

Recognising ADHD in Children

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ADHD (Attention Deficit Hyperactivity Disorder) is characterised by difficulties in attention, activity level, and impulse control. These difficulties are typically present before the age of 7 and can affect many areas of a child's and family's life. It is sometimes called hyperkinetic disorder. Where difficulties are mainly with attention rather than overactivity, it may be referred to as ADD (Attention Deficit Disorder).

Key symptoms

Inattentiveness:

- Listening difficulties; not following instructions.
- Making careless mistakes; highly distractible; daydreaming.
- Forgetting or losing things; not finishing tasks; easily bored.

Impulsivity:

- Finding waiting difficult; interrupting or controlling conversations.
- Trouble taking turns; difficulty resisting temptation.
- Blurting out answers before a question is complete.
- Risk-taking with little or no sense of danger.

Overactivity:

- Squirming or fidgeting; restless, leaving their seat without permission.
- Talking excessively; moving quickly and forcefully.

Symptoms in older children

Older children show the same core symptoms, but risk-taking and impulsive behaviours become increasingly problematic. The impact on social relationships, peer and family dynamics, and vulnerability becomes more apparent. Planning and organisational difficulties tend to increase, and more significant behavioural difficulties including conduct problems may emerge.

How common is ADHD?

ADHD is one of the most common neurodevelopmental conditions in children and young people. Prevalence is estimated at 4–8% in the general population, and up to 20% in children with intellectual disabilities. Around 1.5% of 5–15-year-olds in the UK have ADHD at any given time. It is more commonly diagnosed in boys.

Co-occurring difficulties

More than half of children with ADHD have associated behavioural problems — such as oppositional defiant disorder or conduct disorder. Many also have learning difficulties such as dyslexia, or developmental difficulties with language or motor coordination. Some children with ADHD have social communication difficulties, repetitive behaviours, tics, anxiety, or depression. These can be missed because it is the disruptive behaviour that draws most attention.

Does it need to occur both at home and school?

Largely yes, though some children present with more difficulties in one setting than the other. A child may struggle more at school with task completion and distractibility, while a structured school environment with appropriate support can help them manage. Equally, some children hold it together at school but have more difficulties at home — which can make parents feel blamed or misunderstood. Children also have good and bad days, which can make ADHD harder to recognise.

Risk factors

ADHD is not caused by bad parenting. Contributing factors include:

- **Genetic vulnerability:** ADHD tends to run in families, though inheritance is complex.
- **Brain function and structure:** small differences in particular areas of the brain, including maturation rate and chemical balance.
- **Other factors:** premature birth, low birth weight, and brain damage (including from alcohol, smoking, or drug use during pregnancy).

Long-term consequences

Without support, ADHD can lead to poor educational attainment, school exclusions, and disrupted placements. Poor impulse control can damage peer and family relationships, leading to low self-esteem and social isolation. Young people with ADHD — particularly those with co-occurring conduct problems — are at higher risk of substance misuse, increased risk-taking, and contact with the criminal justice system. ADHD continues to cause difficulties in adulthood for around half of those affected.

What parents and carers can do

- Give simple, clear instructions one at a time.
- Create a low-stimulation environment for completing homework.
- Set realistic goals — for example, ten minutes of work at a time.
- Reinforce achievement and manage disruptive behaviour calmly and consistently.

Parenting programmes that focus on reinforcing desirable behaviour can be helpful, alongside work on the child's self-esteem and impulse and emotional control. Consistency across home and school is important.

What teachers can do

- Help the child understand that ADHD is a condition to be managed — not their fault.
- Pitch teaching appropriately, allow for individual pacing, and use proximity to the teacher, movement breaks, and classroom aides.
- Structure play and lunch breaks; use token economy systems, clear goals, and timely feedback.
- Support peer relationships and monitor for signs of anxiety or depression, which can worsen ADHD symptoms.
- Support any medication treatment through systematic monitoring and facilitating education health care plans.

When and where to refer

Refer when symptoms exceed what would be expected for the child's age and developmental level, and are interfering with learning or other aspects of functioning. Even when disruptive behaviour is the most obvious presenting issue, it is worth referring so that ADHD can be properly assessed. Referral can be made via the GP, school SENCO, or class teacher to CAMHS, a community paediatrician, or another appropriate local service.

Treatment options

- **Group parent/carer training:** psychoeducation about ADHD and strategies to support prosocial behaviour using social learning principles.
- **Individualised parent/carer training:** for more extreme or complex presentations; tailored to the family's circumstances and may include live coaching.
- **Group child-focused programmes:** social skills, problem-solving, stress management, and emotional control for older children, using CBT strategies.
- **Medication:** for severe cases, prescribed and monitored by a child psychiatrist or paediatrician, with GP involvement for ongoing prescriptions.