?

With a narrow definition of Severe ADHD (using criteria from the ICD 10) it affects between 0.5 to 1% of U.K. school aged children between the ages of 5 and 16 years, and this increases to an incidence of 3 to 5 % within the broader definition found in the DSM-IV.

Do only boys have ADHD?

It's true that it seems to be about 3 times more common in boys than in girls. This gender difference may be affected by the referral practices of professionals, i.e. boys' difficulties may attract more attention and consequently more referrals and interventions. Nevertheless it is important to note that boys and girls present with different types of ADHD. Boys more often present with combined type of ADHD - inattention and hyperactivity - and girls with inattentive behaviour or ADD. This means boys will tend to present concerns earlier because their problematic behaviour is more obvious and causes problems for their families and school. By contrast, girls often present difficulties later and are generally less affected than their male counterparts.

Does ADHD mean there is some thing wrong with the person's brain?

No, the problem is believed to be with the functioning of the brain, i.e. the connections in certain parts of the brain, and not due to any brain damage.

How is a diagnosis of ADHD made?

It is a medical diagnosis and as such is usually made by health care specialists who work with children, such as child psychiatrists, and in some areas by specialist paediatricians.

There is no single tool, instrument or specific test or investigation that can make this diagnosis. It is made on the basis of gathering information from multiple sources, i.e. from parents/carers, extended family members, teachers and other adults at school, and observations of the child in multiple settings. Diagnosis is made through a process of exclusion of other difficulties that may present symptoms similar to ADHD, rather than by simply looking for evidence of these symptoms alone.

...It's true that it seems to be about 3 times more common in boys than in girls...

How is ADHD managed once it has been diagnosed?

Firstly by helping the parents, the child and school staff to understand the child's needs in relation to his/her ADHD. There is a range of self-help materials available for children, parents and professionals in schools. In addition, parents/carers are assisted in accessing local parent support/ training programmes in the community as recommended by NICE.

Following this additional therapeutic work may be offered as appropriate, for example:

- Further behaviour management and parenting work for parents
- Individual/group CBT work for children/young people
- Educational support via liaison with schools and other professionals such as Educational Psychologists and members of the Multi Agency Behaviour Support Service.
- Medication is usually not offered in the first instance unless the ADHD is severe. Even then it is not offered alone but in combination with some of the above interventions.

Is there anything a parent can do to help a child with ADHD?

Yes, experience and good practice suggest the following practical tips are of great help:

1. Setting up and sticking to a regular routine and structure for the child's day is crucial, i.e. a regular time for meals, home work and getting up and going to bed etc.

2. A healthy and well balanced diet is important for any young person to grow and develop appropriately but it is particularly important for a child with ADHD. In particular parents should encourage them to eat a well balanced but nutritious breakfast, this will help provide them with not only fuel for the brain but also the necessary vitamins and minerals they need. Some children's behaviour can be affected by certain additives in certain foods; the research in this field remains inconclusive but if a link is noticed by the parent then it is best to avoid those items provided it doesn't compromise the child's balanced food intake. It is recommended that parents should seek advice from a primary care health professional such as their health visitor or GP.

3. Be firm, have clear ground rules and stick to them! Some children find it helpful to have these written in the form of charts or lists which can then be stuck around the house for them to see and read, to help them remember that day's routine, and the rules and expectations for positive behaviour.

4. Negative consequences should match or be in proportion to the severity of the child's misbehaviour. The basic rule is the consequence should follow as soon as possible after the undesirable behaviour and should be of short duration. Once the poor behaviour has received a consequence, there should be no more grumbling or accusations about it afterwards!

5. Recognise and understand the child's differences, their strengths and weaknesses and help others to do the same.

6. Children with ADHD take longer to process multiple requests so help them by making sure one has their full attention before making a request. Keep any request to a single item or issue, and make it clear and simple. Ask the child to repeat what is requested to ensure they have understood and remembered it.

7. Reduce any distractions to a minimum when one wants them to concentrate on a task or home work.

8. Let them ‘blow off steam’ between school and home with some physical activity/exercise.

9. Look after themselves to help maintain their own energy levels and to help them stay calm and optimistic.

10. Take up the offers of training in behaviour management skills that are on the offer to you or are signposted by professionals. (For further advice see Appendix 10)

What about managing behaviour in school?

Please see Appendix 9 for some detailed advice around management of ADHD at school.

What types of medication are used for treating ADHD?

Methylphenidate and Dexamphetamine belong to the class of medicines called Psycho-stimulants. They are controlled drugs and represent the mainstay and the first line of medical treatment as recommended by the NICE guidelines. Within this group of drugs there are two types: immediate and extended release.

Immediate release drugs have effects that last only for a few hours so consequently they need to be taken 2 or 3 times a day. Methylphenidate, or Ritalin as it is more commonly known, and Dexamphetamine fall into this category.

Extended release preparations such as Concerta XL and Equasym XL require only one daily dose because the effects of the medication last between 8 and 12 hours.

Methylphenidate has been in use since the late 1950s. It is not a sedative or a cure and not everyone responds positively to the use of this drug. Despite a lot of media ‘hype’ it is not addictive, and it doesn’t increase the risk of substance misuse in later life. The research suggests a response rate of 70% meaning only 7 children out of 10 will benefit from this medication. This figure is even lower for children with a Learning Disability. Hence, other support measures, as noted above, are also crucial to support the child and their family.

Atomoxetine is the first non-stimulant medication which is also licensed for use in children for ADHD. It works in a different way to Methylphenidate as it acts on pre-synaptic noradrenalin transporter inhibitor, which increases noradrenergic activity in the brain, thereby improving symptoms of ADHD. It is useful in children who also have Tourette’s Syndrome and Epilepsy.

Are there any side effects from the medications prescribed for ADHD?

Although these drugs provide many positive benefits to the child with ADHD there are some recognised side effects, such as: headache, stomach ache, reduced appetite - which may affect the child’s growth and weight gain - sleep difficulties, nervousness and low mood, ‘rebound behaviour’ (return of the difficult behaviour as the medication wears off in between doses) and tics and mannerisms which can occur at any stage of the treatment.

For further details about dose and possible side effects, see Appendix 11

How long would a child need to take their medication for ADHD?

If the medication is effective in improving the child’s daily functioning by improving attention, reducing over-activity and improving motivation and school learning, then they will need to continue taking the medication as long as it benefits them, subject to regular yearly reviews with the prescribing specialist who will also regularly monitor blood pressure, pulse, weight and height.

What happens if the medication doesn’t work?

Sometimes when the medication is not effective, the specialist may decide instead to use one of the other drugs, e.g. Antidepressants such as Tricyclics/SSRIS and Clonidine, especially if the child may also have other conditions such as Tourette syndrome, anxiety and a history of fits. Both require a baseline ECG (heart tracing) and thereafter annually.

Do children grow out of ADHD?

Many children will out grow ADHD but research suggest some young people will continue to have ADHD as adults and that 60% of children will continue to experience some of their ADHD symptoms into adulthood. However, even in these persistent cases there is a reduction in the number of symptoms, probably reflecting continuing maturity of the brain.

What arrangements are there if a child needs to continue taking this medication into adulthood?

As per the NICE guidance, medication should be discontinued at an appropriate time, e.g. after GCSE’s have been completed. The specialist will re-evaluate and assess the needs of young person including on-going medication. If medication is still necessary then arrangements will be made to transfer the young person’s care to adult services by offering appropriate information and support to that young person and their carers.

1. Introduction and definitions

ADHD is a common neuro-behavioural disorder which affects many school aged children and young people. It usually starts in early childhood and some young people will continue to have ADHD as adults.

Its core symptoms are as follows:

- Inattention - unable to listen and concentrate for long or finish a task, often losing things, easily distracted and forgetful, disorganised.
- Over activity - unable to sit still, fidgety and restless, children may be running and climbing much of the time, talking constantly and having difficulty in doing quiet activities
- Impulsivity - unable to wait or take turns, speaking without thinking about the consequences and interrupting other people

All of the above is of such a degree that it is inappropriate to the child's development, is persistent and pervasive across different settings and most of all it significantly Interferes with his/her daily life including social/family relationships and academic functioning.

Many terms are used to describe these difficulties, including hyperactivity, hyper-kinesis, ADHD, AD(H)D or ADD and Hyperkinetic Disorder (HD), the diagnostic label for severe ADHD. This depends upon whether we are using the terminology used in the UK using a narrow definition from the ICD-10, or a much broader American classification system, the DSM IV (see List of Acronyms above and Appendix 1).

This is further complicated by the fact that not all people with ADHD have all the symptoms, and everyone can be inattentive, hyperactive or impulsive some of the time – this is particularly so for children. However, a person with ADHD has symptoms most of the time that can seriously affect their daily life; affecting their learning, making friendships, socialising and work in adults. It can also be difficult to diagnose ADHD because there are other conditions that can cause similar behaviours, such as Conduct disorder, Mood disorder and Autism. The person may also have other conditions such as anxiety disorder and learning difficulties as well as ADHD.

The exact cause of it is unknown and therefore no single cause has been identified yet. It seems clear that ADHD tends to run in families and hence some people have an increased genetic vulnerability. Other reported causes link it to brain insult to the unborn baby arising from causes such as maternal alcohol use, some maternal illness, head injury, epilepsy, diet, lead exposure and psycho-social adversities in early life.

How common is ADHD?

With a narrow definition of Severe ADHD, using the criteria from the ICD 10, it affects between 0.5 to 1% of U.K. school-aged children and this increases to
3 to 5% if the broader definition from the DSM-IV is adopted. It's more common in boys than girls at a ratio of 3 to 1.

The Local Context

In Portsmouth we have a population of approximately 190,000 people and 48,000 of those are children under the age of 18 years. Of those 40,000 are under 16 and at a prevalence rate of 1%, there will be 334 children of 6 to16 years with severe ADHD needing support from a variety of agencies. But this number increases to 1,000 to 1,700 of 6 to16 year olds at 3 to 5%, with a broader definition. Therefore, with such high numbers and the varied and complex needs of such a group, a co-ordinated and integrated approach to supporting these families, involving a number of different agencies, is needed if their needs are to be fully met.

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2. What should happen when concernen is expressed about a child's behaviour at Tier 1 and 2?

For children of pre-school and school-age there is a range of support available that can be matched to a child's needs and increased until their situation is improved. The nature of this support will depend somewhat on the child's situation at the time when concerns about behaviour arise. Some children may already be well-known to many professionals and services if they have recognised special or additional needs in areas other than behaviour. Indeed, a very small percentage of children may have Statements of Special Educational Needs and may even be accessing special educational provision before concerns about their behaviour become prominent.

When a decision is made that a child's behaviour needs to change, it is vital that a clear plan for this is made, with advice and support from a professional who is working with the child or family such as health visitor, nursery worker, Portage worker or teacher as necessary, and that the child is set a simple, 'manageable' behaviour target. Parents and the relevant professional should record how successful the child is in meeting their target, ideally for a period of at least two weeks. When professionals are attempting to assess the severity of a child's behaviour difficulties, and the support that the child needs, they gain very valuable information from feedback about behaviour plans that have already been tried, regardless of whether they were successful or not.

Where concern about a child persists and increases, despite the involvement of appropriate professionals and the implementing of behaviour plans, it is likely that a Common Assessment Framework (CAF) will be used as a way of devising a more successful plan of support.

Children of pre-school age

Initially families should seek advice from their Health Visitor in the locality Child and Family Teams. An immediate appointment with the family doctor or GP is not advised at this point as the GP will be able to give better advice and guidance when the outcomes of advice from other professionals such as the Health Visitor are known. (See Appendix 8 for questions that the GP is likely to ask).

The Health Visitor or other professional from the Child and Family Team can help with clarifying the concern and making a plan or setting a target for behaviour change. They can help 'rule out' some possible explanations for a child's behaviour and will have a good knowledge of services available to families with young children. They will be able to advise parents about accessing some of the behaviour management training courses specifically designed for parents in the city, up to date information on which is available through the web pages at www.portsmouth.gov.uk and the Ask Sherlock online searchable directory for parents, young people and professionals www.asksherlock.info . A member of that team can also support a referral directly to another professional such as PMHWs or, more commonly, to the Local Authority's Early Years Panel. This monthly panel meeting is attended by representatives of most of the key agencies that work with pre-school aged children and is therefore able to make well-informed referrals to other professionals as appropriate. This is the most common referral route through to an Educational Psychologist (EP) who will generally make a home visit to discuss a child's progress with their parents after a referral has been received.

If a child is in a nursery or preschool setting then advice should also be sought from the child's Key Worker and the setting's Special Educational Needs Co-ordinator (SENCo). Early Years professionals will follow the guidance in the Special Educational Needs Code of Practice and can request further advice from the Local Authority's Foundation Stage Advisory Teachers and a Teacher Advisor from the Multi Agency Behaviour Support Service. Any of these professionals will be able to advise parents about relevant behaviour management training available (For links and information see 'Children of pre-school age' above).

If a referral through the Early Years Panel has been made, an Educational Psychologist may visit the nursery or preschool, meet the child's parents, and offer advice about behaviour management strategies.

Unless the difficult behaviour occurs only at home, the child should have a behaviour target written into an Individual Education Plan (IEP) or an equivalent planning document completed by staff after discussion with parents. Nursery or preschool staff can also offer advice to parents about writing a behaviour plan and setting targets for their child even if the behaviour difficulties are being experienced only at home.

Children attending school

School staff and parents should discuss concerns about a child's behaviour at the earliest opportunity and both should try to make discussion of their concerns a regular part of their contact, whether through written means such as a Home/School Book or, time permitting, through regular face-to-face contact. Schools will follow the advice of the SEN Code of Practice and should use the resources available to them in school to devise, implement and monitor a behaviour plan or an Individual Education Plan (IEP) at the 'School Action' stage of the Code of Practice. It is important to clarify whether a child's behaviour difficulties are to any extent due to issues such as learning or literacy difficulties, a lack of differentiation in the classroom, boredom, hearing or vision problems, bullying, or stressful events within the child's family.

Evidence that a behaviour plan or IEP has not successfully changed a child's behaviour will typically be used as part of a shift to the 'School Action Plus' stage of the Code of Practice and a referral to an 'outside' (i.e. not school based) agency such as the Educational Psychologist or the Multi Agency Behaviour Support Service. Professionals from these services are likely to discuss the child's behaviour with staff and parents and make suggestions for support and changes to the child's behaviour plan. They may also carry out observations of the child and individual assessment work with them. At this stage also, any of the professionals involved will be able to help parents to access behaviour management training courses (For links and information see 'Children of pre-school age' above).

Where a child's behaviour difficulties are of such concern that there is a risk of them being excluded from school there should be a more detailed plan called a Pastoral Support Programme showing how the school is dealing with the child's behaviour in cooperation with at least one 'outside agency' professional, the child and their family. As with all plans of this nature, progress should be recorded and it should be reviewed and modified if necessary.

If despite the above measures Child's difficulties continue then a CAMHS PMHWS can be consulted and / or a referral made to Tier 3 CAMHS for further input.

3. The assessment and management of children with ADHD at Tier 3 CAMHS

The local CAMHS generally doesn't offer an ADHD diagnostic assessment for children under the age of 7 years but may offer a generic assessment and interventions as appropriate to the child and family's needs. This is in line with the national guidance from NICE and also current research which suggests that ADHD diagnosis in this very young group of children is not reliable. Therefore the response from CAMHS differs for children who fall above or below this age-related 'cut off' point.

Referral to the local CAMHS service

Sometimes a child may be referred to the local Child and Adolescent Mental Health Service (CAMHS) which includes the CAMHS-LD Team. This is a specialist service for children and young people and their parents. The local CAMHS service is based at Falcon House, St James hospital and consists of health care professionals with special training in child and adolescent mental health, which includes Nurse Specialists, Specialist Therapists including Child Psychotherapists, Child Psychologists and Child and Adolescent Psychiatrists. It provides a range of effective, evidence based assessments, treatments and support for children and young people (0-18) from all ethnic and cultural backgrounds where there are concerns about their behaviour or emotional well-being.

CAMHS may offer a wide range of treatments including:

- Individual therapy for children and young people
- Individual support for parents and carers
- Therapy groups
- Family therapy
- Medication
- Referral onto other services where appropriate

Assessment of Social/Emotional / Behavioural Difficulties and ADHD (children aged 4 to 6 years old)

The child and the parent will be offered a generic assessment and appropriate behaviour and parenting work either at the clinic or via another agency.
A referral to Tier 3 CAMHS or CAMHS – LD team, who only see children from age 5 years, can be made for further assessment and input when:

There are severe behavioural difficulties both at home and nursery/school.

Other reasons for child's behaviour difficulties have been excluded using a holistic approach over time. In many cases, this would involve the use of the Common Assessment Framework (CAF). (See Appendix 6 for links to the DCSF website and further information about the CAF).
Behavioural management advice from the Primary Care Team, for example GP, Health Visitor and

Family Centre and other professionals including PMHWS involved have not changed the situation and the Parenting Groups in community have been unsuccessful

The Tier 3 CAMHS and CAMHS – LD Team will need to know the following information:

- How long has there been a problem, is it recent or long standing?
- Where does it happen? Home / nursery or both?
- How the child is doing at nursery/school?
- Are there any learning difficulties or delays in development?
- What help has been offered/received at nursery/school, voluntary organisation etc, and its outcome?
- That at least two IEPs and/or IBPs have been included with referral information.

What happens next at Tier 3 CAMHS and CAMHS – LD Team

Once the referral is accepted at Tier 3, CAMHS administration staff will contact the family inviting them to book a convenient time to attend the "Options Clinic" appointment with one of the above specialist health professionals in the first instance, to discuss their concerns and what would be helpful to enable them to achieve positive changes.

This first contact with the family by letter will also include some information regarding the Data Protection Act, how the family can book their Options Appointment and leaflets about the CAMHS Service. It is important that families bring all the relevant information, including school or preschool/nursery reports with them to this meeting.

The appointment is usually for 60 minutes and will be to:

- Find out what the family needs.
- Provide some information about our service.
- Think about whether we are the best service to provide help.
- Think about the range of options that may be available.
- Give some ideas that a family can try themselves.

When CAMHS staffs meet with the family at the Options Appointment, they may agree that further help from CAMHS service would be beneficial and a further appointment will be offered. The next appointment may be with another member of CAMHS team who can help with the particular problems or difficulties. Some people may feel that CAMHS service is not required after their Options Appointment or this assessment may identify another service that can provide the family with the help they need and CAMHS staff can help them to access this.

Following this the family may decide to proceed with the generic assessment and a series of appointments will be arranged with the family, the parents and an individual meeting with the child to complete this assessment. The interview with parents/carers is intended to gather information re the child's difficulties, medical history, details of early development and schooling, as well as relevant details about the family's health, relationships and how they have been managing.

An interview with the child will typically cover how s/he gets on in the family, with friends and in school, what s/he thinks about his/her problems and some assessment of their emotional health and self esteem.

At this point, the family and the school would also be requested to complete a number of

behavioural questionnaires. Sometimes, in complex cases, an observation of the child in the school setting may also be needed but this will always be discussed and agreed with parents / carers beforehand. Please note without the information from school and / or other agencies that are involved with the child and family, CAMHS Staff are unable to complete this assessment and hence unable to offer appropriate help for that child's needs.

For further details please see the flow chart in Appendix 2.

Once a referral is accepted by the CAMHS-LD team, an appointment will be offered in writing, often with a phone call to arrange a convenient time and place for the family. An in depth assessment of the child and family will be carried out including completing behavioural questionnaires both at home and from the school. A care plan will be developed and a behavioural management plan implemented.

Assessment of Social/Emotional/Behavioural Difficulties and ADHD (children over 6 years of age)

A referral to Tier 3 CAMHS or CAMHS- LD team can be made for further assessment and input when:

There are severe behavioural difficulties both at home and school

Other reasons for child's behaviour difficulties have been excluded using a holistic approach over time. In many cases, this would involve the use of the Common Assessment Framework (CAF). (See Appendix 6 for links to the DCSF website and further information about the CAF).

Behavioural management advice from Primary Care Team, for example GP, Health Visitor and Family Centre and other professionals involved have not changed the situation and parenting groups have been unsuccessful.

The Tier 3 CAMHS team will need to know the following information:

- How long has there been a problem, is it recent or long standing?
- Where does it happen, home/school/ or both?
- How the child is doing at school?
- Are there any learning difficulties or delays in development?
- What help has been offered/received at school, voluntary organisation, etc, and its outcome?
- That at least two IEPs and/or IBPs have been included with the referral

What happens next at Tier 3 CAMHS

Once the referral is accepted at Tier 3 CAMHS, administration staff will contact the family inviting them to book a convenient time to attend the "Options Clinic" appointment, with one of the above specialist health professionals in the first instance to discuss their concerns and what would be helpful to enable them to achieve positive changes.

This first contact letter to the family will also include some information regarding the Data Protection Act, how the family can book their Options Appointment and leaflets about the CAMHS Service. It is important that the family brings all the relevant information including school reports with them to this meeting.

This appointment is usually for 60 minutes and will be to:

- Find out what the family needs.
- Give them some information about our service.
- Think about whether we are the best service to help them.
- Think about the range of options that may be available to them.
- Give the family some ideas to try themselves.

When CAMHS Staff meets with the family at the Options Appointment, they may agree that further help from CAMHS service would be beneficial and a further appointment will be offered. The next appointment may be with another member of the team who can help with the particular problems or difficulties. Some people may feel that further CAMHS input is not required after the Options Appointment or CAMHS staff` can help them access this.

Following this appointment the family may decide to proceed with ADHD assessment and a series of further appointments will be arranged with the family, the parents and an individual meeting with the child to complete this assessment. The interview with the parents/carers is intended to help gather information re the child's difficulties, medical history, details of their early development and schooling, as well as relevant details about the family's health, relationships and how they have been managing. The interview with the child will typically cover how s/he gets on in the family, with friends and in school, what s/he thinks about his/her problems, and some assessment of their emotional health and self esteem.

At this point, both the family and the school will also be requested to complete a number of behavioural questionnaires. Sometimes, in complex cases, an observation of the child in the school setting may also be needed but this will always be discussed and agreed with parents / carers beforehand. Without the information from school and/or other agencies that may be involved with the family and their son or daughter, CAMHS are unable to complete their assessment and are therefore unable to offer appropriate help and support for that child's needs.

For further details please see the flow chart in Appendix 3.

Once a referral is accepted by the CAMHS-LD team, an appointment will be offered in writing, often with a phone call to arrange a convenient time and place for the family. An in depth assessment of the child and family will be carried out including completing behavioural questionnaires both at home and from the school. A care plan will be developed and a behavioural management plan implemented

Diagnosis and Management of ADHD:

Once the above assessment is complete the CAMHS Staff will collate all the information they have gathered from child, parent /carers, school and their own observations into a structured report. By now they will also have formed a professional opinion and view as to whether the child's difficulties and needs fit into the ADHD pattern or are there other problems that may fit better and how best the child and family's needs can be met.

This further management would also depend on the child's age, whether the child has moderate (DSM - IV Criteria) to severe (ICD - 10 Criteria) ADHD and how it is affecting his/her daily life. Consideration will also be given to the possibility of there being other associated conditions such as Tics, Oppositional Defiance Disorder, Mixed Emotional and Behaviour Difficulties and emerging antisocial/conduct problems.

A care plan will be agreed with the family which may include one of the following inputs from

CAMHS to the parents and the child:

- Referral to a group parent training programme in community as per NICE recommendations
- Structured advice and behaviour work for parents including CAMHS advice leaflets
- Family work/therapy
- Individual work including Cognitive Therapy for the child
- Social Skills and Self Esteem work
- Information to the school regarding appropriate behaviour management
- An appointment with one of the Child Psychiatrists in the team for those aged 7 and above with severe ADHD (ICD -10 Criteria), to consider the use of medication along with some of the above support for possible associated difficulties. (Medication under the age of 7 is not recommended by NICE).

The specialist health care professional involved will evaluate the child's progress on a regular basis, and that would include the child's and the family's views as well as obtaining up to date information from their school. A joint child/parent/professional decision would then be made as to whether the child is making satisfactory progress with his/her learning, behaviour and relationships at home and school and, if so, how long the support work would need to continue. Alternatively, a decision might be made that there needs to be a referral to another appropriate agency that could help meet the family's and child's needs, or there may need to be a further review with one of the Consultant Child Psychiatrists in the team if this is appropriate.

What may happen at the appointment with the psychiatrist?

This appointment will include the CAMHS worker involved with the family so far, one of the Child Psychiatrists in the team and the parents/ carers and the child. At this meeting the psychiatrists may go over some of the earlier information in the report and the Behavioural work offered. They will also ask questions about child and parents / extended family's physical and mental health. This is to rule out any physical problems that may explain child's difficulties but also to ensure there are no contraindication to the use of medication if that was deemed necessary.

- Confirm diagnosis
- Consider other co-morbid disorders
- Pre–drug treatment assessment: If proceeding with medication, seek information re child's physical health via the family doctor. Ask about any problems with breathlessness and other cardiac symptoms. In some situations requesting a physical examination by the doctor and/ or arranging an ECG (Heart tracing) if there is a family history of serious cardiac disease, a history of sudden death in young family members or abnormal findings on cardiac examination, EEG(Brain Wave test) and blood tests. Also conduct a risk assessment for substance misuse and drug diversion.
- Discuss with the family and the child the most appropriate medication and its associated benefits and risks.
- Offer appropriate medication advice leaflet.
- If all in agreement and no contra indications, measure weight, height, pulse and blood pressure prior to starting medication.
- Commence first line treatment with psycho-stimulant medication, either immediate release or long acting, and provide an instruction leaflet as to how to use this medication.
- Arrange a follow up appointment in 4 weeks time and give details of who and how to contact in between appointments if there are problems

Management of children on medication:

The psychiatrist will offer follow up appointments at 6 weekly intervals for the first three appointments to dictate the dose and effective monitoring.

Thereafter, three- to six-monthly appointments will be offered during the first year of treatment or earlier as appropriate to the child's needs.

At each subsequent visit the psychiatrist will:

Check if the medication is effective by asking how the child is doing at home and at school before agreeing to continue with medication

Check weight, height, pulse and blood pressure.

Ask the child and parents for any side effects.

Request information /update from school possibly via short Connors Behaviour Report (10 item version).

Follow the procedure for prescribing controlled drugs.

Re-evaluate the child's progress on each visit regarding learning, behaviour, self esteem, relationships with peers and family.

Regularly liaise with school via school teacher, SENCO, Educational Psychologist as appropriate.

Keep General Practitioners and other professionals' involved informed regarding current dosage and medication.

As per NICE guidelines, review the need to continue medication on a yearly basis and consider 'Drug Free Holidays' every 2 years to see if the medication is still necessary.

NICE guidance suggests that medication should be discontinued at an appropriate time, e.g. after GCSEs, to re-assess the continuing need and if the medication is still needed then continue with it until transition of care to Adult Services.

If medication is not effective:

Check the dosage is appropriate for child's weight and height

Consider other factors especially co-morbid conditions

If there is still no change, reconsider the diagnosis and arrange appropriate therapeutic input.

Arranging the transition of care to Adult Services:

Consider the transition of care to Adult Services 3 months prior to the young person's 18th birthday as per local transition protocols.

Offer appropriate information and support to the young person and parents/carers re future care arrangements.

Appendix 1
Diagnostic criteria from ICD 10 and DSM IV

A. Either 1 or 2.

1. **Inattention:** 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 levels.

	Client	Collateral	Clinician
a. Often fails to give enough attention to details, or makes many careless mistakes in schoolwork, work or other activities.			
b. Often has difficulty sustaining attention in work-related tasks (unable to keep paying attention for a long time).			
c. Often does not seem to listen when spoken to directly.			
d. Often fails to follow through on instructions and to finish schoolwork or chores on time.			
e. Often has difficulty organizing tasks or activities. (often loses track of assignments and has trouble organizing homework).			
f. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort, such as schoolwork or homework. (Has a lot of trouble doing lengthy reading assignments or long writing assignments).			
g. Often misplaces or loses things necessary for tasks or activities (e.g. keys, pencils, notes, books, school assignments).			
h. Is easily distracted by extraneous stimuli (other things going on).			
i. Is often forgetful in daily activities			

The Diagnostic and Statistical Manual of Mental Disorders 4th Edition, American Psychiatric Association 1994.

2. **Hyperactivity/Impulsivity:** Six or more of the following symptoms of hyperactivity/impulsivity have persisted for at least six months to a degree that is maladaptive and inconsistent with developmental levels.

Hyperactivity

	Client	Collateral	Clinician
a. Often fights with hands or feet or squirms in seat (or plays with objects in hand).			
b. Often leaves seat in classroom or in other situation in which remaining seated is expected; has difficulty staying seated for very long (e.g. homework, meetings, meals).			
c. Is very easily bored, often feels very restless.			
d. Often has difficulty engaging in leisure activities quietly (prefers to surround self with noise and dislikes having it quiet).			
e. Is often “on the go” or often acts as if “driven by a motor”.			
f. Often talks excessively.			

Impulsivity:

g. Often blurts out answers before questions have been completed.			
h. Often has difficulty awaiting turn (e.g. standing in lines, waiting in traffic, taking turns to speak, waiting for service in stores)			
i. Often interrupts or intrudes on others (butts into conversations or games)			

The Diagnostic and Statistical Manual of Mental Disorders 4th Edition, American Psychiatric Association, 1994.

B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years.

C. Some impairment from the symptoms is present in two or more settings (e.g. at school and at home).

D. There must be clear evidence of clinically significant impairment in social, academic, or oc cupational functioning.

E. The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g. Mood Disorder, Anxiety Disorder, Dissociative Disorder or a Personality Disorder).

The Diagnostic and Statistical Manual of Mental Disorders 4th Edition, American Psychiatric Association 1994.

The Diagnostic criteria for hyperkinetic disorder: ICD – 10

A. Demonstrates abnormality of attention and activity at home for the age and developmental level of the child, as evidenced by at least three of the following attention problems:

a) Short duration to spontaneous activity.
b) Often leaving play activities unfinished.
c) Over-frequent changes between activities.
d) Undue lack of persistence at tasks set by adults.
e) Unduly high distractibility during study.

At by at least two of the following activity problems:

f) Continuous motor restlessness.
g) Markedly excessive fidgeting or wriggling during spontaneous activities.
h) Markedly excessive activity in situations requiring relative stillness.
i) Difficulty in remaining seated when required.

B. Demonstrates abnormality of attention and activity at school or nursery, for the age and developmental level of the child, as evidenced by at least two of the following attention problems:

a) Under lack of persistence at tasks
b) Unduly high distractibility, i.e. often orienting towards extrinsic stimuli
c) Over-frequent changes between activities when choice is allowed
d) Excessively short duration of play activities

And at least two of the following activity problems:

e) Continuous and excessive motor restlessness in school
f) Markedly excessive fidgeting and wriggling in structured situations
g) Excessive levels of off-task activity
h) Unduly often out of seat when required to be sitting

C. Directly observed abnormalities of attention or activity. This must be excessive for the child's age and development level. The evidence may be any of the following:

a) Direct observation of the criteria in A or B above
b) Observation of abnormal levels of motor activity, or off task behaviour, or lack of persistence in activities, in a setting outside home or school
c) Significant impairment of performance or psychometric test of attention

D. Does not meet criteria for pervasive developmental disorder, mania, and depressive or anxiety disorder.

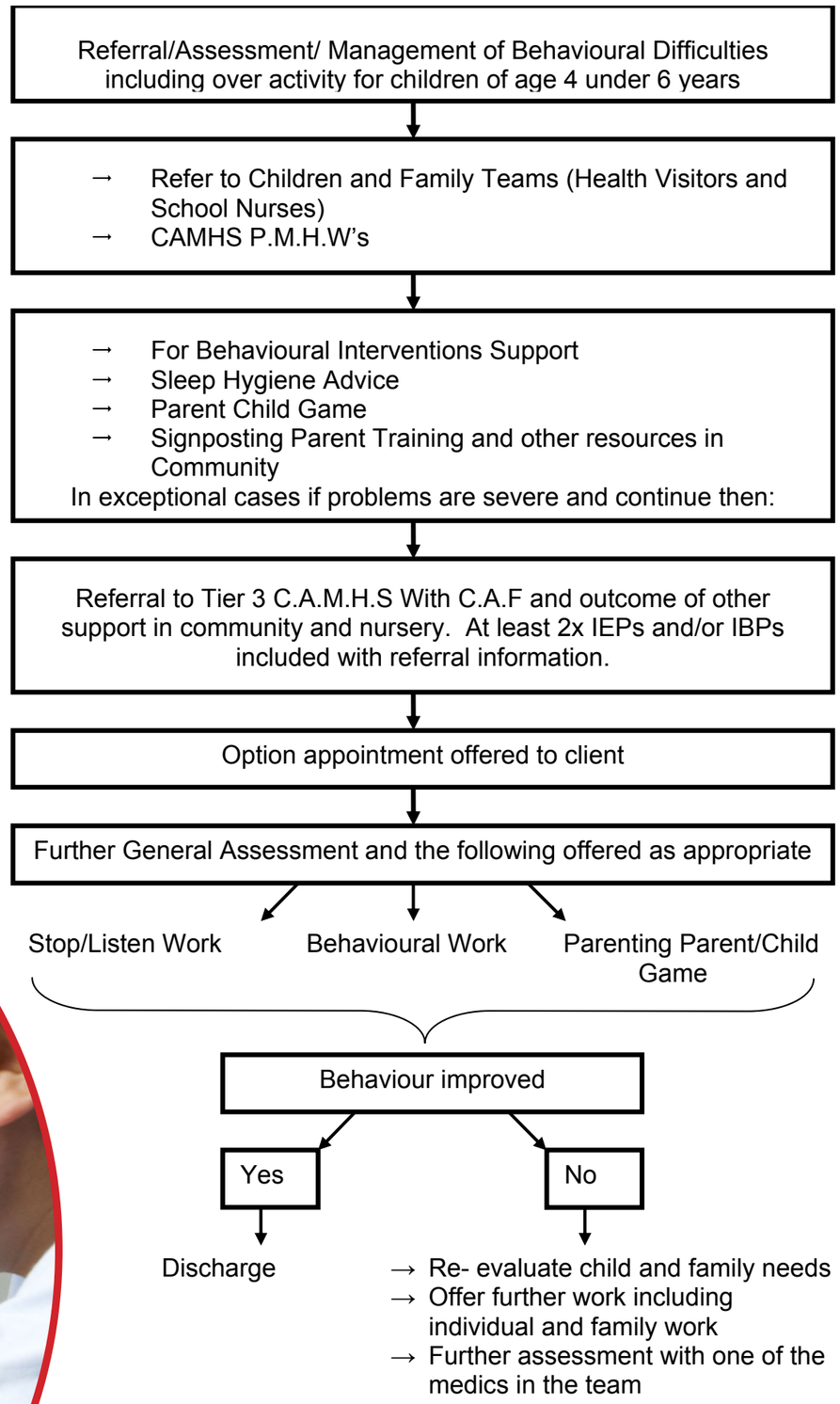
E. Onset before the age of 6 years.

F. Duration of at least 6 months

G. IQ above 50.

The ICD – 10 Classifications of Mental and Behavioural Disorders, World Health Organisation 1994

Appendix 2
Care pathway for children aged 4 to 6 years

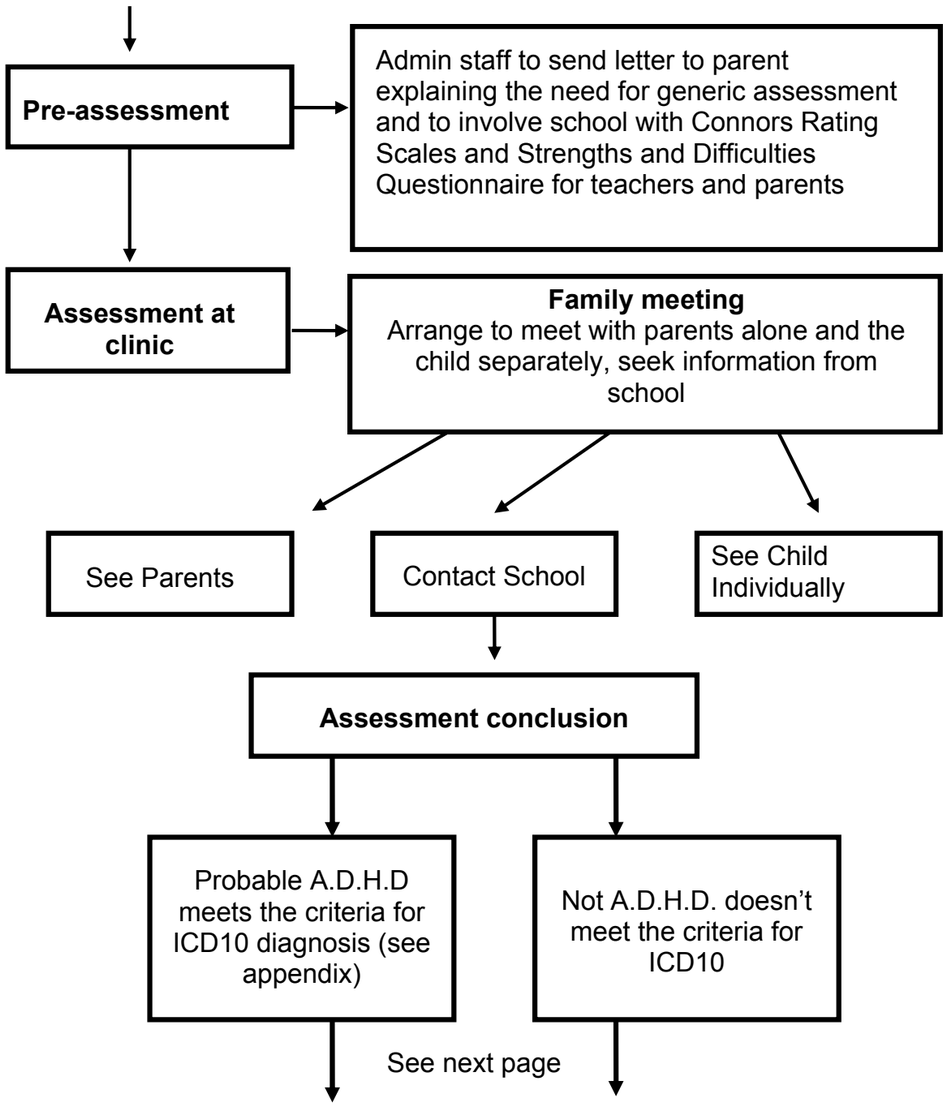


Appendix 3
Care pathway for children aged 6 and over

Assessment

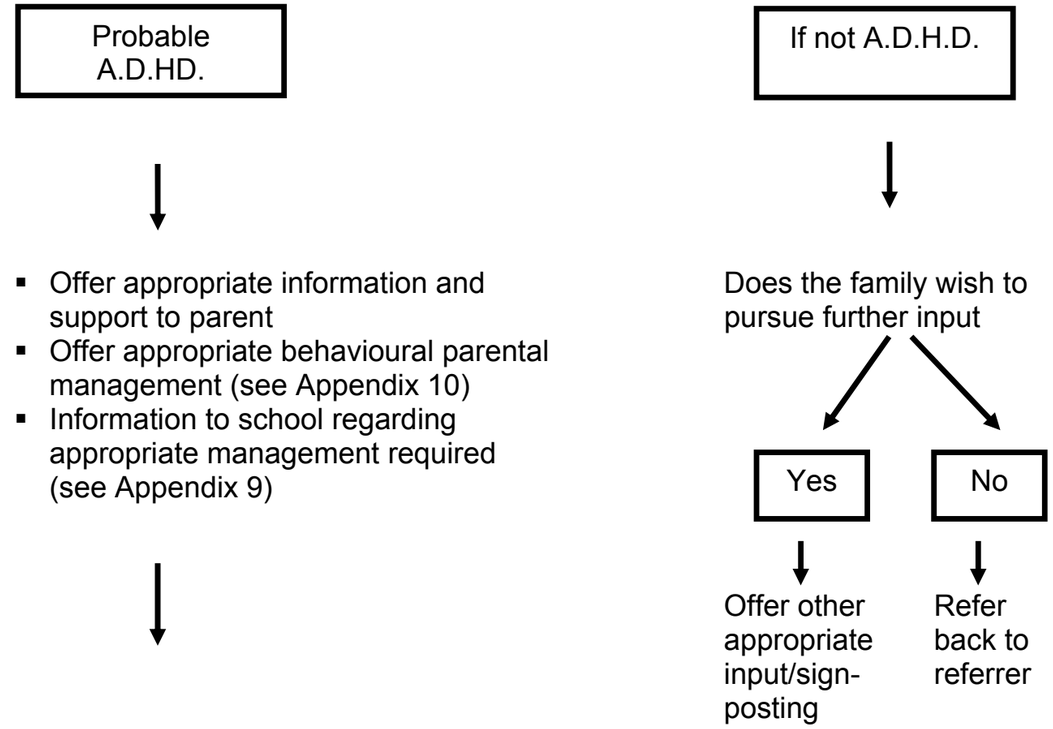
Social/Emotional/Behavioural Difficulties and A.D.H.D. 'care pathway'
(over 6 years old)

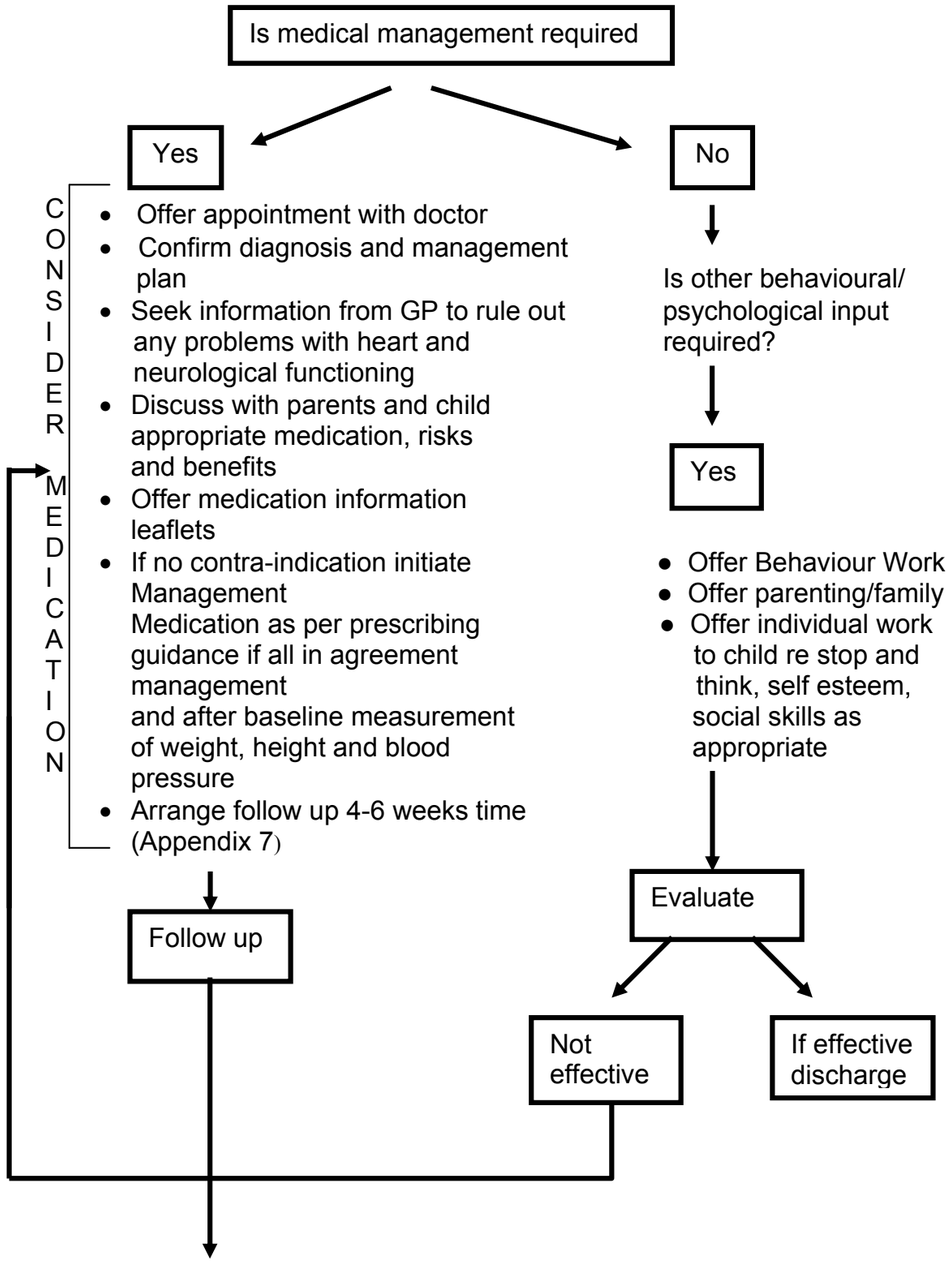
Referral to CAMHS Tier 3 will only be accepted if at least two IEPs and/or IBPs are included.



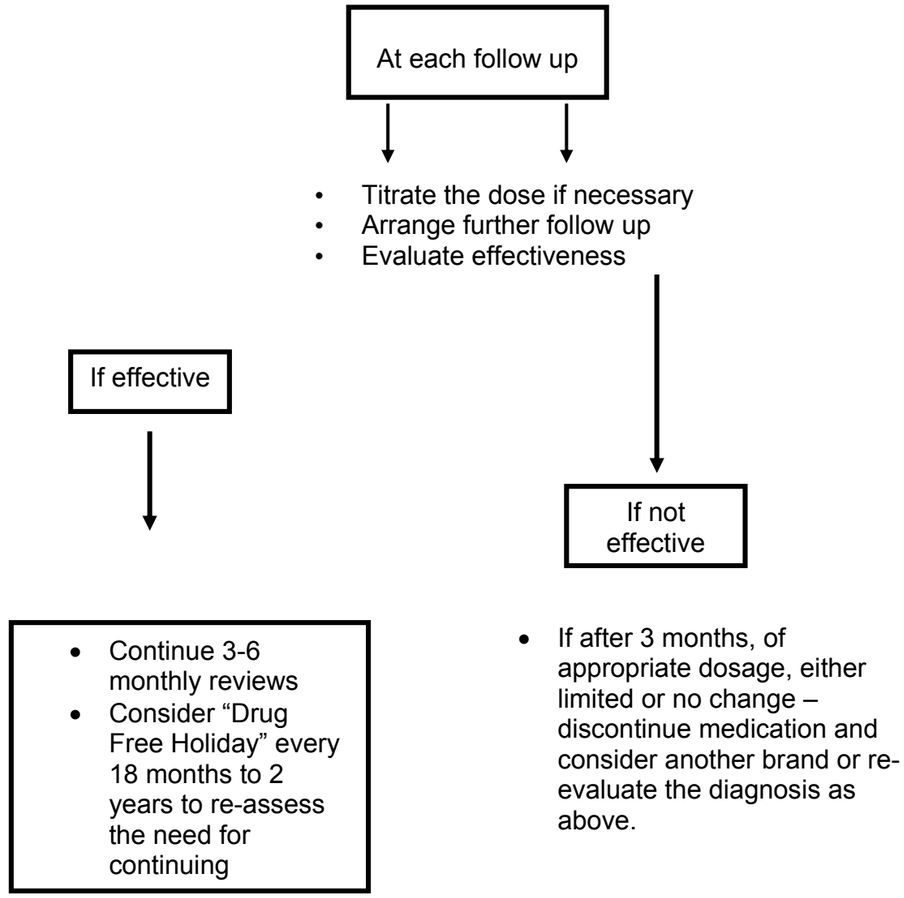
Management

Social/Emotional/Behaviour Difficulties including A.D.H.D. (over 6 years old)





- Evaluate effectiveness of medication
- Ask about side effects
- Check weight, height and blood pressure



- If after 3 months, of appropriate dosage, either limited or no change – discontinue medication and consider another brand or re-evaluate the diagnosis as above.

Appendix 4
Useful contacts and addresses

- **Child and Adolescent Mental Health Services (CAMHS)**
  Battenburg Avenue, Portsmouth OP2 0TA
  023 9267 0346

- **Falcon House**
  St James' Hospital, Locksway Road, Portsmouth PO4 8LD
  023 9268 4700

- **Portsmouth Educational Psychology Service**
  Portsmouth City Council, Floor 4-Core 4, Civic Offices, Guildhall Square,
  Portsmouth PO1 2 EA
  023 9268 8781

- **Portsmouth Parenting Service**
  Floor 2-Core1, Civic offices, Guildhall square, Portsmouth, PO1 2EA
  023 9268 8841

- **Multi Agency Behaviour Support Services**
  Harbour School@Milton, 151 Locksway Road, Portsmouth PO4 8LD
  023 9281 8547

- **Health Visitors Children and Family Teams**

  Mid City Central – The Pompey Centre, Unit 8F, Fratton Way, Portsmouth PO4 8TA
  023 9285 1350

  Mid City East – The Pompey Centre, Unit 8F, Fratton Way, Portsmouth PO4 8TA
  023 9287 3722

  North – Cosham Health Centre, Vectis Way, Cosham, Portsmouth PO6 3AW
  023 9221 9888

  South – Overton Centre, St James' Hospital, Locksway Road, Portsmouth PO4 8LD
  023 9272 8100

  West – Kingsway House, 4th Floor, 130 Elm Grove, Southsea, Portsmouth PO5 1LR
  023 9261 2789

- **Child Development Centre**
  151 Locksway Road, Portsmouth PO4 8LD
  023 9289 4410

- **Children's Social Care and Safeguarding**
  Civic Offices, Floor 4- Core 4, Guildhall Square, Portsmouth PO1 2BG
  023 9283 9111

- **Civic Offices**
  Civic Offices, Guildhall Square, Portsmouth, PO1 2BG
  Main switchboard - 023 9282 2251
  City Help desk - 023 9283 4092

Appendix 5
Information about the Early Years Panel

What is the Early Years Panel?

The Early Years Panel works to support pre-school children who may have additional or special needs and their families.

The panel is a group of key people from Portsmouth City Council's Department for Children, Families and Learning and Portsmouth City Teaching Primary Health Care Trust. It meets regularly to make sure that we are aware of children with special needs and that we have plans in place to support the children and their families.

The Early Years Panel aims to work in co-operation with parents and carers to make sure that:

- All pre school children with special needs are identified as early as possible.
- Assessments of the children's needs are well co-ordinated.
- Support plans for the children and their families are in place, co-ordinated and regularly reviewed.

Who are the members of The Panel?

The panel consists of representatives from:

- Solent NHS Trust
  (Community Paediatrician, Speech and Language Therapist, Occupational and/or Physiotherapist, Health Visitor)
- The Portsmouth City Council Department for Children, Families and Learning
  (Principle Educational Psychologist, Education Officer for SEN, Specialist Teacher Adviser, Head Teacher of the Willows Nursery School, Foundation Stage Advisory Teacher, Portage Service Manager, Social Worker, Children with Disabilities Team.)
- Representatives from voluntary organisations who provide services in this area.

What does the panel do?

Parents' permission will always be sought before any child's name is brought to the panel.

The panel brings together referrals on all pre school children where there is a concern about their early development and/or possible special educational needs and co-ordinates support for the children.

The panel takes referrals from General Practitioners, Health Visitors or any education or health professional involved with the child . The panel meets monthly at the Civic Offices, Guildhall Square, Portsmouth.

The panel will consider all the assessment information on the child's needs and parents' views about their child's development and needs.

The panel will:

- Ask for further assessment if necessary.
- Make sure that the assessment information is co-ordinated.
- Ensure that the right provision is in place to support the child, in line with parents' wishes.
- Review the child's progress and make sure that plans are in place to support them over moves into nursery or into school.

What arrangements might be put in place to support your child?

The panel will consider recommendations that have been made for different types of placement and provision. Parents' views will be vital;
no provision or placement will be arranged without parents' expressed permission.

The main options available to support a child with special needs in the early years are:

- A mainstream nursery or child-care setting, perhaps with some additional support if necessary.
- Placement at a special nursery provider such as the Willows Nursery, Mary Rose School Nursery, the Elizabeth Foundation Nursery etc.
- A Home based teaching and support programme from the Portage Service or from a Specialist Teacher Adviser for hearing or visual impairment.

Appendix 6
Links to web/internet resources

The National Institute for Health and Care Excellence (NICE) website
http://www.nice.org.uk/

The NICE guidelines for ADHD
http://guidance.nice.org.uk/CG72

Department for Children, Schools and Families (DCSF) – the starting point for information about Every Child Matters, the Common Assessment Framework, Think Family, Think Father, etc.
http://www.dcsf.gov.uk/

The Local Authority's web pages with searchable links for information for parents, professionals including information about training opportunities
http://www.portsmouth.gov.uk

A searchable directory of activities, courses, services and training opportunities for parents, young people and professionals in the Portsmouth area
http://www.asksherlock.info

A guide to parenting courses available in Portsmouth as part of the city's parenting strategy
http://www.portsmouth.gov.uk/media/Portsmouth_Guide_to_Parenting_Courses.pdf

Information about ADHD from the NHS website
http://www.nhs.uk/conditions/attention-deficit-hyperactivity-disorder/Pages/Introduction.aspx

Information about ADHD from the Royal College of Psychiatrists' website
http://www.rcpsych.ac.uk/mentalhealthinfo/mentalhealthandgrowingup/5adhdhyperkineticdisorder.aspx

The National Attention Deficit Disorder Information and Support Service (ADDISS)
http://www.addiss.co.uk

A national charity addressing mental health and emotional wellbeing issues for children and young people
http://www.youngminds.org.uk

Appendix 7
Attendees at the city's ADHD Strategy Group meetings

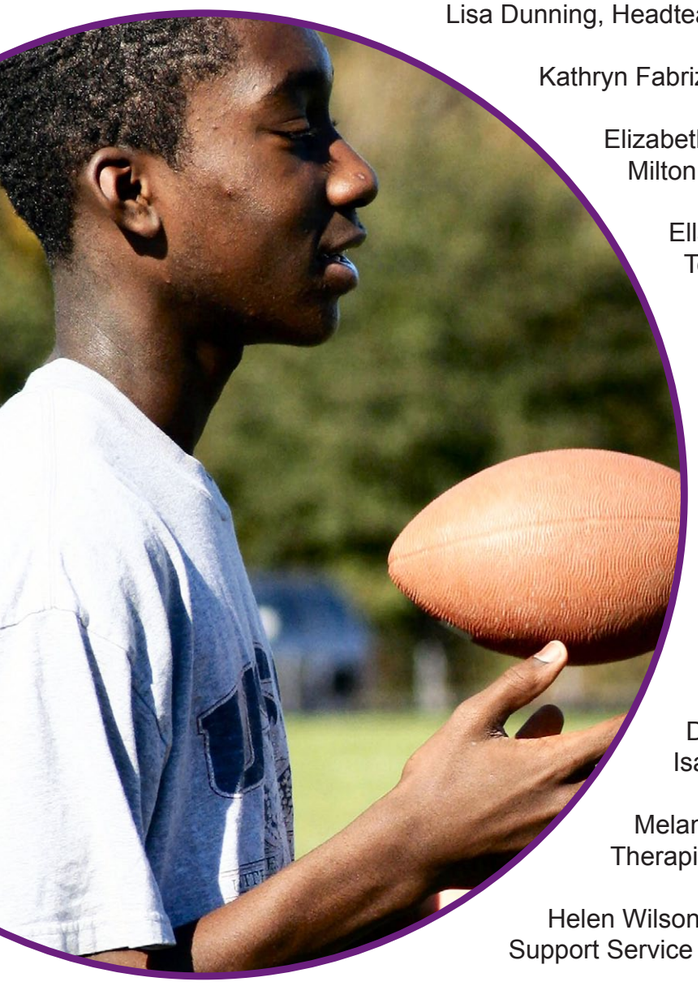
The following have all made a contribution to these guidelines through attendance at the ADHD Strategy Group meetings

Zam Bhatti, Consultant Child and Adolescent Psychiatrist, CAMHS

Simon Burnham, Senior Educational Psychologist

Anne Chapman, Deputy Head, Somers Park Primary School

Donna Cleminson, Parent representative



Lisa Dunning, Headteacher, Langstone Junior School

Kathryn Fabrizi, Parent representative

Elizabeth Fellowes, General Practitioner, Milton Park Surgery

Ella Harbut, Foundation Stage Advisory Teacher, Early Years Service Team

Kate Olliver-Kneafsey, Senior Mental Health Practitioner, CAMHS and I&A

Chris Penney, Senior Social Worker, Merefield House Family Intervention and Prevention Team

Jenny Shutler, Senco and Inclusion Manager, Isambard Brunel Junior School

Kumkum Venkat-Raman, Consultant Paediatrician, Child Development Centre

Deb Welling, Assistant Inclusion Manager, Isambard Brunel Junior School

Melanie Wells, Highly Specialist Community Therapist, CAMHS

Helen Wilson, Teacher Advisor, Multi Agency Behaviour Support Service

Also, sincere thanks to our colleagues at Portsmouth CAMHS and Educational Psychology Services, for their helpful and constructive comment to help conclude this guideline in its final format.

Appendix 8
Prompt questions for professionals' consultations with parents

- For how long has the child's behaviour been a concern?
- Is the child's behaviour challenging or difficult at all times and in different places? Can they modify their behaviour for certain adults?
- Is the behaviour difficulty present at school or preschool as well as at home?
- What progress is the child felt to be making at pre/school?
- Is there any evidence of learning difficulties or other developmental delays?
- Are the parents accessing any support from pre/school or other agencies or voluntary organisations?
- If the child is at school or preschool do the parents have copies of behaviour plans (IEPs or IBPs etc) or targets that have been set for their child? Do they have any evidence of strategies that have been tried (prompt to obtain this if they haven't already done so)?

Appendix 9
Guidelines for managing children with ADHD and concentration difficulties in school

Kate Olliver-Kneafsey, Senior Mental Health Practitioner
Child & Adolescent Mental Health Service, Portsmouth

These guidelines are aimed at teachers and other school staff in both Primary & Secondary education settings. They are also of use to Educational Psychologists, Teacher Advisors, Educational Welfare staff and other children's practitioners who work to support children and young people in schools.

Children with ADHD and concentration difficulties need support in school in order that their educational, social and emotional needs can be met and their self esteem and feelings of positive self worth are preserved.

There is more than one reason why children have difficulty concentrating. (Most of us have concentration difficulties at some time or another!). Sometimes the reasons for this are not as important as how we manage it. It is crucial that despite their difficulties, children with ADD/ADHD are encouraged and supported to reach their full potential in all aspects of their lives. Children need to thrive not just survive!

INFORMATION

Definitions: ADHD is an abbreviation for Attention Deficit Hyperactivity Disorder.
ADD is an abbreviation for Attention Deficit Disorder.

Children with ADHD have the following difficulties:

1) Overactive, excessively boisterous behaviours
2) Difficulty in paying attention and easily distracted
3) Frequently impulsive

Children with ADD have significant problems with concentration and attention but are not frequently impulsive and overactive.

A child with a diagnosis of ADD/ADHD should have been assessed by a specialist clinical team led by a Consultant Child and Adolescent Psychiatrist. This clinical team may include Specialist Mental Health Nurses, Clinical Psychologists and other health professionals with a specialism in child mental health. Unfortunately assessment for ADD/ADHD is not that simple or straightforward. There is (as yet!) no blood test or X-ray, etc. that can quickly confirm the diagnosis. It is necessary to carry out a thorough comprehensive assessment, using specific psychometric questionnaires, observations in different settings and clinical interviews including a history of health and development. This involves a lot of patience on behalf of the family and as a teacher of a child undergoing an assessment for ADHD you may be asked to complete a questionnaire (such as a behavioural checklist) as part of this assessment.

A thorough and accurate assessment is important because there are other difficulties/disorders that can present with similar signs and symptoms, for example; anxiety states, attachment disorders and depression. Consideration of temperament and family dynamics, culture and environment also plays an important part. Some children may come from families where energetic play and spontaneity in children is celebrated, encouraged and seen as an important part of creative expression and development.

Other families may be of the mindset that children should adhere strictly to rules and should automatically defer unquestionably to authority figures. Careful assessment for all medical and mental health conditions is of course important. (You really wouldn't want to be told that indigestion is the cause of your chest pain when you are actually having a heart attack!).

Guidelines

EXPECTATIONS: - Children with concentration difficulties will not sit still and stay on task as well as others in the class. So don't expect them to, it is unrealistic! (It's a bit like expecting a child with asthma not to wheeze or a child with juvenile arthritis not to limp!) Such children will need constant gentle and firm reminders to finish their work and lots or praise when they do so!

LIMITS AND BOUNDARIES: - All children need firm clear limits and boundaries, children with ADHD/ADD even more so. Give the child one instruction at a time:

"Jack please hang your coat up"
"Mary look at the board, thank you"

Children with concentration difficulties will not respond to chain commands very well. They will need regular reminders about the class rules and what is expected of them. It is a good idea to have classroom rules displayed on the wall for everyone to see. It is also a good idea for classroom rules to start with a "DO" rather than a "DON'T":

"Do walk quietly and calmly around the classroom"
NOT
"Don't run, push or shout in the classroom"

If you are a particularly creative teacher, you could ask the children in your class to make up their own rules and to think of rules that will keep them safe and happy. It is after all their classroom and they are much more likely to stick to the rules if they have had a hand in creating the rules themselves. This also fosters a greater understanding of why we need some rules.

Remember however that rules are occasionally broken by all children (and adults too!) and the consequences should be the same for all the children in the class. Children learn from making mistakes and finding out what happens when rules are broken, it is part of normal childhood development and a good learning opportunity!

When talking to the child specifically, it is a good idea to get down to his/her level, (where possible) say the child's name first and get eye contact before issuing an instruction. Consistent limits and boundaries help all children feel secure and this is especially important for children with poor concentration, (which may be due to ADHD, low self esteem or anxiety).

DISTRACTION: - Children with ADD/ADHD are more easily distracted than some of the other children and their physical position in the class is important. Sitting by the window where they can look at what's going on outside, or by the door where there is more traffic is not always helpful. They need to sit somewhere near the front of the class where the teacher can easily get eye contact with them, smile at them and where it is easier for the teacher to note when the child is staying on task, behaving appropriately and then praise the child or make positive comments:

"It's so good Joe to see you writing neatly in your English exercise book"

"I like it when you put your hand up to answer a question Susie"

DISRUPTION: - Many children disrupt the class occasionally and this is to be expected. It is helpful if all the children in the class learn to keep this to a minimum. Sometimes when a child is fidgeting and struggling to stay focused he/she may need to stop and come back to that particular task later if possible. They may benefit from getting up and walking quietly round then sitting down and continuing with their work again. This can be successfully managed, usually with the support of a learning support assistant. Stretching, breathing and relaxation exercises can be done in the class unobtrusively with help, so as to avoid disruption and/or the child bringing unnecessary attention to themselves.

SELF ESTEEM: - This is very important. Children who struggle to concentrate and stay on task, for whatever reason, frequently have low self-esteem and a poor self image. Children with low self-esteem are less inclined to please the important adults in their lives, such as parents and teachers. ("Why should I bother I only get told off anyway" "What's the point the teacher just tells me I'm naughty all the time"). Children need to be set realistic easily obtainable goals and all their successes celebrated, no matter how small:-

- "Well done for sitting still for 10 minutes Robert" rather than "Why can't you sit still for ½ an hour?"

- "Good boy Simon for finishing your art work" rather than "You finished your picture now, shame you couldn't finish it yesterday".

All children need positive unconditional regard!

Praise shapes behaviour better than criticism!

Confident children make enthusiastic learners!

Every time the child is compliant and does what he/she is told, or is seen to be trying and making an effort, this should be reinforced with praise. Physical rewards are not always necessary.

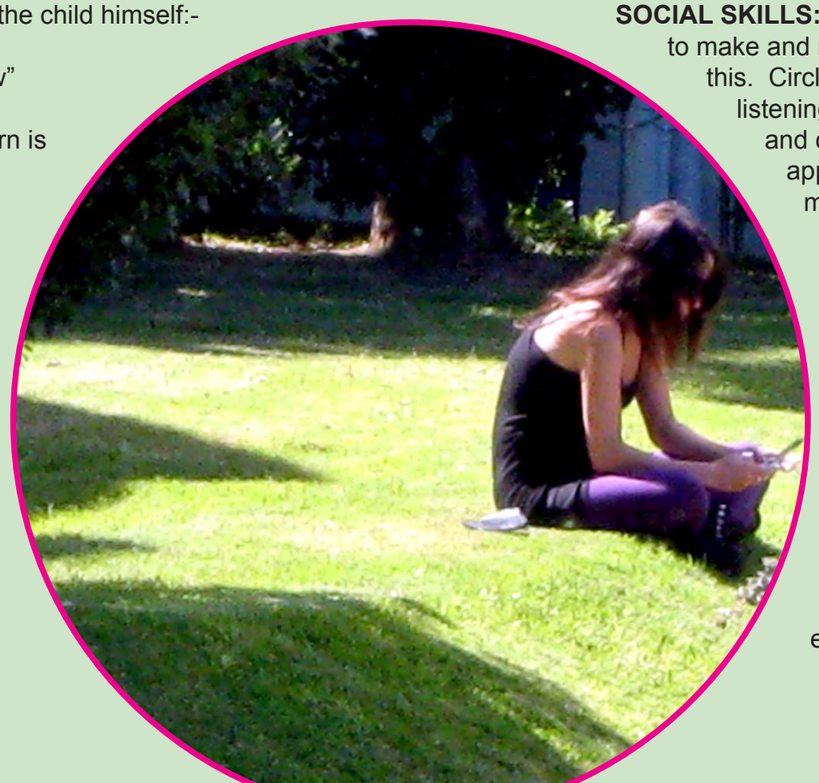
It is a good idea to start every 'telling off' with a positive affirmation of the child himself:-

"I like you Johnny but I don't like what you are doing right now"

"You are a good girl Maisie, but pushing in and not waiting for your turn is not a good thing"

"For a clever boy Ryan, that was not such a smart thing to do"

Teachers and parents approval is actually more valuable and meaningful to young people and is a reward in itself. Lots of schools employ a variety of creative reward systems, such as teachers giving out stickers at the end of the day or certificates at the end of the week, letters of commendation home and positive postcards etc. The child with ADHD should receive their fair share along with all the other children if he/she has reached their targets.



PATIENCE AND UNDERSTANDING: - Children with concentration difficulties can often be a challenge. They will undoubtedly have good days and bad days. At times when the child is needing lots of intervention, it is a good idea to try and remind ourselves about their positive qualities. All children have endearing and likeable qualities if we look for them and the child with ADHD needs to be given a clear message that it is not him/her that is unacceptable but some of their behaviours. More positively reframed, the child is good; it's just some of their behaviours that are not so good!! Try not to use words with negative connotations such as 'naughty', 'bad' or 'evil' when talking to a child about their behaviour. Learning Support Assistants (LSA's) and Special Needs Assistants (SNA's), along with Learning Mentors are often in a very good position to help children with concentration difficulties in the classroom. They have the opportunity to build up positive trusting relationships on a one-to-one level and give valuable praise and approval. Such children will respond favourably to an LSA who he/she knows, likes and gets on well with.

PEER RELATIONSHIPS: - It is important that the child with ADHD is not seen to receive special attention or rewards for what would normally be considered unacceptable or unsafe behaviours in the classroom. Special attention for the more needy children in the class has to be carefully and sensitively managed. It is also vitally important that these children are not singled out for criticism, humiliation and scapegoated in any way too! (A child's name should be written up on the board for being well behaved not for being misbehaved!). The class needs to be given a clear message in more ways than one that we are all individuals within the class, all with individual needs within the group, all with varying abilities. It is good to celebrate diversity! Just as some children need extra help with literacy and numeracy skills, some children need that extra help with their concentration. The children in the class who need no extra help at all need to be openly complimented and praised too. This will help prevent any resentment towards the child with ADHD or any copying of undesirable behaviour (i.e. "Sally gets lots of rewards whenever she finishes her work, I always finish my work but I never get praised"). It is very important that children with ADHD/ADD or concentration difficulties due to anxiety are not seen simply as 'naughty children'. A positive and nurturing teaching style fosters a warm and friendly ambience in the classroom, which is conducive to learning (both academically and emotionally), for the whole class. Teachers who set the standard for respecting their pupils will be rewarded by receiving the respect of their pupils!

SOCIAL SKILLS: - It is crucial for all children's social and emotional development to make and maintain friendships. The child with ADHD may need help with this. Circle time and PSHE lessons are a great way of helping children learn listening, sharing and turn-taking skills, as well as learning to cooperate and communicate better. Emotional literacy should be a whole school approach. Healthy schools initiatives should include both physical and mental well-being.

Feeling happy and good about yourself, is just as important as exercise and healthy eating!

Children with concentration difficulties can do well in a structured classroom environment where the expectations of behaviour are clear, the expectations of the staff realistic, there are consistent limits and boundaries and they have SNA/LSA support. However, at less structured times (playtimes/lunchtimes, etc) such children will continue to need some support. It is a good idea to liaise with lunchtime supervisors to make them aware of the child's needs in the playground. Regular communication between school staff is also important to enable staff to support each other in the care, encouragement and nurturing of the child.

HOME/SCHOOL LIAISON: - This is helpful for all children and should to be very much a part of school ethos and practice. A 'link book' could be set up so that two-way communication between the child's parents and teachers can happen on a daily basis. It is vital to provide balanced feedback however, as the child should read it and be aware that his/her parents, teachers and other school staff are working together to help him/her. Positively reframed constructive comments have a much better impact than criticism and negative comments. Feedback should always start with what the child has done well followed by areas of improvement and, if possible, end on a success:

"Charlene arrived nice and early to registration this morning but was late back to class at lunch time. Try to keep an eye on the time Charlene! Thanks for being helpful in the library this afternoon by staying behind to help put away some books"

"Billy has nearly completed all his maths task sheets today and has only two more to go, keep up the good work Billy you are nearly there" is a better comment than "Billy has not finished his maths work today".

Children with ADD/ADHD are normal in most ways and like lots of children with learning difficulties, just need that extra bit of support and understanding.

Focus on the things the children are good at to help to them achieve and reach their own personal potential.

Everyone has some sort of learning difficulty just as everyone has some sort of talent or special skill!

The above guidelines will be helpful for managing children who do not have ADHD but present with similar difficulties are previously mentioned (i.e. highly anxious children).

If you have any concerns about a child in your class who may have ADHD or has been diagnosed with ADHD, please speak to the parents in the first instance. The majority of parents who have children diagnosed with ADHD are likely to be receiving, or have received a great deal of information and intervention from Specialist Clinicians/CAMHS Professionals and other resources. Therefore they are more likely to be experts in managing their particular child's behaviour and can be in a good position to offer guidance and suggestions to school and education staff as regards their child's ability and progress. Parents can share specific effective behaviour management strategies with teaching staff. Some children who have ADHD may also have been prescribed medication and the parents can share information and advise the school regarding this.

Child and Adolescent Mental Health Professionals who may be able to offer help with managing the behaviour of a child with ADHD include Primary Mental Health Workers and Practitioners in the Child & Family Therapy Team.

Other professionals who may be able to offer help with behaviour management include:-

- Educational Psychologists
- School Nurses
- Health Visitors
- Specialist Teacher Advisors
- Special Needs Co-ordinators (SENCO's)
- Parent Support Workers

Also

- Parents of children with ADHD

Parents of children with ADHD can be a great source of support to both teaching staff and other parents who are struggling to manage children who act impulsively and struggle to concentrate, regardless of whether their child has been given a diagnosis.

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Appendix 10
Practical ideas to help parents leaflet

Portsmouth Child and Adolescent Mental Health Service

What the

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is

ADHD?

This booklet is for kids with ADHD and their parents.

Our hope is that some of the information contained will prove useful to you.

What does ADHD stand for?

Attention Deficit Hyperactivity Disorder

What is ADHD?

When someone has ADHD it means they may well have big problems with:

- paying attention/concentrating
- thinking before doing things
- sitting still
- ignoring distractions
- keeping control of their emotions
- sticking to rules
- making and keeping friends
- keeping quiet
- waiting
- memory

ADHD affects 4%-8% of school age kids. Approximately 60% of these kids will continue to have some problems when they're adults.

There is believed to be three times more boys with ADHD than girls. In fact the figure may be more than this. Girls with ADHD tend to be more likely to quietly 'daydream' as opposed to boys who are more active, louder and more challenging. Some children might have big problems paying attention, but might not be overly restless. These kids may receive a diagnosis of ADD (Attention Deficit Disorder).

What causes ADHD?

The truth is we're not really sure! There is evidence to suggest ADHD has a genetic cause. It's not unusual to find that kids with ADHD have parents, particularly a father, with similar difficulties.

ADHD is a biological brain-based problem for which there is no cure. This doesn't mean someone with ADHD is mad or stupid! Inside our brains we have different chemicals that move from one part of our brain to another, taking information along for the ride. Different parts of our brains are responsible for different things, such as emotions and aspects of behaviour. The chemicals of particular interest when considering ADHD are Dopamine and Noradrenaline. The parts of the brain of interest are the Frontal Lobe and the Cerebellum. It is believed that not enough Dopamine or Noradrenaline is released in these parts of the brain. Genetics may not be the only reason why a child has ADHD. Problems with the brain at birth or at an early stage of development may also trigger ADHD type problems. Neglect and other social problems may cause ADHD type behaviour alongside many other emotional problems.

New research has started to point the finger of blame toward television, but only when it is watched by a child under two years of age for too long.

So are parents to blame?

Parents should not be blamed for causing their child's difficulties unless they have been abusive. However, parents can, in some cases, be responsible for making their child's problems worse.

The way a parent brings up a child is vitally important. Parents or carers need to understand their child's difficulties and must know how best to help their child overcome them.

So, what should parents be doing?

Although there is no cure for ADHD there is a lot that can be done to improve things.

Parents should stay calm with their child. If they don't the child will probably get just as angry, if not more. Remember, kids with ADHD struggle to contain their feelings.

To be certain a child with ADHD is listening to and understanding something they are being told you need to have their full attention. Make sure you have eye contact and keep the things you are saying short and to the point. If you're asking them to do some jobs give them one thing to do at a time. Try asking the child to repeat what you've said in order to be sure they have listened and understood.

Children with ADHD prefer to be active and struggle to stay focussed when reading, drawing or doing other similar activities. It is important that parents still encourage their child to do these activities on a daily basis. Parents should gradually increase the length of time they expect their child to do these activities. Kids need to practise if they're going to get better at staying focussed on quiet and calm activities. Parents should break up these quieter activities with more energetic ones that enable kids to 'let off steam'.

Parents of children with ADHD need to be tolerant. Expecting a child to sit still, not interrupt or be organised etc. will only lead to disappointment and frustration. Kids with ADHD will fidget, will interrupt, will do things without thinking and will struggle to be organised. What they will need is support and ideas to make these aspects of their personality and behaviour less of a problem. No matter how frustrating, getting angry will be pointless. Kids with ADHD just need more help than others to develop these skills.

If a child with ADHD is going to achieve their potential at school they will need their parent/s to take a close interest in their education. Parents will need to stay in close contact with teachers, reinforce class work and support their child with completing homework. A teacher should be an invaluable asset to a parent. A teacher should know their child well and should have the knowledge and experience necessary to come up with ideas that will get the most out of a child when it comes to learning.

As well as keeping a close eye on their child's education a parent must carefully monitor their child's friendships at home and school. Children with ADHD will need guidance and support to play fair, say the right things, take turns, keep calm etc. Most kids with ADHD will struggle socially if they are left to find their own way with other people.

Children with ADHD can get frustrated by their problems and start to feel bad about themselves. Parents need to do more than usual to keep their child feeling good about themselves. They will need lots of praise and encouragement. It would be a good idea to keep a scrapbook of a child's accomplishments that can be turned to when a child is feeling a bit of a failure. Stick anything in the scrap book: drawings, little notes that say "well done", etc; photos from days out that went well. Parents need to be imaginative when it comes to celebrating their child's achievements.

(A more comprehensive list of ideas for parents is available on request).

What should school be doing?

Schools have access to a variety of resources that will help them to develop plans that increase the likelihood of a child with ADHD learning and behaving. Schools can be expected to use these resources to develop Individual Education Plans (IEP) for children.

Schools should not use informal exclusion.

Teachers could try the following:

- making sure the child sits where there will be the least distraction and most supervision
- allowing the child to stand up and move about from time to time
- providing clear mapped out instructions for school work, home work and behaviour
- pairing or sitting the child with children who have good learning skills
- using accepted emotional 'literacy' programmes to help children learn to understand and control their feelings
- providing incentives for working and behaving
- breaking down tasks into smaller steps
- forewarning children when they are going to give important instructions
- checking the child has understood instructions
- using accepted 'Stop and Think' programmes to help children learn to be less impulsive.

There are many other strategies teachers can use to help children learn and behave. Further information on these strategies can be obtained from ADHD websites, from an Educational Psychologist and where appropriate the Portsmouth Child and Family Therapy Service.

(A more comprehensive list of strategies is available on request).

What about Medication?

There are a variety of medications that can help children with ADHD. Your child's doctor will decide with you which medication is most suitable. Stimulant medication is the most commonly used form of treatment. Methylphenidate is the most commonly used stimulant and is also known by the trade names Ritalin, Equasym, Concerta XL and Equasym XL. Methylphenidate works, in part, by increasing Dopamine levels in the brain. Approximately 60% of people with ADHD benefit, or could benefit, from taking Methylphenidate.

Ritalin and Equasym should have a beneficial effect approximately one hour after being taken and will be effective for 2 - 4 hours. Concerta XL and Equasym XL can take a little longer to take effect and will be effective for 6 - 10 hours.

Dexamphetamine, or Dexedrine as it is also known, is another stimulant that is used less often.

Like most medications, stimulants might have side effects. These could include: reduced appetite and subsequent weight loss, raised blood pressure and insomnia. If a child has a tic disorder or 'twitches' they might get worse.

Sometimes an antidepressant is given to children with ADHD. The antidepressant likely to be used is Imipramine. A newer non stimulant medication, Atomoxetine is available. In the case of Atomoxetine, Noradrenaline levels in the brain are increased. Once again these medications can have side effects. These might include stomach problems, urinary problems, liver damage and unwanted sedation.

Clonidine is another medication found to be helpful. Clonidine is more widely used to lower high blood pressure. With regards to it's impact on ADHD symptoms, Clonidine increases Noradrenaline release in the frontal lobe of the brain. Side effects include sedation and low blood pressure.

Lots of parents struggle to decide whether or not they should allow their child to take medication. There is no easy answer. Medication can trigger dramatic improvements but can also trigger side effects. If a child does take medication their progress, height, weight, blood pressure and heart-rate must be monitored.

What about alternative treatments?

There is little evidence to suggest dietary treatments are effective. However, some children, parents and professionals report positive outcomes after cutting out certain food additives or after adding Essential Fatty Acids to a child's diet. Information on dietary intervention can be obtained from some ADHD websites.

There have been reports discussing the effectiveness of an approach called Sensory Integration Therapy (SIT). At any one time sensory experiences include touch, movement, smell, vision, body position, etc. The process by which the brain interprets and sorts out all this information is called Sensory Integration. It is believed that children with ADHD might not develop Sensory Integration as readily as they should and so sensory information gets caught up in the brain like a traffic jam. SIT uses exercises and strategies to help sensory integration develop. An Occupational Therapist is usually the best person to advise on SIT.

What does the future hold?

For your children, much will depend on the quality of support they receive throughout their childhood years. With appropriate support a child can reach their full potential as an adult. The many people with ADHD who have forged successful lives for themselves are proof of this.

With regards to future developments in our understanding of ADHD there is much we can look forward to. As our understanding of the brain develops and our ability to track chemicals advances, a diagnostic test will become a reality. Equally, genetic testing will be likely to become available. Medications will become more refined and effective.

Perhaps most importantly parents, teachers, employers, etc will be more aware of the nature of a person's needs; more experienced in responding to these needs and more able to accommodate differences within the mainstream of life.

Useful websites

www.mk-adhd.org.uk

www.addiss.co.uk

www.adhdmatters.co.uk

(Please note. The Child and Adolescent Mental Health Service do not necessarily support everything contained in these websites).

This booklet was written by Rob Matthews on behalf of Portsmouth City Child and Adolescent Mental Health Services, with the help of the ADHD parents group.

If you have any comments regarding the booklet please write to:-

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This booklet will be subject to periodic amendments.

Appendix 11
Table of medication prescribed in ADHD

Medication	Onset and duration of action	Dose	Comment	Recommended monitoring
Methylphenidate immediate release (Ritalin)	Onset: 20-60 min Duration: 2-4 hours	Initially 5-10mg daily titrated up to a maximum of 60mg/day in divided doses using weekly increments of 5-10mg	Usually first-line treatment. Generally well tolerated 'Controlled Drug'	BP Pulse Height and weight (risks probably overstated) Monitor for insomnia, mood and appetite change and the development of tics
Methylphenidate sustained release (Concerta XL) Also Equasym XL	Concerta: Onset: 30 min-2 hours Duration: 12 hours Equasym XL: Onset: 20-60 min Duration: 8 hours	Concerta: Initially 18 mg in the morning, titrated up to a maximum of 54 mg 18 mg Concerta = 15 mg Ritalin Equasym XL: Initially 10 mg increasing as necessary to 60 mg once daily	An afternoon dose of Ritalin may be required in some children to optimise treatment 'Controlled Drug'	Discontinue if no benefits seen in one month
Dexamfetamine Immediate release (Dexedrine)	Onset: 20 - 60 min Duration: 3-6 hours	2.5-10 mg daily to start, titrated up to a maximum of 20 mg (occasionally 40 mg) in divided doses using weekly increments of 2.5 mg	Considered to be less well tolerated than methylpenidate 'Controlled Drug'	

Atomoxetine (Strattera)	Approximately 4-6 weeks (Atomoxetine is an NA reuptake inhibitor)	When switching from a stimulant, continue stimulant for first 4 weeks of therapy For children <70kg: start with 0.5mg/ kg/day and increase after a minimum of 7 day sto 1.2 mg/kg (single or divided doses) and increase up to 1.8 mg/ kg/day if necessary For children >70kg: start with 40 mg and increase after a minimum of 7 days to 80 mg	Open, randomized study reports equal efficacy to methylphenidate May be useful where stimulant diversion is a problem. Once-daily dosing convenient in school children Not licensed in adults Not a CD.	Pulse BP Height Weight LFTs

Reference: The South London and Maudsley NHS Foundation Trust
OXLEAS NHS Foundation Trust
Prescribing Guidelines, 9th Edition
David Taylor, Carol Paton, Robert Kerwin
Publisher: Informa Healthcare

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