

**Exploring boys' experiences of ADHD and good practice in  
mainstream secondary schools; a multi-informant study**

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May 2018

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Doctorate in Professional Educational, Child and Adolescent Psychology

I, Emma Louise Flack confirm that the work presented in this thesis is my own.  
Where information has been derived from other sources, I confirm that this  
has been indicated in the thesis.

Signed

Emma Flack

The word count (exclusive of appendices and list of references) is 35,886

## **Acknowledgements**

I would like to thank the following people:

The young people, parents and SENCOs who volunteered to take part in this research and shared their experiences.

Dr Fran Knight, Vivian Hill and Prof. Emily Farran at the IOE for their guidance, belief and wise words. Thanks also to my colleagues in LA X for supporting this project.

Finally, my family, friends and fellow TEPs, for their encouragement, empathy, support and for tolerating me! Particular thanks to my partner Ben who has been my rock, and my mum for proofreading the entire thing. This is dedicated to my Gran, who was an inspiration.

## **Abstract**

Despite ADHD being one of the most widely studied conditions, there is scarce literature on the views of young people with ADHD about their diagnosis, its impact and how they should be best supported. This research aims to: give young people with ADHD a voice in relation to their experience of ADHD and systems that impact on them; explore successful strategies and interventions from a range of perspectives; and test the use of tools aimed at helping vulnerable young people express their views.

This research enlisted a critical realist position and a qualitatively-driven mixed-method research design. Twenty-three participants were interviewed: nine male pupils age 11-15, six SENCos, and eight parents. Qualitative semi-structured interviews were supplemented by participant characteristic data gathered through the Conners 3 self-report questionnaires. This research was conducted in a large town in the south of England, UK.

The findings highlight the complexity of ADHD, heterogeneity of its symptoms and pros and cons of the impact of the label on young people and their families. Strategies and interventions were suggested as good practice but are not always ADHD-specific and are likely to benefit pupils with a range of SEN. A trial-and-error, tailored approach is needed to account for an individual's strengths and difficulties. Teachers, TAs, SENCos, EPs and CAMHS all have an important role to play in helping young people with ADHD and their families. Local Authority support was found to be lacking in several areas. Tools to gain pupil views were used and described so they can be used by school staff or other professionals including EPs. A range of tools should be used and selected based on the young person's strengths and needs. Appropriate support for pupils with ADHD is needed in schools to avoid negative life consequences frequently reported in adolescent and adult ADHD.

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# 1. Chapter 1: Introduction

In this chapter, key terms are defined and ADHD prevalence rates are outlined. The different discourses about ADHD, the systems that affect the disorder and its impact on the UK are discussed. Then, the challenges young people with ADHD may face and key NICE guidelines for the diagnosis and treatment of ADHD are summarised. My personal and professional interest in this area is explained. Finally, I present the aims and research questions of this study and outline the organisation of the thesis.

## 1.1 Definition of key terms

### ADHD: Attention deficit hyperactivity disorder

ADHD is classified in the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5) as:

*“A persistent pattern of inattention and/or hyperactivity-impulsivity  
that interferes with functioning or development.”*

*(ADHD Institute, 2017, para.2).*

### Inclusion

‘Inclusion’ is a debated term. For the purpose of this thesis, the definition of inclusion is in line with ‘The Index for Inclusion’ which argues that inclusion in education involves: supporting everyone to feel that they belong; increased participation for children in learning activities, relationships and communities of local schools; and reduced exclusion, discrimination and barriers to learning (Centre for Studies on Inclusive Education, 2018). This means that all pupils receive the support they need in order to reach their potential.

### LA X

In order to preserve the anonymity of research participants, the Local Authority (LA) in which the data was collected will be referred to as LA X. References to documents and websites produced by LA X have also been anonymised.



## SEN(D): Special Educational Needs (Disabilities)

The SEND Code of Practice states:

*“A child or young person has SEN if they have a learning difficulty or disability which calls for special educational provision to be made for him or her.”*

*(Department for Education (DfE) & Department of Health (DoH), 2015, para.xiii).*

## SENCo: Special Educational Needs Coordinator

By law, all schools must employ a SENCo, a member of staff who holds qualified teacher status and:

*“...has day-to-day responsibility for the operation of SEN policy and coordination of specific provision made to support individual pupils with SEN”*

*(DfE & DoH, 2015, para.6.88).*

## **1.2 Research context**

This research was conducted as part of a doctoral training course in Educational, Child and Adolescent Psychology at UCL Institute of Education.

### **1.2.1 What is ADHD?**

Two diagnostic systems are used in the UK: International Classification of Mental and Behavioural Disorders 10th revision (ICD-10; where the equivalent of ADHD is termed ‘hyperkinetic disorder’; World Health Organization, 1992) and DSM-5 (American Psychiatric Association & American Psychiatric Association, 2013; NICE, 2018). The symptoms of ADHD include being hyperactive, inattentive and/or impulsive to the extent they interfere with a person’s psychological, social and/or educational functioning; and are excessive for their age or developmental level (ADHD Institute, 2017; NICE, 2018). The symptoms must present in two or more settings and be evident in early life (NICE, 2018).

Traditionally, ADHD was considered to be a childhood disorder, however, emerging research shows few young people with ADHD and their parents say they have 'outgrown' ADHD in adolescence (16% and 9% respectively; Anixt, Vaughn, Powe, & Lipkin, 2016). Figures suggest more than two-thirds of children diagnosed with ADHD will have problems as teenagers and most of these will continue to experience symptoms into adulthood (Crimlisk & Royal College of Psychiatrists' Public Education Editorial Board, 2018).

### **1.2.2 Prevalence**

ADHD has been described as the most commonly diagnosed child psychiatric disorder in the world and around three times more boys than girls receive a diagnosis (Singh, 2012). However, prevalence rates reported in studies vary within and across countries, time and when using different diagnostic criteria (Thomas, Sanders, Doust, Beller, & Glasziou, 2015). This can be explained by the use of different study methods and a lack of consensus on how to identify the disorder (Polanczyk, Willcutt, Salum, Kieling, & Rohde, 2014). When standardised diagnostic procedures are followed, there is no evidence to suggest an association between worldwide geographical location and ADHD prevalence nor an increase in the number of children who meet criteria for ADHD over time (Polanczyk et al., 2014).

Different ADHD prevalence rates have been reported for the UK. A recent study estimated it to be 1.5%, which is low compared to American estimates using the same parent-report measure (Russell, Rodgers, Ukoumunne, & Ford, 2014). However, parents of children aged 6-8 years were included in the research, and the authors acknowledged they expect approximately half the young people that would go on to receive a diagnosis were not identified in the study. Newly-published NICE guidelines (2018) say childhood prevalence is 1-2% when using ICD-10 (identifying hyperkinetic disorder) and 3-9% using DSM-4. Using ICD-10 results in smaller prevalence rates because of more rigorous criteria for pervasiveness of symptoms than DSM-5, as well as requiring all three core symptoms to be present (DSM-5 calls for inattention and/or hyperactivity-impulsivity; Lee et al., 2008). A recent article summarised UK diagnosis rates have remained stable for the last decade (Centre for Educational Neuroscience, 2017). However, Taylor (2017) estimated in the UK, more than half of affected children have not received an ADHD diagnosis.

### **1.2.3 Discourses regarding ADHD**

Competing discourses have different views on the causes of and treatment for ADHD. The three main discourses are biomedical, social-cultural and bio-psychosocial.

The biomedical discourse perceives ADHD as a disease caused by neurological dysfunction, for which psychostimulant medication is an effective intervention (Visser & Jehan, 2009; Wheeler, 2010). Research has focused on molecular genetics, brain activity and dopamine dysfunction in the search for a primary cause of ADHD and the efficacy of ADHD medication has been significantly demonstrated in clinical trials, indicating a biological cause (Visser & Jehan, 2009). However, Timimi (2015) argued the biomedical discourse must be questioned because research has not reached any definitive conclusions, e.g. different neurological factors are said to underpin ADHD. Also, although ADHD medication has been shown to reduce ADHD symptoms in the short-term, long-term efficacy does not continue to be significant (Swanson et al., 2017).

The socio-cultural discourse proposes ADHD does not exist as an objective disorder but is a social and cultural construct (Visser & Jehan, 2009). Diagnosis depends on culturally-constructed and subjective criteria rather than scientific processes (Timimi, 2015). For example, diagnosis can depend on one's definition of 'often' or 'excessive' (Wheeler, 2010). Multifactorial, non-pharmaceutical treatments such as counselling and behaviour modification are promoted in this discourse and ethical concerns about treatment by medication are raised (Singh, 2012; Wheeler, 2010). However, critics have argued there is 'overwhelming' scientific evidence that ADHD is a genuine disorder and families may not seek treatment if seen otherwise (Barkley et al., 2002).

More recently, there has been movement towards a bio-psychosocial perspective, which includes features of biomedical and socio-cultural discourses, where ADHD is perceived as a complex interaction between biological factors (e.g. genetic influences and atypical brain function) and social-environmental factors (e.g. parenting practices and classroom management; Wheeler, 2010). Proponents of this view have argued the biomedical discourse oversimplifies ADHD but acknowledges biological factors in its aetiology (Honkasilta, Vehmas, & Vehkakoski, 2016; Wheeler, 2010). From this perspective, treatment should be a combination of medication (if appropriate) and non-pharmacological intervention (Visser & Jehan, 2009).

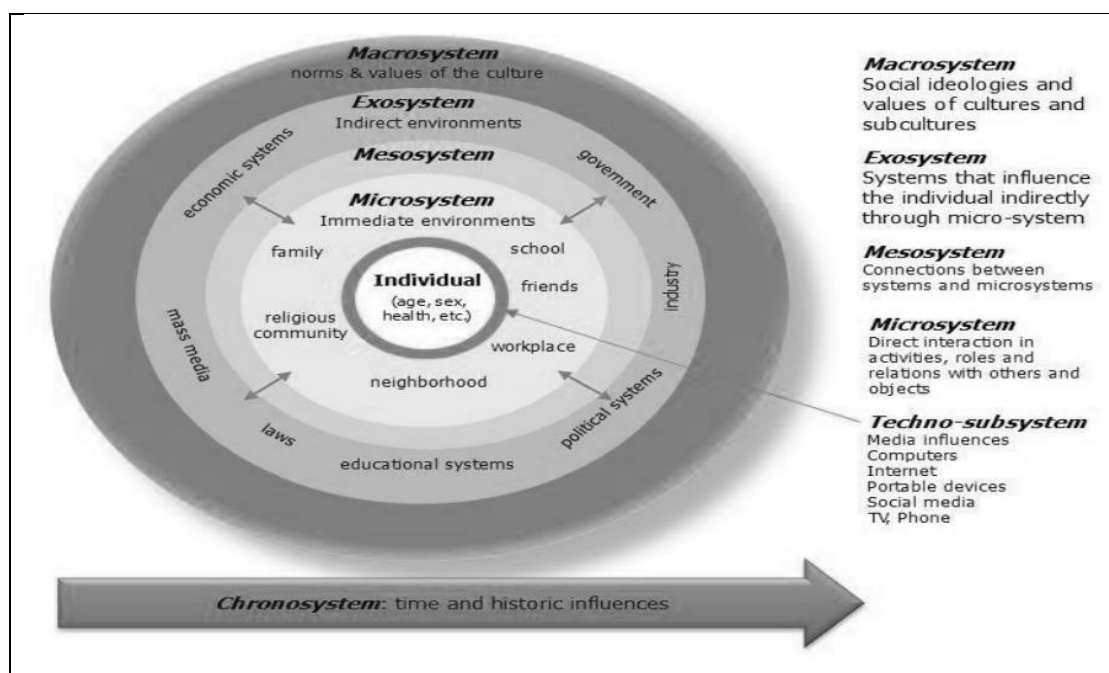
This research will endeavour to explore how those with a diagnosis of ADHD and their parents and SENCos perceive it and determine how we can support young people diagnosed with ADHD in school.

## 1.2.4 Systems that impact on ADHD

Bronfenbrenner's bioecological model (2005) provides a framework of the systems that influence a person's development and behaviour, from within-child factors, the people closest to him/her and their relationships with one another, to wider societal and cultural norms and time (Figure 1.1). This theory suggests the impact of ADHD on a young person will be influenced by these multilevel systems and their interactions with one another.

Figure 1.1: Bronfenbrenner's bioecological model

(taken from: Tudge, 2017)



This model is based on four establishing principles and their interactions, known as PPCT (Bronfenbrenner, 2005; Tudge, Mokrova, Hatfield, & Karnik, 2009):

- Proximal processes: reciprocal interactions between a person and the objects, symbols and people in his immediate environment, which vary depending on the individual, time and place.
- Person: three types of characteristics are described:
  - *Demand characteristics*: biological and genetic factors.
  - *Resource characteristics*: mental, emotional, social and material resources (e.g. skills, intelligence, good housing, educational opportunities).
  - *Force characteristics*: temperament, motivation, and persistence.

- Context: the microsystems, mesosystem, exosystem and macrosystem as shown in Figure 1.1.
- Time: three levels are described:
  - *Micro-time*: what occurs during a specific activity or interaction.
  - *Meso-time*: the extent to which activities and interactions occur with consistency.
  - *Macro-time/ the chronosystem*: the impact of time (e.g. reaching puberty) and historical events (e.g. global financial crisis).

This research considered all the systems around a young person with ADHD and the PPCT model by including questions in the interview schedules relating to each aspect. Information about demand, resource and force characteristics in was also gathered through questionnaires. Figure 1.2 exemplifies the key systems addressed in this research.

Figure 1.2: The systems influencing a young person with ADHD

<b>TIME/ CHRONOSYSTEM</b>	What happens in school Impact of ADHD over time Adolescence Historical context
<b>CONTEXT/ MACROSYSTEM</b>	Societal attitudes towards: <ul style="list-style-type: none"> <li>• SEN</li> <li>• ADHD</li> <li>• mental health</li> <li>• ADHD medication</li> <li>• challenging behaviour</li> </ul> Funding for schools, SEN support & mental health services
<b>CONTEXT/ EXOSYSTEM</b>	CAMHS LA Services Community services
<b>CONTEXT/ MESOSYSTEM</b>	Relationships between: <ul style="list-style-type: none"> <li>• Parents-school staff</li> <li>• Parents-professionals</li> <li>• Parents-young people</li> <li>• School staff-young people</li> <li>• School staff-professionals</li> <li>• Young people-professionals</li> <li>• Young people-peers</li> </ul>
<b>CONTEXT/ MICROSYSTEM</b>	School Classroom Home Social contexts
<b>PROXIMAL PROCESSES</b>	What happens in school (good practice) Understanding of ADHD
<b>YOUNG PERSON</b>	Demand, resource and force characteristics

### 1.2.5 The impact of ADHD nationally

A diagnosis of ADHD is associated with increased use of health, social and education services which are estimated to cost the UK £670 million annually (Telford et al., 2013). Education resources account for most of this (76%) and the cost for each individual remains substantial for several years after diagnosis. The authors concluded there is a need to evaluate early interventions that could ease the burden on education.

Beau-Lejdstrom, Douglas, Evans, and Smeeth (2016) reported a huge increase in ADHD stimulant medication use in children with ADHD in the UK between 1995 and 2008 (rising from 1.5 to 50.7 per 10,000 children). Sixty percent were still under treatment after two years. This indicates relatively long periods of treatment compared to other countries, which suggests higher than necessary costs to the UK health service.

### **1.2.6 The impact of ADHD on young people and their families**

A literature search into the perceptions of children with a diagnosis of ADHD and their parents found ADHD impacts on many aspects of a young person's life including social interactions, parent-child relationships, quality of life and self-esteem (Wong, Hawes, Clarke, Kohn, & Dar-Nimrod, 2018). ADHD is associated with academic failure, as pupils with ADHD are more likely than their non-ADHD peers to:

- have worse grades,
- have lower test scores,
- be absent from school,
- need SEN services, and
- drop out of school.

(Anixt et al., 2016; Bussing, Koro-Ljungberg, Gagnon, et al., 2016).

The educational difficulties of young people with ADHD may be explained by its core symptoms as well as comorbid learning difficulties, deficits in executive functioning, and teacher attitudes and practice (Wiener & Daniels, 2016). Prosser (2008) outlined how traditional pedagogical practices require students to have skills that are at odds with ADHD symptoms e.g. sitting silently and listening attentively to the teacher.

The impact of ADHD continues into young adulthood. Nelson (2011) cites previous research which states adults with ADHD are less likely to attend university, have shorter durations of employment, and lower attainment in work than peers without ADHD. This provides a rationale for finding ways to support young people to control their ADHD symptoms before they enter further education or work.

Wong et al.'s (2018) literature search demonstrated ADHD impacts on the family of children with ADHD. For example, parents can feel stressed and helpless in trying to meet their child's needs and angry or disappointed in their child's disruptive behaviour.

However, some research has indicated there can be positive aspects of ADHD. Young people with ADHD and their parents have reported it brings benefits including increased energy and drive, hyper-focus, needing less sleep, and being outgoing, creative and social (Mahdi et al., 2017; Walker-Noack, Corkum, Elik, & Fearon, 2013).

### 1.2.7 Treatment of ADHD

In the UK, the National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care (NICE, 2017), including guidelines for the diagnosis and management of ADHD for practitioners (Table 1.1).

Table 1.1: Key guidelines for the management of ADHD

(adapted from NICE, 2018)

Guideline reference	Description
1.4.3; 1.4.4; 1.4.9; 1.5.10; 1.6.1	Following diagnosis, young people with ADHD and their family should be offered advice on: <ul style="list-style-type: none"> <li>• positive and negative impacts of diagnosis and symptoms;</li> <li>• the causes of ADHD;</li> <li>• the importance of environmental modifications;</li> <li>• support groups and voluntary organisations;</li> <li>• informative websites;</li> <li>• where they can find support for education and employment;</li> <li>• the importance of positive parent–child contact, clear and consistent behaviour management, and structure; and</li> <li>• the value of a balanced diet and regular exercise.</li> </ul>
1.4.12	The educational setting should be offered advice on: symptoms; treatment plan, including reasonable adjustments; and the value of feedback.
1.1.7	ADHD teams should develop training programmes for the diagnosis and management of ADHD for educational professionals.
1.5.2	Ensure people with ADHD have a comprehensive, holistic treatment plan that addresses psychological, behavioural and educational needs.
1.5.13	Offer medication for young people only if their ADHD symptoms are causing a persistent significant impairment after environmental modifications have been implemented and reviewed.
1.5.14	Consider a course of cognitive behavioural therapy (CBT) for young people with ADHD who have benefited from medication but whose symptoms are still causing a significant impairment.
1.8.4	Ensure young people receiving treatment for ADHD have review and follow-up, regardless of whether or not they are taking medication.



There are growing concerns that psychological treatments are not always available due to a lack of funding, meaning medication is often the only option for many families (Brady, 2014; Hill & Turner, 2016).

### **1.3 Personal and professional interest**

Qualitative research relies on the researcher subjectively interpreting discourse data, so it is important to be transparent about the researcher's background and interests (Edwards & Holland, 2013). Prior to joining the doctoral training programme, I worked with children with a range of SEN in different settings. I noticed within LAs I worked for, there was often a team dedicated to working with pupils with Autism Spectrum Disorder (ASD) but this specialist support did not exist for pupils with ADHD, even though prevalence rates for ADHD are higher than or similar to ASD (e.g. 38 per 10,000 boys and 8 per 10,000 girls for ASD compared to 50.7 per 10,000 children for ADHD (Beau-Lejdstrom et al., 2016; Taylor, Jick, & MacLaughlin, 2013). I had been told by school staff that they felt unsure about what they could do in the classroom, both for pupils on medication who still had difficulties and those who declined medication. My reading of the literature evidenced these beliefs.

Young people with ADHD are of particular interest to Educational Psychologists (EPs) because they often present with challenging behaviour in school and EP input is frequently requested. Working within school contexts, EPs can work systemically to reframe perceptions and develop interventions with staff. As CAMHS' waiting lists can be long and they often offer little in the way of support to schools, EPs can play an important role in engaging and training the school staff that work with pupils with ADHD.

In LA X, when working as a Trainee EP, I was involved with six pupils where I or school staff have felt the pupil was displaying ADHD symptoms, and were struggling to engage with work and regulate their behaviour. My work with these pupils has involved: discussing what ADHD is and the diagnosis pathway with parents; developing strategies and interventions to put in place at home and school; reviewing this support; and, with one pupil, carrying out a therapeutic play intervention. I worked in the same schools weekly, meaning I was able to have a higher level of input on these cases than is possible in LAs where the EP service is more limited.

## **1.4 Research aims**

This research aims to: give young people with ADHD a voice in relation to their experience of ADHD and systems that impact on them; explore successful strategies and interventions from a range of perspectives; and test the use of tools aimed at helping vulnerable young people express their views.

The research questions are:

1. How do secondary-aged boys with ADHD experience their ADHD?
2. How do parents and SENCOs perceive ADHD?
3. What do secondary-aged boys with ADHD think good practice is when supporting them in school?
4. What do SENCOs and parents of secondary-aged boys with ADHD think good practice is when supporting young people with ADHD in school?

## **1.5 Organisation of thesis**

Chapter 1 defines the area of study and describes the context of ADHD in terms of: prevalence; different discourses; the impact of the disorder; and guidelines for diagnosis and management.

Chapter 2 contains a review of the literature including: perceptions of key stakeholders about: ADHD and its impact; treatment and intervention for ADHD; and research eliciting the views of young people with ADHD.

Chapter 3 outlines and justifies the methodology used in the research, including: the paradigm adopted; issues of validity, reliability and generalisability; a description of the LA the research was conducted in and participants; the data collection and analysis procedures used; and ethical considerations.

Chapter 4 reports on the findings of the research and a discussion of the key findings in relation to previous research can be found in Chapter 5.

Chapter 6 discusses the limitations of the research. Finally, Chapter 7 outlines recommendations for practice and research.

## **2 Chapter 2: Literature review**

This chapter considers why it is important to elicit the voice of young people, especially those with a SEN such as ADHD. Then, the findings of a systematic literature search on recent studies regarding young people's perceptions of their ADHD are described. The theory of Personal Illusionary Bias, which is linked to ADHD is explained. Then, literature in terms of parent and teacher views and knowledge of ADHD; young people's views on ADHD medication; and effective school support for young people with ADHD is outlined. The summary illustrates how the current study seeks to address gaps in research, thereby providing a rationale for this study.

### **2.1 Eliciting young people's views**

Since the late 1980s, there has been ever-increasing interest in child voice as an area to research in its own right and include in policy (O'Kane, 2008; Prunty, Dupont, & McDaid, 2012). Historically, research and practice have moved from seeing children as passive, where they are tested and observed, to tokenistic listening where the adult hears the child's viewpoint but then decides on actions, and finally to empowerment where the child's views are taken seriously and inform action (Gersch, Lipscomb, & Potton, 2017).

The United Nations' convention on the rights of the child states, "*Every child has the right to express their views, feelings and wishes in all matters affecting them, and to have their views considered and taken seriously*" (United Nations, 1989). Recent UK legislation including the Children and Families Act 2014 and the SEN Code of Practice (DfE & DoH, 2015) place a duty on LAs to put the views of young people and their families' views at the heart of decisions regarding their education, health and care (Pellicano et al., 2014).

Child voice can challenge dominant discourses and offer suggestions for how support for them could be managed (Brady, 2014). Learning is a transactional process so it is important to hear from both teachers and students (Herz & Haertel, 2016). Pupils that are more included in decisions regarding their education are more engaged and enjoy being consulted (White & Rae, 2016).

Adults, including researchers and educational professionals, may need to use creative approaches to gain the views of young people with SEN (Hill et al., 2016). Therefore, the likely strengths and difficulties of pupil participants were taken into account when developing the interview protocol (see methodology chapter). EPs have a key role in

gaining child voice and using various tools to do this, both in research and everyday practice (Gersch et al., 2017).

## **2.2 Young people's views of ADHD**

Despite ADHD being one of the most widely studied childhood developmental conditions, the views of children with ADHD have been largely neglected in research, policy and practice (Brady, 2014; Sciberras, Efron, & Iser, 2010). More research focuses on adult perceptions, which are typically negative, or on the efficacy of treatment (Gajaria, Yeung, Goodale, & Charach, 2011; Wong et al., 2018).

A systematic literature search was conducted search using the Boolean search terms:

- ADHD OR “attention deficit hyperactivity disorder” AND
- views OR opinions OR perceptions OR beliefs AND
- child\* OR adolescent OR teenager OR young people OR youth

This identified sixteen studies and two reviews since 2010 that used qualitative or mixed methods to explore children and young people's perceptions of their ADHD (Appendix 9.1). The search was limited to this decade to reflect current perspectives as discourses about ADHD are evolving. The findings are summarised below.

### **2.2.1 Performance and conduct niches**

For the VOICES project ('Voices on Identity, Childhood, Ethics and Stimulants'; Singh, 2012), 151 children aged 9-14 with ADHD, children without a psychiatric diagnosis and parents in the UK and USA were interviewed. Singh has written several papers based on this data, including one that focused on perspectives of ADHD in the UK (Singh, 2011). To increase participant numbers in the UK, some children from the UK sample did not have a diagnosis of ADHD but were 'teacher-identified ADHD' so may not have met formal diagnosis criteria. A variety of data collection methods were used and justified and are available online so could be used by others. Quotes and case studies were used to increase the validity of the findings.

Singh (2011; 2012) identified two constructions of ADHD: the 'performance niche', where the focus of the children's views is on academic performance and ADHD is perceived to cause difficulties with academic achievement; and the 'conduct niche' where the focus is on behaviour and ADHD is seen as a disorder of anger and aggression. According to their responses, a small number of children inhabited both

niches. The performance niche was more typical in the USA and these children were more likely to keep their ADHD diagnosis a secret. The conduct niche was more prevalent in the UK and ADHD was sometimes used as an excuse for poor behaviour because children were aware adults see their behaviour as uncontrollable, even though the children themselves did not believe this. The author acknowledged adolescents may feel differently to the children in her research, something this study can go some way to address. In other research, young people with ADHD have also mentioned anger problems and aggression (Kendall, 2016; Moen, Hall-Lord, & Hedelin, 2014).

### **2.2.2 Three ADHD constructs: personality trait, medical disorder or minor concern**

Singh's two ADHD niches differ from studies from Canada, USA and Finland (Brinkman et al., 2012; Charach, Yeung, Volpe, Goodale, & dosReis, 2014; Honkasilta et al., 2016), which showed young people perceive their ADHD as one of three conflicting constructs:

- *a personality trait* or mental quirk, thereby distancing themselves from stigma;
- *a medical disorder*, which externalises responsibility for behaviour; or
- *a minor concern*, which is something they are in control of.

In these studies, young people aged 11-18 years with a diagnosis were interviewed about their experience of ADHD traits (Honkasilta et al., 2016) or ADHD treatment (Brinkman et al., 2012; Charach, Yeung, Volpe, Goodale, & dosReis, 2014). Two of the three studies (Brinkman et al., 2012; Honkasilta et al., 2016) did not indicate whether most of the young people identified with one construction of ADHD over the others, nor if there was any overlap between them, so the pervasiveness of each construct is unclear. Charach et al. (2014) found six of the twelve Canadian participants viewed ADHD as being part of who they are, four perceived ADHD as a medical disorder, and two saw ADHD as a minor concern, suggesting ADHD as a personality trait is the most dominant discourse. The focus of Brinkman et al. (2012) and Charach et al.'s studies (2014) was the use of stimulant medication, which may have influenced the nature of the questions and thus the responses. Brinkman et al. (2012) used focus groups to interview 44 adolescents in the USA and Honkasilta et al. (2016) for 13 Finnish youths. All three studies employed a heterogeneous group of participants in terms of gender and medication-use. It is difficult to generalise their findings because it was not reported if there were significant between-group differences regarding participant perceptions of their ADHD. However, the results are strengthened when put together because all

three studies independently described similar constructions of ADHD. All three studies enlisted rigorous analysis processes e.g. they used professionals from different academic disciplines to code the data and identify themes co-operatively and provided data examples in the results.

Wong et al.'s literature review (2018) included 101 studies that looked at the perception of ADHD among children and young people with ADHD and their parents and concluded there were heterogeneous beliefs that align with the three constructions above. The authors added some youths said ADHD was caused by environmental factors such as watching television or experience of trauma. Because this study was a literature review, its findings are limited by the methodologies of the research included within it and generalisability is hampered by the representativeness of participants e.g. most were taking medication.

### **2.2.3 Blending the three constructs**

Brady (2014) interviewed seven children aged 6-15 years with a diagnosis of ADHD in the UK about their understanding and experience of ADHD and concluded they maintain control over their lives by neither fully accepting nor rejecting the medical discourse around ADHD. This could be seen as a blend of the constructs indicated above because the participants recognised advantages and disadvantages of diagnosis and psychostimulant treatment. However, this data was collected between 2000-2001 and so discourses may have changed since then. For example, the introduction in Brady's article reports psychologists have embraced the biomedical framework and pharmaceutical treatment has become normalised. However, contrary to this, NICE guidelines state medication should only be used if environmental modifications have not improved the behaviour of the child (NICE, 2018, para.1.5.13), and research indicates EPs work to increase the awareness of contextual factors in children's behaviour (Hill & Turner, 2016).

Singh et al. (2010) sought the views of young people aged 9-14 with ADHD in the UK on medication in order to inform the 2008 NICE guidelines. These young people felt they needed medication, which is in line with the biomedical discourse about ADHD. Some participants said they were 'berserk', 'mental', 'annoying' and 'out of control' when not taking medication. This was compounded by the young people feeling they had a bad reputation, and were seen as 'stupid'. However, participants did not fully embrace the medical discourse as they challenged assertions their problematic behaviour was due solely to ADHD or a lack of medication. This provides evidence for

Brady's blended constructs described above (Brady, 2014). Both are UK studies but do not seem to fit with Singh's later finding that UK children see ADHD as a disorder of anger and aggression (2012). There is no clear explanation for this difference; all three studies used a range of activities with participants, who were of a similar age and questions focused on experiences of ADHD and/or medication. The main difference was Singh's 2012 sample was significantly larger.

Singh et al. (2010) reported the older participants in the study, those in adolescence, were more likely to question the on-going need for medication and said they wanted to stop taking it in the near future. The authors recommended adolescents should take part in separate research in order to accurately represent their views, something this study will address.

Gajaria et al. (2011) analysed postings over eight months in twenty-five ADHD support groups for young people on Facebook, and found the members created a positive group identity, for example more than three times as many posts discussed positive compared to negative elements. Young people tended to label ADHD as a 'disorder', not a disability or disease, meaning it was just something that made them different from their peers, suggesting a blend of the medical disorder and personality trait constructs. The methodology used in this study removed the risk of researcher influence that might affect interview-based research as the participants did not know that what they said would be used for research. However, due to the nature of Facebook, it was impossible to verify the age of participants and their diagnosis, though they self-identified as high school or university students. The researchers made several unfounded assumptions in their findings and discussion. For example, they interpreted the use of young people saying 'we' and 'us' in their posts as evidence of the participants creating in/out group boundaries and separating themselves from others. But since they are communicating with other people in a group, it seems reasonable language to use and does not mean they cannot identify with people not in the support group. The authors also assumed the young people in the study do not have a 'real life' support network, perhaps they do but used Facebook as additional support. Gajaria et al. (2011) do not discuss how their findings can be applied by adults working with young people with ADHD which limits the usefulness of the study.

#### **2.2.4 ADHD as a disorder**

Two studies and one review in the systematic literature search provided evidence that young people with ADHD can identify with the perception of ADHD as a medical disorder.

Ljusberg (2011) interviewed ten Swedish children age 10-12 who attended remedial classes due to concentration difficulties. The author found participants stressed their difficulties originated in themselves, rather than looking to their context. This reflects the biomedical discourse. The pupils interviewed were in remedial classes, which may have impacted on their views because they were treated differently because of their difficulties.

A Canadian study (Wiener & Daniels, 2016) into the school experience of pupils aged 14-16 with ADHD reported participants wanted their peers to know they cannot always control their ADHD and to be more forgiving of their problems concentrating. These young people viewed ADHD as a medical disorder and externalised responsibility for their behaviour onto the ADHD.

Wong et al.'s literature review (2018) concluded young people have mixed views on the causes of ADHD, including some who believe in biological causes such as genes and brain abnormality.

Studies have shown diagnosis brings empowerment, feelings of relief, and behavioural and academic improvements at school (Bringewatt, 2015; Kendall, 2016). This is in line with research about other diagnoses such as dyslexia, where the label provides a welcome explanation for the young person's difficulties (Riddick, 2010). However, some children with ADHD do not want to tell peers about their ADHD for fear of being seen as 'different' or 'stupid' (Bringewatt, 2015).

#### **2.2.5 ADHD as a struggle**

In contrast with Gajaria et al.'s (2011) more positive findings, analysis of the logs of online coaching sessions for twelve young people with ADHD and/or ASD painted a bleak picture of everyday life (Ahlström & Wentz, 2014). Two themes were identified: 'fighting against an everyday life lived in vulnerability' and 'struggling to find a life of one's own'. Both themes centred on difficulties and perhaps align most closely with the construct of ADHD as a medical disorder; something the young people find difficult to control. This could be because the data were taken from coaching sessions where the



focus was on supporting participants with problems they faced, making the nature of the dialogue more negative. It should be noted the participants in this research were aged 15-26, so some were adults rather than adolescents. Also, some participants had both ADHD and ASD, and some had one diagnosis, yet the authors did not reflect on any differences across the findings between these participant groups.

A Norwegian study involving young people with ADHD age 8-17 and their families (Moen et al., 2014) described two themes: 'safeguarding a functioning family' and 'fighting for acceptance and inclusion'. The families discussed special skills and strategies they had developed to cope with living with a child with ADHD. Bullying, exclusion and having few or no friends was common for young people with ADHD. This reflects Ahlström and Wentz's depiction (2014) of ADHD as a struggle. However, parent, rather than child views were more prominent in Moen et al.'s research.

A Canadian study, where 25 young people aged 10-21 with ADHD were interviewed in focus groups, found they viewed ADHD as a series of difficulties that occur across contexts, including those directly associated with the core symptoms and others such as social and academic problems (Walker-Noack et al., 2013). However, participants were also asked about the positive aspects of having ADHD and though many did not seem to have considered this before, responses included increased energy, needing less sleep, and being outgoing and social. The authors explained talking about difficulties due to ADHD came more easily to participants than talking about benefits and participants also felt the general public had negative perceptions of ADHD. The findings were reported with supporting quotes and indications of how many statements were made about each sub-theme, making the validity of the findings stronger.

Young people with ADHD and caregivers were interviewed in eight European countries, including the UK, to explore their unmet needs (Sikirica et al., 2015). Adolescents reported difficulties with schoolwork, social interactions and forming relationships. They also had negative feelings about the diagnosis such as embarrassment, annoyance and feeling different to peers. Limitations of this study included the need to translate some interviews into English and all youth participants were taking medication, making the sample less generalisable to those not on medication.

Mahdi et al. (2017) interviewed focus groups of young people with ADHD aged seven and above and their caregivers in five countries across the world. Participants discussed a range of difficulties spanning physical, cognitive, social and behavioural aspects that impact on everyday life. However, the findings also highlighted positive aspects to ADHD such as having high energy, drive, and hyper-focus when interested

in something, and being creative and empathic. This research represented views from five continents, strengthening its generalisability. However, some interviews were translated into English, increasing the risk of misrepresentation. In two continents, children did not take part. Adult and youth views were presented together so differences between groups could not be easily assessed.

### **2.2.6 Summary**

ADHD as an uncontrollable medical disorder appears to be the dominant discourse among young people internationally. Other constructs include ADHD as a personality trait, a minor concern, a disorder of anger and aggression and something that impacts on academic performance. In UK studies, young people are often shown to blend these constructs and neither fully accept nor reject one over another.

Studies show young people experience variable difficulties because of their ADHD and there is emerging evidence of strengths too (Wong et al., 2018).

## **2.3 Gender differences**

Three times more males than females have ADHD, according to community-based samples, and there is little research on girls with ADHD (Arnett, Pennington, Willcutt, DeFries, & Olson, 2015). The male to female ratio for those referred to clinics has been reported as being up to 9:1 and there are concerns that only girls with the most substantial impairments are referred to mental health services, possibly because they tend to display less disruptive behaviours (Gershon, 2002; Rucklidge, 2008). Females are more likely to be diagnosed as predominantly inattentive than males, which suggests they can display different symptoms (Rucklidge, 2008). However, only small gender differences have been found and they tend to cease by adulthood e.g. girls have lower self-efficacy and boys have better coping strategies (Rucklidge, 2008).

Possible explanations for the higher rate of diagnosis in males include: sex differences in regards to underlying cognitive processes such as processing speed, inhibition and working memory; males having greater overall variance in symptom severity, meaning more boys fall at extreme ends of the spectrum; and males displaying behaviours closer to the diagnostic criteria on average (Arnett et al., 2015). Some studies have found that internalising difficulties and comorbidities are higher for females, and boys have higher rates of externalizing disorders (e.g. Levy, Hay, Bennett, & Mcstephen,

2005) but other research disputes this finding (Rucklidge, 2008). Girls with ADHD still have significant difficulties academically, cognitively, socially and psychiatrically (Rucklidge, 2008).

## **2.4 Parent views of ADHD**

Charach et al. (2014) reported parents have a more homogeneous belief in the biomedical discourse. However, this may have been influenced by the nature of the study, which explored views on stimulant treatment e.g. participants were not asked about non-pharmaceutical intervention so may have been less likely to mention psychosocial aspects of ADHD. Illustrating this critique, Wong et al. (2018) concluded parent perceptions of ADHD were as varied as young people's. In some studies, more parents subscribed to the biomedical discourse but in others, family context, psychological or developmental factors were more prevalent. Also, many felt they did not sufficiently understand ADHD.

ADHD can impact on the whole family. In a Norwegian interview study involving four children with ADHD and thirteen family members, Moen et al. (2014) found families of children with ADHD developed skills and strategies to live with ADHD. For example, spontaneity was avoided in favour of structure and routine and parents were described as strict. However, the families' striving could lead to closer bonds. The authors concluded daily life was steered by the difficulties of the child with ADHD and all family members needed to be supported so problems did not become significant. Parents felt they were solely responsible for supporting their children and felt blamed by teachers for their child's behaviour. Cultural differences may exist between Norway and the UK, in both family and education contexts and so this study may not reflect British experiences.

Similarly, in Sikirica et al.'s European research (2015), caregivers reported ADHD can cause strained family relationships and mean they have to limit activities and expend extra effort supporting their child. A quarter said they had to reduce working hours or stop working to care for their child. Caregivers reported a range of variable difficulties young people with ADHD faced, including academic, social, behavioural and cognitive difficulties, in much the same way the young people themselves do, and worried about their child's future. Three-quarters of parents discussed issues with obtaining a diagnosis, including lengthy waiting lists and being blamed for their child's symptoms.

Forty-eight parents of children and young people who had received a recent diagnosis of ADHD were interviewed in the USA (dosReis, Barksdale, Sherman, Maloney, &

Charach, 2010). Most (77%) reported stigmatising experiences leading up to their child's diagnosis of ADHD and 21% felt health professionals and school staff were dismissive of their concerns. Moldavsky and Sayal's (2013) review of research regarding knowledge and attitudes about ADHD also demonstrated parents of children with ADHD felt stigmatised and people continued to believe myths about ADHD. However, the authors described the findings of several studies but did not provide a critique of them so it is difficult to assess the strength of their findings. Given the stigma and misconceptions around ADHD, it is easy to see why there are different discourses and constructs which may be dependent on each person's beliefs and knowledge of ADHD.

Wong et al.'s literature review (2018) found a small number of parents described positive consequences of ADHD including high energy, good cognitive abilities, and qualities including being bubbly, social and bright. Some parents mentioned successful people that had ADHD symptoms or said it had benefitted them, for example, by leading to better communication and relationships within the family.

## **2.5 Teacher views and knowledge of ADHD**

A doctoral dissertation compared American and British teacher and parent perspectives of ADHD (Robinson, 2017). Data collected from 6 primary school teachers and 6 parents in both countries reflected the VOICES project's findings of a performance niche in the USA versus a conduct niche in the UK (Singh, 2012). In the UK, discourses revolved around behavioural concerns, for example, interpreting hyperactivity as naughty behaviour.

Teachers' lack of knowledge regarding ADHD is repeatedly evidenced in the literature in studies from UK, USA, Canada and Australia (Kendall, 2016; Wiener & Daniels, 2016). A poll conducted for Shire Pharmaceuticals (2017) of 803 primary and secondary school teachers in the UK found almost half of teachers that participated said they had not been trained to teach children with ADHD. Many did not recognise some key symptoms of ADHD, including impulsive behaviour (41% did not recognise) or difficulty with organisation (74%). Nearly three-quarters agreed ADHD is not well recognised or understood within society. A review of attitudes towards and knowledge of ADHD highlighted several international studies indicating professionals (including teachers and general physicians) can have misconceptions about ADHD and its management (Moldavsky & Sayal, 2013). Most strikingly, 80% of 202 Sri Lankan teachers surveyed in 2011 believed ADHD was a result of 'bad upbringing'. More

promisingly, in the USA, trainee teachers had significantly more knowledge of ADHD compared with other undergraduates.

Ohan, Visser, Strain, and Allen (2011) gave 66 primary school teachers or education students in Canada vignettes describing children who met ADHD criteria. Some vignettes included the label ADHD and some did not. ADHD-labelled vignettes elicited greater perceptions of the child's difficulties and negative emotions in the participants, which suggests the label itself has negative connotations for teachers.

To enable inclusion in UK schools, there is room for improvement in regards to teacher understanding of ADHD and knowledge of strategies (Kendall, 2016). Kendall recommends more input regarding ADHD during initial teacher training, but does not address what could be done for practicing teachers. The current study could help to fill this gap by identifying and sharing knowledge about ADHD and good practice for school support.

## **2.6 ADHD medication**

Research that seeks the child's voice in relation to ADHD has tended to focus on opinions regarding medication and views it as positive and something to be encouraged (e.g. Charach et al., 2014; Ferrin et al., 2012). Fourteen papers from the systematic search of ADHD and child voice included views on medication. Only five of these studies investigated potential ethical, physiological and psychological harms of ADHD diagnosis and stimulant medication (Sikirica et al., 2015; Singh, 2012; Singh et al., 2010; Walker-Noack et al., 2013; Wong et al., 2018).

Treating ADHD with psychostimulant medication has been shown to have positive short-term effects, but there is little convincing evidence to show long-term benefits in the fields of improved academic outcomes and sustained behavioural improvements (Charach et al., 2014; Travell & Visser, 2006). For example, Swanson et al. (2017) reported on the Multimodal Treatment Study (MTA) which started as a randomised clinical trial of behavioural and pharmacological treatments of 579 children with ADHD aged 7–10 and transitioned into an observational long-term follow-up of 515 cases, 2–16 years after baseline. Findings showed a significant decline in ratings of symptom severity in the groups with, compared to without, stimulant medication after 14 months. However, the most recent findings indicate in the long-term, symptom-related benefits of medication may dissipate and do not continue to be significant.

Young people with ADHD have reported medication was beneficial in areas related to school success and lessens but does not take away ADHD symptoms completely (Kendall, 2016; Sikirica et al., 2015). However, there can be negative physiological and psychological side-effects (Walker-Noack et al., 2013). Despite this, participants viewed medication as more effective than behavioural treatments.

As they get older, young people and their parents tend to question the need for medication, worry about side effects and some choose to discontinue it (Brinkman et al., 2012; Ferrin et al., 2012). Bussing et al. (2012) reported 67% of adolescents and 85% of parents expressed concerns about over-medication. A literature review found a combination of medication and behavioural intervention is most effective for behavioural improvements (Wong et al., 2018). Therefore, it is advantageous to investigate effective non-pharmaceutical, school-based intervention, as this research aims to do.

## **2.7 Supporting pupils with ADHD in school**

Studies that investigate school support tend to emphasise parental views and find educational support is limited and inappropriate (Baric, Hellberg, Kjellberg, & Hemmingsson, 2015).

### **2.7.1 Young people's views**

Twelve articles in the systematic literature search explored the school experience and/or views about school intervention of children and young people aged 18 and under with ADHD using qualitative or mixed methods.

Kendall (2016) interviewed twelve young people aged 10-18 years with ADHD in England. Participants reported difficulties including concentration, being distracted, working memory, planning, organisational skills and following instructions. The useful strategies identified include having a learning mentor or TA (but not all the time); teachers repeating information in different ways; being allowed to leave the classroom at times; having a 'distractor object' to fiddle with; and better communication to staff about which pupils have ADHD. The participants also mentioned disliking teachers shouting at them and the negative consequences of this. Some pupils reported their teachers' attitudes changed for the better towards them after diagnosis. Whilst the sample used in this study was a small (N=12), self-selected sample from an ADHD

support group, participants were heterogeneous in their medication-use, comorbidities and gender. The current study will further explore these findings and add SENCo and parent views on the effectiveness of strategies.

In interviewing twelve young people with ADHD aged 14-16 years about their school experiences, Wiener and Daniels (2016) found, conversely to Kendall (2016), teachers in Canada did know about ADHD and used evidence-based interventions and strategies. The adolescent participants could clearly describe their ideal classroom and teacher, which lends support to using this technique in the current study. All participants wanted a 'funny' or 'fun' teacher, with other strong themes around being approachable, strict, understanding and helpful. Pupils most valued strategies in the classroom that minimised distractions and captured and sustained their attention e.g. practical activities, discussions and a quick pace of learning. However, it was found although pupils knew what factors contribute to academic success, they struggled to put them into place. The interviews were lengthy (over two hours) and the researchers conducted a second follow-up interview to check their analysis with participants.

Interviews with six males aged 15-16 with ADHD, and their mothers and teachers in Australia found teachers should be tenacious, patient and tolerant, set boundaries and consequences, use humour, offer clear instructions and create an engaging learning environment (Gibbs, Mercer, & Carrington, 2016). All the adolescents had experienced friendship difficulties in primary school that improved in secondary school. The authors hypothesised improvements may have been due to ADHD symptoms becoming less overt over time, better pragmatic language skills being developed, or pupils not wanting to appear different to their peers and so being reinforced by managing their behaviour. The authors stated the importance of friendships to young people with ADHD needs to be considered when creating an optimal educational environment. Parents felt their children needed more emotional support and breaks in school and a key worker approach would be effective. The study indicated teachers had not given much prior thought to the learning environment for pupils with ADHD and would benefit from up-to-date information about ADHD and time for professional development. The authors recommended 'innovative strategies' are used in the classroom, but did not describe what these could be. The pupils attended an Australian independent school, and it is unclear how generalisable the findings are to mainstream schools in the UK.

Singh (2012) found knowledgeable teachers and a supportive school environment were instrumental in helping children with ADHD. She suggested, "*Both the child and the environment need treatment in order for there to be real, lasting change*" (Singh, 2012, p.13). Pupils reported some teachers contributed to stereotypes and stigma

related to ADHD, e.g. by telling other pupils to stay away from a child with ADHD and using ADHD as an excuse for poor behaviour. Singh suggested strategies including:

- giving the child a 'fiddle toy',
- allowing the child to ask for short breaks,
- keeping an even tone and temper,
- giving the child jobs with responsibility, and
- discussing strategies with the child.

Singh focused on perceptions of ADHD and medication-use, so the strategies she suggested were limited. The current study has more of a focus on school intervention and aims to identify a greater number of effective strategies.

In Singh et al.'s earlier UK study (2010), few participants spoke about helpful non-pharmaceutical interventions and did not show strong views on interventions their parents had initiated, such as changes in diet. Several participants reported sport helped them to release energy and feel good, and drawing and stress balls were effective strategies for managing behaviour. However, the adolescents in this study felt medication would be more effective than non-pharmacological interventions and medication made other interventions more successful. This may be because the pupils also reported teachers assumed their behaviour would be more challenging than that of their peers and used ADHD as an excuse to avoid making changes in the classroom that could help them.

Pupils in Sweden with ADHD aged 10-12 years old described a good teacher as, *"...one who can keep order in the classroom, is patient, not too strict but kind, fair, good at listening, does not make subjects too advanced and is helpful."* (Ljusberg, 2011, p.443). The study also found separating pupils with ADHD-type difficulties into special classes created social difficulties, providing an argument in favour of inclusion.

Walker-Noack et al. (2013) reported young people with ADHD in Canada aged 10-21 said they needed assistance with ADHD symptoms, most frequently inattention (e.g. staying focused and filtering distractions), followed by hyperactivity and impulsivity (e.g. being quieter and thinking before acting), and social skills, academic work and frustration. Participants said they would like to be in smaller classes, have opportunities to release energy and less homework. They reported rewards can motivate them and help them to understand consequences but became less helpful as they got older. Participants did not want intervention to make them feel different to their peers.

Ahlström and Wentz (2014) reported young people with ADHD and/or ASD described difficult situations in school, such as being made fun of by peers or teachers, which



resulted in anxiety and losing respect for the teacher. The participants, who attended school in Sweden, felt they needed support with understanding homework and assignments. The nature of this study was the analysis of coaching logs and so did not report on positive aspects of school nor on specific strategies or interventions the participants had found useful, something the current study aims to address.

### **2.7.2 Educator's views**

In the UK, prevalence rates for ADHD and typical mainstream classroom sizes mean there should be approximately 1-2 pupils per class. Therefore, teachers can expect to work with young people with ADHD as a matter of course. A poll of UK teachers found 69% said their school had a good structure in place to support students with ADHD (Shire Pharmaceuticals, 2017). However, a 2017 study claimed to be the first qualitative study to focus on the experiences of school staff in the UK regarding how they work with pupils with ADHD (Moore, Russell, Arnell, & Ford, 2017). They found staff drew on a range of strategies to include pupils with ADHD in the classroom but these strategies did not necessarily target ADHD symptoms nor were evidence-based ADHD interventions. Rather, they were flexible to the needs of the individual student. A 'pupil passport' detailing the student's strengths, needs and appropriate strategies was reported as a way to manage this. A key factor to success was a positive teacher-pupil relationship but it was acknowledged they can be hard to build. However, the authors argued there is a lack of knowledge about evidence-based ADHD interventions.

Kendall (2016) summarised there has been little progress in providing teachers with knowledge and skills to support pupils with ADHD. The SEN Code of Practice asserts teachers are responsible for the progress and development of all pupils in their class and this starts with differentiated and high quality teaching (DfE & DoH, 2015). However, without appropriate training, teachers cannot be sure what this high-quality teaching and differentiation should entail. For example, Australian teachers of pupils with ADHD reported they had some knowledge about ADHD but less about teaching methods and classroom management strategies (Gibbs et al., 2016).

A review of the literature regarding the impact of teacher factors on outcomes for elementary-aged pupils with ADHD in USA found teachers' opinions about intervention and their attitude towards, and reactions to, ADHD behaviours can influence children's self-efficacy, perception of themselves and social and academic outcomes (Sherman, Rasmussen, & Baydala, 2008). The authors suggested teachers' opinions and values

should be considered when designing intervention for a pupil with ADHD. It should be noted this review included a small number of papers, fourteen in total. Kendall (2016) drew on previous research to explain if a teacher reacts negatively to a pupil's behaviour, it can lead to low self-esteem, aggression, withdrawal, embarrassment or social isolation for the pupil.

### **2.7.3 Meta-analyses on school-based intervention**

A meta-analysis compared one hundred studies about the effectiveness of psychosocial interventions for pupils with ADHD symptoms, aged 6-17, that can be applied by teachers (Gaastra, Groen, Tucha, & Tucha, 2016). All intervention types resulted in positive behaviour changes, with the strongest effects shown by behavioural interventions. Behavioural interventions included consequence-based interventions, such as the use of rewards and mild punishment, and self-regulation interventions, where pupils used self-monitoring strategies to evaluate their behaviour. Larger effect sizes were found for mainstream compared to special settings. The authors suggested a psychologist could support teachers to define 'good' and 'bad' behaviours for the consequence-based interventions. Antecedent-based interventions, where adjustments were made to the environment, yielded small-to-medium effect sizes. The paper does not make clear where the studies took place and the authors acknowledged the results are most representative for boys aged 6-11 years. Few studies included adolescents, something this study aims to address.

An over-arching synthesis of four systematic reviews regarding non-pharmacological interventions for ADHD in school settings involved 138 studies and found most interventions were rated neutrally or positively (Moore et al., 2015). The intervention with the most consistently positive feedback was the use of daily report cards, which can help with home-school relationships. They could be seen as a type of consequence-based strategy as reported by Gaastra et al. (2016). However, a Canadian study found report cards are infrequently used; less than 20% of teachers reported using them frequently (Martinussen, Tannock, & Chaban, 2011). The synthesis reported on three types of intervention: behavioural, neurofeedback and cognitive training. Behavioural interventions, which Gaastra et al. (2016) found to be most effective, were thought to be at risk of being resisted by adolescents. Neurofeedback had beneficial effects but requires specialist equipment that is not usually found in schools in LA X. Cognitive training again requires specialist equipment, and no beneficial effects were found. Training about ADHD and classroom strategies

improved teachers' attitudes and confidence. The authors noted the outcomes pupils with ADHD see as important are rarely reported in the literature, including their attitude towards interventions, something this study will address.

A meta-analysis of school-based interventions for ADHD included 60 studies of children and young people aged 5-18 (DuPaul, Eckert, & Vilaro, 2012). As in previous meta-analyses, positive effects were reported for a range of interventions including contingency, academic and cognitive-behavioural intervention strategies. The authors concluded given the moderate-to-large effect sizes found, school-based intervention should be the first-line treatment for young people with ADHD. This study will seek the views of students, SENCos and parents to add to the evidence-base of what can happen in schools to best support pupils with ADHD.

#### **2.7.4 Factors that impact on the effectiveness of school intervention**

In a Norwegian study, parents of children and young people with ADHD reported their child needed positive reinforcement from peers in order to develop socially (Moen et al., 2014).

Two large-scale surveys in the USA completed by young people, parents, teachers and other professionals looked at feasibility and willingness to use school-based and self-management ADHD interventions (Bussing, Koro-Ljungberg, Gagnon, et al., 2016; Bussing, Koro-Ljungberg, Gurnani, et al., 2016). These studies analysed data from the same pool of participants at several time points over eleven years. Young people with ADHD expressed significantly less willingness towards almost all interventions than the key adults in their lives. Activity-based ADHD interventions, such as taking part in sports or martial arts, were shown to be acceptable across all demographic and ADHD-risk groups. Thinking an intervention was effective had a positive correlation with willingness to use it. However, school-based interventions were thought to increase stigma by making pupils feel 'different' and this meant students saw them as less feasible. As these studies used surveys, they did not allow for further clarification or elaboration on participant views. These studies suggest student views should be included when developing interventions to lower the risk of them being resisted by pupils. One of these studies uncovered a widely-held perception that interventions foster inequality because making adjustments for pupils with ADHD gives them an 'unfair advantage' (Bussing, Koro-Ljungberg, Gagnon, et al., 2016). This is a misunderstanding of equal opportunities, which are not about everybody receiving exactly the same resources but providing all pupils with the adjustments they need to

access learning and reach their potential (e.g. Equality Act 2010). However, the data were collected in 2007-8 and so attitudes may have changed since then. The current study aims to identify interventions and strategies that are perceived to be effective by key stakeholders so others can use the results to implement interventions that are more likely to have a higher level of engagement.

## **2.8 Summary**

Despite ADHD being one of the most widely studied conditions, there is scarce literature on the views of young people with ADHD about their diagnosis, its impact and how they should be supported. The few studies on what ADHD means to young people with a diagnosis in the UK have reached different conclusions.

ADHD can impact negatively on young people academically, socially and behaviourally, yet teachers can find it difficult to know how to best support them. Research into school interventions and strategies often identifies approaches that would work for pupils with many other types of need and do not seem to be ADHD-specific. For example, having a Teaching Assistant (TA), the teacher repeating information and the use of clear boundaries would benefit most students. Some strategies seem more compatible with targeting ADHD symptoms e.g. the use of fiddle toys and access to sporting activities. UK ADHD guidelines state young people should be offered a range of non-pharmaceutical support (NICE, 2018). However, there is evidence to suggest this often does not happen because of a lack of funding and teacher knowledge.

Qualitative research into the views of young people with ADHD is often limited in terms of sample size (Brady, 2014; Gibbs et al., 2016; and Moen et al., 2014 all had seven or fewer young people as participants) and many studies exclude comorbidities, despite the majority of people with ADHD having at least one other diagnosis (e.g. (Sikirica et al., 2015; Singh et al., 2010; Wiener & Daniels, 2016). Two studies identified in the literature search relied on participant-reported diagnosis (e.g. Gajaria et al., 2011; Walker-Noack et al., 2013) and some included children without a formal diagnosis (e.g. Ljusberg, 2011; Singh, 2012). Recruitment for studies is sometimes through support groups, which may mean findings are skewed towards those that feel they need more support (e.g. Honkasilta et al., 2016; Kendall, 2016). Also, previous research is often narrow in terms of the representation of different ethnicities (Gibbs et al., 2016; Singh, 2012; Singh et al., 2010; and Walker-Noack et al., 2013 had mostly white participants) and medication-use (e.g. Sikirica et al., 2015; Walker-Noack et al.,

2013; Wong et al., 2018). This means more studies need to be carried out in order to widen the transferability of the findings.

It would benefit young people with ADHD, families and professionals working with them, and the UK economy to further our understanding of ADHD and identify effective strategies and interventions to support pupils with ADHD. Chapter 3 describes the design of the research and methodology used.

### 3 Chapter 3: Methodology

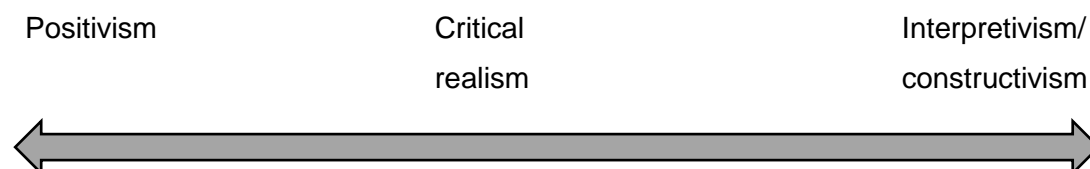
#### 3.1 Introduction

In this chapter, I consider my position as a researcher in terms of the paradigm adopted and through reflexivity, the recognition of oneself as part of the research process. The research design is outlined, and the local context and data collection tools are described. The concepts of validity and reliability, and the steps taken to strengthen both are reported. Participant recruitment is explained along with who they are, and the data collection procedure used. Key ethical concerns are discussed and finally, the data analysis methods are described.

#### 3.2 Research paradigm

Braun and Clarke (2013) assert a research paradigm comprises the beliefs, assumptions, values and practices that provide a framework for research. Paradigms sit along a spectrum from positivism to interpretivism:

Figure 3.1: Spectrum of paradigms



Positivism states there is a straightforward relationship between the world and our perception of it (Willig, 2001). Its proponents seek objective and quantifiable scientific statements based on observable data (Kvale, 2007). At the other end of the spectrum is interpretivism. At its most extreme form, this paradigm asserts there is no external reality, only meanings people attach to the world (Robson, 2002). Knowledge is formed by explaining how participants interpret and make sense of their experiences (Edwards & Holland, 2013). Interpretivists criticise positivism for being reductionist, whilst positivists criticise interpretivists for being too subjective and politicised (Guest, MacQueen, & Namey, 2014).

Critical realism combines a positivist ontology with constructivist epistemology by establishing some things exist independently of human knowledge, whilst recognising

knowledge is created from an individual's interpretation of reality (Bhaskar, 2013; Maxwell, 2012). Critical realists believe social reality has layers of individual, group, institutional and societal realities (Robson, 2002). This fits with Bronfenbrenner's ecosystemic model (1994) which was used as a framework for the interview questions employed in this research. Bronfenbrenner proposes different systems, from wider culture down to a person's individual difficulties, all impact on a person's development and behaviour.

A critical realist position was selected for this research because it fits with my personal perspective as a psychologist and the research aims. For critical realists, the meaning we attach to things has consequences for our actions and the physical world (Maxwell, 2012). In this research, this means how students, parents and SENCos understand ADHD, and the value they place on interventions, will impact on ADHD pupils' success in school, so it is important to understand their perspectives. Interviewing participants directly allows for the production of knowledge that reflects the truth about an individual's experiences of the world and creates an understanding of the causal mechanisms that underpin events and behaviour (Maxwell, 2012).

Emancipatory research promotes marginalised groups on their own terms and focuses on the experiences of traditionally marginalised groups (Edwards & Holland, 2013). This research has an emancipatory aspect in that it promotes the voices of a disadvantaged group: young people with ADHD.

### **3.2.1 Reflexivity**

Critical realism asserts researchers must be reflexive; they must recognise themselves as part of the research process (Edwards & Holland, 2013). Therefore, I acknowledge this research will be influenced by my culture and experiences. Below, some key features of my experience and values, which may be valuable resources as well as sources of possible distortion, are outlined (Maxwell, 2012).

I have worked in education since 2005, firstly, one-to-one with children and young people with ASD and then in a mainstream primary school as an Inclusion TA. I worked for one year as a Psychology Assistant in an EPS before starting doctoral training.

I am in favour of inclusion if it is in the best interests of a pupil, but also believe some children and young people are best placed in specialist provision. I believe teachers should support pupils with SEN by differentiating work, and using strategies and

approaches, so pupils can be included in a mainstream classroom and reach their potential.

Owing to personal experience of working with those with a diagnosis of ADHD, as well as through exploration of the literature, I subscribe to the bio-psychosocial perspective of ADHD. It is my view CAMHS and schools are underfunded and this impacts on the services and support children have access to.

The fact I am a white female in my mid-thirties may have impacted on the relationships I was able to build with participants, particularly the pupils, who were aged 11-15 and may have viewed me as a teacher figure, despite me explaining my job and role as researcher to them. The highest risk of power imbalance during interviews was with pupil participants because of the adult-child dynamic. For this reason, pupil participants were regularly reminded they could stop the interview at any time and given choices whenever possible e.g. drawing or talking.

Robson (2002) stated the quality of research is dependent on the quality of the researcher. Owing to my EP training and career experience, I feel confident in my interactions with the participants in the role of interviewer. For example, I have received training as part of the EP doctoral course and am practiced in active listening and building rapport, have an enquiring mind and show sensitivity towards difficult and personal topics. Also, at the time of interviews, I had one year's experience of the local schools and LA X, affording my understanding of the interventions, strategies, services and professionals which were referenced in discussion.

### **3.3 Research design**

The research questions are:

1. How do secondary-aged boys with ADHD experience their ADHD?
2. How do parents and SENCos perceive ADHD?
3. What do secondary-aged boys with ADHD think good practice is when supporting them in school?
4. What do SENCos and parents of secondary-aged boys with ADHD think good practice is when supporting young people with ADHD in school?

The research questions are explored using a qualitatively-driven mixed-method research design. This is where the core component of the research is qualitative and is supplemented by quantitative aspects in order to strengthen findings and knowledge



development (Morse, 2017). In this research, this was achieved by qualitative semi-structured interviews and activities being supplemented by pupil characteristic data gathered through questionnaires (described in section 3.3.1). Pupil participants were characterised in regard to their comorbidities, ADHD symptoms, attainment at school, medication use, comorbidities, and family context. All findings that related to pupil participants were compared to see if any of these attributes explained differences between participants. Using a mixed-method allowed different layers of social reality to be examined, both positivist and constructivist, in line with a critical realist perspective (Scott, 2010). A control group was not used because the research was not experimental by design.

### **3.3.1 Participant characteristic data**

Qualitative and quantitative information about pupil participants was gathered alongside interviews to give more understanding of each young person's circumstances. This information is important because knowledge is situated and it allows one to reflect on the relationship between the findings and the sample (Braun & Clarke, 2013).

A questionnaire was completed by a parent of each pupil that participated. It gathered demographic information and supplied context regarding their child's ADHD diagnosis and the support they had received (Appendix 9.8). Guidance from Braun and Clarke (2013) was followed to develop the questionnaire, including only asking questions the parent could reasonably be expected to be able to answer, and using questions that were as short as possible, expressed unambiguously, non-leading and non-judgemental. The questionnaire was developed in consultation with the research supervisors and someone who was selected because she is a mother and works in a school. The list of professionals the parents and pupils may have been in contact with was developed using the CAMHS website (LA X Council, 2017), and my knowledge from working within LA X.

Pupils were asked to complete a Conners 3 questionnaire (Conners, 2008a) to gain some insight into the perceived severity of their ADHD symptoms and as a basis for comparisons e.g. do pupils who report more hyperactivity-impulsivity symptoms view ADHD differently to those who report more inattention symptoms? These scales were designed to assess ADHD and common co-morbid problems in children and adolescents aged 6-18 (Conners, 2008b) and are described as a 'valuable adjunct' to the ADHD diagnosis in NICE guidelines (2018, para.1.3.2). However, they have been

criticised because there is little research into its validity and reliability (Gianarris, Golden, & Greene, 2001).

The SENCo for each pupil provided a school report where possible, and other information about the pupil including his attainment at school, if he knew about his diagnosis and if there was a way to help build rapport with him (Appendix 9.7). This information was used to create a pen portrait for each pupil (Appendix 9.16) and to aid comparisons between participants.

### **3.3.2 Semi-structured interviews**

Qualitative interviews were used to answer the research questions on the basis they provide rich and deep understanding of contextual factors; are suited to educational settings, especially in reference to the efficacy of interventions; and are exploratory in nature (McDuffie & Scruggs, 2008).

Research questions drive the direction of semi-structured interviews whilst leaving room for the participant to discuss concepts that are novel to the researcher (Willig, 2001). Semi-structured interviews allowed for question wording, order and explanations to be adapted to each participant's developing account (Braun & Clarke, 2013).

The interview schedules were developed in consultation with research supervisors, and based on interviews I had designed and carried out for a pilot research project which explored good practice for pupils with dyslexia (Flack, 2016). That research had transferable research questions about the experience of secondary school pupils with dyslexia and good practice in supporting those pupils and I found the SENCo and pupil interview schedules worked well in answering them. Bronfenbrenner's ecosystemic model (1994) was used to address the systems that may impact on a young person with ADHD in the interview questions (see Figure 1.2).

In constructing the interview schedules, questions that were closed, long, multi-step, leading, biased or contained jargon or unclear language were avoided, as suggested by Robson (2002) and Braun and Clarke (2013). Whilst the rest of the interview was semi-structured, each interview closed with a 'clean-up' question which queried whether participants felt we had sufficiently covered what it is like to have ADHD and how to support it in school (Braun & Clarke, 2013). See Appendix 9.9 for the interview schedules used.

The interview schedule for pupil participants was designed so it was accessible to them, given their likely strengths and needs based on age and diagnosis (Coates & Vickerman, 2013). A mixture of questions and activities were used (outlined in 'Pupil activities', Section 3.3.3), so were 'activity oriented' interviews (Gersch et al., 2017). Using a variety of methods reduces the risk of systematic bias occurring due to the specific set of limitations associated with any one method and can also reveal different aspects of a complex phenomenon, thereby providing richer data (Maxwell, 2012).

### **3.3.3 Pupil activities**

The use of activities supported pupils that find it difficult to sustain attention and by offering choices, empowered them to decide how they participated in the research (Mertens, 2015). All activities had been used in previous studies and were reported to be effective (the process of selection is described in Appendix 9.4). Some tasks offered the opportunity to draw, which previous research indicates is motivating and takes pressure off young people by giving the opportunity to respond without having to talk (Coates & Vickerman, 2013).

The activities were piloted to see how well they worked and if they were likely to result in data that would answer the research questions (Appendix 9.5). Because the number of possible pupil participants that could be approached was small, the activities were trialled with younger children in Key Stage 2 with a diagnosis of ADHD or behavioural difficulties consistent with ADHD symptoms. Following this, one activity was omitted and others were amended.

The activities used were:

- Timeline: participants were asked to draw or describe a timeline of their life with key moments related to school and ADHD (Appendix 9.10).
- Vignettes: participants were shown a picture of a teenage boy in school uniform and told he had just found out he has ADHD. Participants were asked what advice they would give and what could the boy expect to happen, feel and think.
- Strategies chart: participants used a grid to rate how useful they thought different strategies and interventions were for them in different lessons (Appendix 9.10). The strategies were identified from SENCo interviews and any the pupil mentioned. The participant rated the strategies using between 1-5 dots: from 'not very useful' to 'very useful'.
- Ideal school, classroom and teacher: participants were asked to draw or describe each of these.

- 'Post-it Note' activity: participants put 'Things I like about school' on one colour Post-it Notes, 'Things I don't like about school' on another, and 'Things I wish teachers knew about ADHD' on another.
- Three comments: participants were asked how others (e.g. teacher, parent, friend) would describe them and how they would describe themselves. Strengths cards with personality traits were provided as a prompt.

Responses for certain tasks and questions were collated and shared with pupil participants via email and they were asked for feedback. This was based on the idea of a 'graffiti wall' as described by Hill et al. (2016) where perspectives and experiences were put onto a wall that participants had access to in their own time. The authors reported it to be a popular and effective technique. Because time and distance constraints meant the pupil participants could not visit a physical wall, this technique was recreated virtually by setting up a Dropbox Paper website (Appendix 9.12). One pupil provided feedback through the website.

To assess whether the tools used in this research were effective in gaining the views of young people with ADHD, the ease of use of each tool and quality of response it elicited from each participant was rated on a scale from 1-5 by the researcher. A mean was calculated for the quality of response (Appendix 9.17). This was a separate analysis to the main research design so as to take advantage of the opportunity to share effective tools for gaining pupil voice.

### **3.3.4 Data collection procedure**

Data collection happened in the following order within each school that participated:

1. Information sheet given to the SENCo and informed consent obtained (Appendix 9.6).
2. SENCo interviewed.
3. Parent information sheets, consent forms and questionnaires completed (Appendices 9.6 and 9.8). Parents indicated on the consent form whether they would like to be interviewed or not.
4. Contextual information about consenting pupil/s gathered from their SENCo.
5. Pupils who met criteria and agreed to participate were interviewed after giving informed consent (Appendix 9.6).
6. Pupils completed Conners 3 questionnaire.
7. Consenting parents of the pupils interviewed.

8. Data gathered from pupils on five themes were collated on an online website and shared with pupils. Pupils were asked to give feedback.

### **3.4 Transparency, credibility and transferability**

The quality of a qualitative study can be judged by its transparency, coherence, commitment and rigour (Yardley, 2000).

Transparency and coherence are achieved by having transparent methods and data presentation, a good fit between theory and method, and reflexivity (Yardley, 2000).

Commitment and rigour can also be termed 'credibility', which is the qualitative equivalent of validity and reliability (Marchel & Owens, 2007). This is a judgement about whether the research is sound, defensible and well-grounded, if the research was carried out to a consistent process and the findings accurate (Guest et al., 2014; Robson, 2002). Guest et al. (2014) argue without this, research is useless or even dangerous.

Transferability is the extent to which the findings can be transferred to other contexts (Braun & Clarke, 2013). It has been argued if an experience is possible, it is subject to being universal (Willig, 2001).

Table 3.1 outlines how this research enhanced its transparency, credibility and transferability.

Table 3.1: Enhancing the transparency, credibility and transferability of this research

<b>Procedure:</b>	<b>How this enhanced transparency, credibility and transferability:</b>
Reflexivity to acknowledge researcher bias.	Transparency to the reader.
Description of time, place and context.	Readers can assess if findings could be transferred to their setting.
Use of multiple data sources.	Findings in analysis compared for confirmation or disconfirmation.
Sought feedback on instrument development.	Multiple perspectives reduced bias from any one person.
Piloting of instruments.	Ensured questions and activities made sense to participants.
Researcher as interviewer.	Interviewer knew the purpose of questions, improving their relevance.
Use of same interviewer every time.	No issues with inter-rater reliability.
Reassured participants their opinion was important; no right or wrong answers.	Reduced risk of respondent bias.
Audio-recorded interviews when participant consented.	Reduced risk of incomplete or inaccurate data.
Data monitored as it was gathered.	Improved data quality and consistency.
Sought feedback from pupil participants after interview.	Opportunity for clarification and to gather extra data.
Data transcribed using a protocol.	Transcription was consistent and appropriate for the analytic aims.
Precise codebook developed and used by one researcher.	Reduced risk of misinterpreting code meanings. Transparent documentation of codes and themes for supervision.
External peer review of coding and themes.	A check on individual bias and interpretation of codes.
All data coded at least twice, with a week or more in between coding.	Reduced risk of missed data and supported revision of the codebook.
Analysis methods and processes documented.	Increased transparency of analysis process for others to review. Facilitated internal review of processes.
Negative case analysis.	Mitigated bias by looking for evidence contrary to prevailing patterns identified in the data.
Supported themes and interpretations with quotes.	Directly connected interpretation with what participants said.
Findings compared to other studies.	Accumulative transferability.

Table references: Guest et al. (2014), Mertens (2015), Robson (2002), Willig (2001), Braun and Clarke (2013).

### **3.5 Local context**

Young people's experience of ADHD is different depending on their geographical and social context (Brady, 2014). By focusing on one LA, this research can focus in depth on the discourses around ADHD and support available for it without the added complication of different and possibly conflicting systems.

This research was conducted in a Local Authority (LA X) in the south of England which is a large town. The council's website (LA X Council, 2015) gives the following demographic information about LA X:

- It is estimated almost 150,000 people live there, a quarter of which are children.
- Around 40% of the population identify themselves as Asian and 35% as White British.
- Two-thirds of households have English as their first language.
- Approximately 40% of the population are Christian and almost one-quarter Muslim.

The Local Authority was ranked in the top 25% most deprived Local Authorities overall in 2013 (Department for Communities and Local Government, 2015).

Between March-December 2017, two ADHD practitioners from CAMHS in LA X were observed and spoken to informally to discuss the local ADHD assessment and treatment pathway. See Appendix 9.3 for a summary of this information.

In LA X, a pupil with ADHD and their family may receive support from a local SEN charity and a traded emotional, behavioural and social difficulties outreach team that offer one-to-one or family support and teacher training. The EP Service in LA X is traded and all but one school buy-in EP time.

### **3.6 Participants**

#### **3.6.1 Recruitment**

The research was restricted to secondary schools because primary and secondary schools differ in the way they are organised, and so the support they provide is disparate. Also, secondary-aged pupils are more likely to have been living with their diagnosis for longer than primary-aged pupils and this, along with their increased maturity, may mean they have more insight into their ADHD and the support they receive. Corroborating this, Moen et al. (2014) interviewed children and young people

with ADHD of different ages and reported older children were more reflective than younger children.

The research was limited to mainstream schools because the pedagogy and organisation of special schools is quite different. A survey conducted in September–November 2016 indicated there were at least 22 mainstream secondary school pupils with ADHD in LA X.

Homogenous purposive sampling was used; participants were selected according to characteristics that related to the objective of the research (Crossman, 2017). The SENCo of every mainstream secondary school in LA X was approached. Seven of fourteen schools participated. I was not the link EP to any of these schools at the time the interviews took place. The SENCos sent information and consent forms to every pupil that met criteria, which were:

- currently attends mainstream secondary school; and
- has a diagnosis of ADHD.

A balance of genders with pupil participants was aimed for but proved impossible due to the available participant pool. Pupils were not excluded for any comorbid diagnoses but those identified as anxious were not approached for ethical reasons (see ‘Ethical considerations’, Section 3.8). Pupils with a comorbid diagnosis were not excluded (as is commonly practiced), so as not to contribute to the marginalisation of this group, whose perspectives and requirements for support also need to be understood (Hill et al., 2016). It has been estimated between 59–87% of children with ADHD may have at least one comorbid disorder, and as many as 20% have three or more (Wolraich, Hannah, Pinnock, Baumgaertel, & Brown, 1996). Therefore, those with a comorbid disorder reflect how ADHD presents in reality. The interview schedules focused on ADHD and did not ask about the impact of comorbidities so that the aims of the research were upheld.

### **3.6.2 Participant details**

In total, twenty-three participants were interviewed. This comprises nine pupils, six SENCos (five female), and eight parents who also completed a questionnaire (six natural parents and two step-parents). One SENCo and two parents completed questionnaires but were not interviewed. Two SENCos agreed to participate, but no pupil participants were recruited in their schools. Their interviews have been included



in the analysis. Eight pupils completed Conners 3 questionnaires. All participants spoke English as their first language.

Two of the seven schools are grammar schools that have some pupils from outside LA X meaning they can access some services from LA X and some in the LA they live in. One of the schools has a resource base for ASD and another has one for physical disabilities.

All the schools included in the research buy-in between half to one day a week of time from the EP Service, meaning EP involvement is feasible for all participants.

Further details on pupil participants can be found in Table 3.2. Details of each interview type and length can be found in Appendix 9.11.

**Table 3.2: Key information about pupil participants**

<b>Year Group</b>	<b>Age</b>	<b>Ethnicity</b>	<b>Conners inattention criteria reached?</b>	<b>Conners hyperactivity-impulsivity criteria reached?</b>	<b>Comorbid diagnoses (as identified by parent)</b>	<b>EHCP? *</b>	<b>Age at diagnosis</b>	<b>Taking medication?</b>
7	11	Mixed white/black Caribbean	No (but 'very high' score)	Yes	Had Speech and Language Therapist input	No	7	No
7	11	White British	Yes	Yes	ASD	No	6-7	Yes
7	12	White British	Yes	Yes	ASD	Yes	7-8	Yes
8	13	White British	Yes	Yes	ASD	No (in process)	9	Yes
8	13	White British	Yes	No	ASD, Dyslexia	Yes	9	Yes
8	12	White British	No	No	Sensory processing, developmental delay	No	7	No
9	13	White British	No	No (but above average score)	ASD, Dyspraxia	Yes	10	Yes
9	14	White British	N/A	N/A	ASD, Dyspraxia/ DCD, Dyslexia, Hypermobility	No (in process)	5	Yes
10	15	British/ other mixed	Yes	No (but above average score)	Learning difficulties	Yes	4-5	No

\*EHCP is an Education, Health and Care Plan. They are for children and young people aged up to 25 who need more support than is available through the SEN support a school is expected to put into place. EHCPs identify educational, health and social needs and set out additional support the child requires to meet those needs (Great Britain, 2017).

### **3.7 Ethical considerations**

Ethics should be an integral part of research planning and implementation to guard against possibly harmful effects of research (Mertens, 2015). This research gained ethical approval from the ethics board, in line with the UCL Code of Conduct for Research (University College London, 2013) and the UCL Statement of Research Integrity (University College London, 2015; see Appendix 9.2). The research was carried out in accordance with British Psychological Society guidelines (The British Psychological Society, 2014). Special consideration was given to the inclusion of child participants with ADHD, who represent a vulnerable population.

#### **3.7.1 Informed consent**

Informed consent was gained from all research participants. It involves informing the participants about the: overall purpose of the research; main features of the design; and possible risks and benefits of taking part in the study (Kvale, 2007).

All potential participants received an information sheet (Appendix 9.6) that explained the nature of the research, confidentiality, data security and their right to withdraw from the research. This was reiterated at the start of interviews. Permission was sought from each participant to audio-record the interview. If the participant did not agree to being recorded, permission to take written notes was sought. One pupil participant did not wish to be audio recorded but consented to written notes.

There are particular ethical concerns when working with children, including whether they can truly give informed consent (Robson, 2002). For this reason, parents gave written consent for their child to participate, and an information sheet and consent form was developed in age-appropriate language, specifically for pupil participants (Appendix 9.6).

#### **3.7.2 Confidentiality**

Confidentiality ensures the masking of any private data that could lead to the identification of participants (Kvale, 2007). To ensure participant quotes cannot be linked with them in any way, pseudonyms are used on transcripts and in this thesis. Pen portraits (Appendix 9.16) and participant details (Table 3.2) are not named so the people that know the pupil took part in the research (i.e. parents and SENCOs) cannot identify the pupil's quotes.

Participants were informed the only instance in which what they said would be reported to someone, was if a safeguarding issue arose. This did not occur.

Electronic data are stored in password-protected files on one laptop and one USB. Paper data are stored in a locked document storage box. Data will be kept for five years.

### **3.7.3 Participant welfare**

The principle of beneficence ensures the least possible harm to participants (Kvale, 2007). Potential pupil participants identified by the SENCo as being anxious were not approached in case taking part in the research would put them at increased risk of psychological harm or distress. SENCos were asked if pupils had any sensitivities about ADHD and interview questions would have been amended if needed. This was not required.

Participants may later regret disclosing certain information during an interview (Kvale, 2007). Participants were informed they could choose not to answer any question and of their right to withdraw from the study before, during or after the interview. My email address was provided to all participants, who were encouraged to make contact with any concerns or questions they had.

All pupils and SENCos were interviewed in their school so they felt comfortable. Parents indicated their preferred interview setting, either in their home, at their child's school or over the telephone. Each interview was conducted in a private room. Effort was made to build rapport with all participants and empathy, active listening and humour were used in interviews as appropriate.

## **3.8 Data analysis**

Data was analysed using thematic analysis, as outlined by Braun and Clarke (2013) alongside some elements of applied thematic analysis (Guest et al., 2014). These two analysis methods are described below followed by the exact process of analysis used. A table describing alternative data analysis methods that were considered and not selected for use can be found in Appendix 9.13.

### 3.8.1 Thematic Analysis

The seven stages of thematic analysis (Braun & Clarke, 2013) are:

1. Transcription.
2. Familiarisation with the data.
3. Coding.
4. Searching for themes.
5. Reviewing themes.
6. Defining and naming themes.
7. Writing/ final analysis.

A code is a word or short phrase that captures the essence of why a piece of data may be useful. One excerpt of data can be coded in as many ways as fits the purpose of the analysis. Coding must be inclusive, thorough and systematic. It is an evolving process where codes are revisited and modified throughout. See Appendix 9.15 for an example of transcription with coding.

A theme captures an important pattern or meaning in the data in relation to research questions and has a central organising concept that runs through the codes within it. See Appendix 9.15 for examples of a theme and its corresponding codes. Theme-based analysis allows the salient features of the data to be identified and for the interpretation of patterns.

Braun and Clarke (2013) outline how thematic analysis has been criticised for:

- Lacking the substance of theoretically driven methods such as interpretative phenomenological analysis and grounded theory.
- The possibility it can be descriptive rather than interpretative.
- Losing the voices of individual participants when there are large datasets.
- Not investigating the effects of language use.

To counter these criticisms, aspects of applied thematic analysis were used, which added the benefit of quantitative aspects in the reporting of findings. Interpretation was included in the analysis and findings took account of all participant views. The research aimed to represent participant views rather than analyse their choice of language to the depth discourse or conversation analysis would.

### **3.8.2 Applied Thematic Analysis**

Guest et al. (2014) describe the steps of applied thematic analysis:

1. Read and re-read the data, looking for key words, themes or ideas.
2. Identify key themes in text.
3. Develop codes and apply them to the data.
4. Develop codebook.
5. Form themes from implicit and explicit ideas within the data.
6. Graphically display relationships between codes within the dataset.
7. If appropriate, develop theory from the analysis.
8. Create a narrative and use quantitative aspects in the reporting of themes.

This process is similar to Braun and Clarke's thematic analysis (2013) in that it identifies, analyses and reports themes within data but themes are identified before coding and it employs a wider range of analytic devices, most notably by providing statistics in the reporting of themes (Guest et al., 2014). A basic comparative analysis can also be carried out where themes present for different participant groups are compared for similarities and differences (Guest et al., 2014). This research reports on the number of participants that correspond to a theme and compares pupil to adult participant groups and different pupil factors e.g. those with ASD to those without. Applied thematic analysis invites the researcher to draw on previous constructs and theories, as I do throughout this research (Mertens, 2015; Willig, 2001).

### **3.8.3 The process of analysis**

An analysis plan, adapted from Guest et al. (2014), was created (Appendix 9.14). This set out the purpose of the analysis, timeline, size of the dataset and audience of the analysis.

This research is exploratory so the codes were inductive, meaning they were derived from the data (Guest et al., 2014). Codes were defined using NVivo 11 (QSR International Pty Ltd, 2015). A codebook was printed so codes could manually be sorted into themes. Using NVivo made coding quicker, created an audit trail and meant data were more organised and searches could quickly be carried out (Braun & Clarke, 2013). A limitation of NVivo is the temptation to over-code (Braun & Clarke, 2013).

Child and adult data were analysed separately to place child voice at the centre of the research. This is a unique feature of this research.

The process of analysis is detailed in Figure 3.2 below:

Figure 3.2: Process of analysis

Stage	Step	Timeline
Gathering data	<p>Interview transcribed by researcher or transcription company.</p> <p>Transcription checked by researcher<sup>1</sup>.</p> <p>Transcriptions and other contextual data added to NVivo as completed.</p>	June-December 2017
First stage of analysis	<p>↓</p> <p>Transcriptions and parent questionnaires each coded twice using NVivo<sup>2</sup>.</p> <p>Codes checked by supervisors and other Trainee EPs intermittently.</p> <p>Codebook revised regularly throughout coding<sup>2</sup>.</p>	By mid-January 2018
Second stage of analysis	<p>↓</p> <p>Final round of coding.</p> <p>Code book finalised<sup>2</sup>.</p> <p>Codes grouped into themes semantically<sup>2</sup>.</p>	By end of February 2018
Final stage of analysis	<p>↓</p> <p>Data for semantic themes and sub-themes read and level of interpretation added by describing what was said about each theme. Child and adult data analysed separately and compared.</p> <p>Developing themes and sub-themes looked at with supervisors and edited.</p> <p>Key quotes identified.</p> <p>Negative cases identified.</p>	By end of March 2018

<sup>1</sup> See Appendix 9.15 for examples of: transcription with codes; how the codebook was developed; final codes; and how the codes were grouped into themes.

Reporting	<div data-bbox="721 174 798 264" data-label="Image"> </div> <p>Themes and sub-themes described in findings chapter.</p> <p>Diagrams of themes and sub-themes created.</p> <p>Key quotes selected to illustrate each sub-theme.</p> <p>Quantitative aspect added to describe strength of each sub-theme and compare groups of participants.</p> <p>Key findings compared to previous research.</p>	By end of April 2018
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### 3.9 Summary

This chapter outlined the critical realist stance and qualitatively-driven mixed-method design adopted in this research. Semi-structured interviews were selected to explore constructions of ADHD and views on good practice when supporting pupils with ADHD in school. Participant information was also gathered to give greater richness to the data and analysis. Thematic analysis was used inductively to describe and interpret patterns in the data; the findings are described in Chapter 4.



## **4 Chapter 4: Findings**

This chapter presents the findings from the analysis of data. Perceptions of ADHD are presented first, followed by views on good practice. Finally, a summary of the findings is presented.

### **4.1 Analysis of interview data**

All data were inductively coded and pupil views were initially themed separately to adult views to preserve the promotion of young people's voice in the research. However, many of the codes, themes and sub-themes were evident across all participant groups, therefore the research questions were grouped according to their overarching theme.

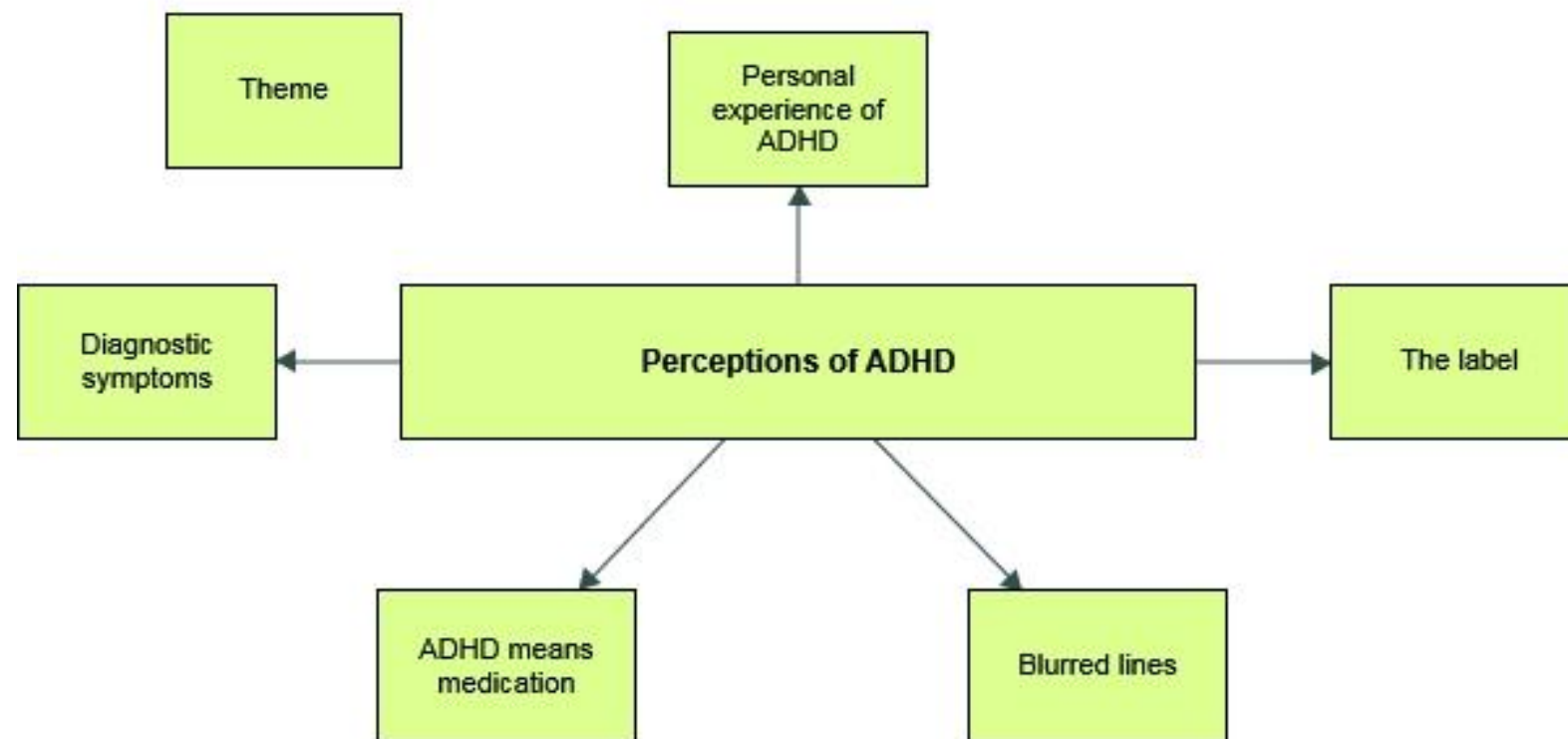
Pupil views are privileged by being reported first under each subtheme, followed by parent and then SENCo views.

All participants have been given a pseudonym: pupils have been given a first name, parents are referred to as Mr or Ms (surname) and SENCos are SENCo A, B, C etc. Where I do not attribute opinions or quotes to a participant, this is so their anonymity is preserved e.g. they may be identifiable by an intervention they have participated in. The term 'son' is used for both natural- and step-son. Unless specified, findings are from participant interviews.

### **4.2 Perceptions of ADHD**

Five main themes were identified from the thematic analysis regarding perceptions of what ADHD is (Figure 4.1). A more detailed thematic map showing themes and subthemes can be found in Appendix 9.18.

Figure 4.1: Thematic map for perceptions of ADHD



### 4.2.1 Diagnostic symptoms

The account of all but one participant on the definition of ADHD was in line with the current diagnostic symptoms of hyperactivity, impulsivity and inattention (NICE, 2018), reviewed below. The one pupil that did not identify these symptoms equated ADHD with anger (see ‘personal experience of ADHD’ theme, Section 4.2.2).

Eight of the nine pupils completed Conners 3 questionnaires after their interview. Their scores did not always match how they explained ADHD in themselves and others qualitatively. For example, Owen reported stronger inattentive than hyperactive-impulsive symptoms on the questionnaire, yet he described someone with ADHD as being hyperactive.

#### Hyperactivity

Six pupils, all eight parents<sup>2</sup> and five of the six SENCOs talked about hyperactivity. Many directly used the words ‘hyper’ or ‘hyperactivity’ or described having lots of energy, finding it difficult to sit still and fidgeting. For five parents, hyperactivity meant their children did not sleep much.

*Harry: “Energetic... That’s pretty much it. You’re just really hyper...”*

*SENCO F: “...ADHD is like hyper... hyper-ness.”*

#### Impulsivity

Three pupils, five parents and two SENCOs talked about impulsive behaviours, such as swearing or shouting out in class. Two pupils said they can tell if someone else has ADHD because they often ‘mess about’ in class. Ms Arnold related impulsiveness to brain chemistry. Adult participants described impulsivity ranging from irritating but harmless behaviours such as repeatedly pressing the bell on the bus, to dangerous behaviours.

*Patrick: “...a bit more shouting out... Impulsive, if that’s the word...”*

*Mr Wade: “... things being cut with sharp knives, things being cut with blunt knives... hobs being lit...”*

#### Inattention

Five pupils, all parents and six SENCOs mentioned inattention or being easily distracted. Owen and Ben talked about it being easier to focus at break-times because

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<sup>2</sup> N.B. Two of the parents interviewed were parents of the same pupil participant.

they can eat. Alfie said it was easier to concentrate in the morning. For adult participants, inattention was something young people with ADHD cannot control and it impacts on their learning. Inattention means young people get bored easily, flit between activities, are restless and can be 'away with the fairies'.

*Dominic: "...attentions is really hard."*

*SENCo B: "...you can just see that they are fighting everything inside of them not to be a bit more restless or... to really try and pay attention."*

#### Level of severity

Two pupils, three parents and three SENCos discussed different levels of severity of ADHD. Both pupils felt they were at the milder end of this spectrum. Adults said it was not always obvious if a young person has ADHD. One SENCo described how the symptoms can affect each young person so differently the label of ADHD did not tell her anything useful.

*Patrick: "...there is a spectrum... you can have it really badly, like you can't concentrate, you get distracted... And you can have it mildly..."*

*SENCo E: "I think it's one of those words that gets bandied about and attributed to lots of pupils, that seems to vary from child to child what the symptoms are...it doesn't tell me very much when they say ADHD."*

### **4.2.2 Personal experience of ADHD**

As well as the diagnostic symptoms, all participants discussed other aspects of ADHD.

#### Conduct problems

Eight of the nine pupils, all eight parents and four of the six SENCos mentioned conduct problems including hurting or threatening others, walking out of school, not adhering to behavioural expectations and risky behaviours such as setting fires and taking a knife into school. The only pupil that did not mention antisocial behaviour scored as meeting criteria for Conduct Disorder on Conners 3, suggesting he had conduct problems but did not talk about them in the interview. Five pupils said ADHD explained some of their challenging behaviour, including three who reported medication had improved their

behaviour. Just one pupil admitted to using ADHD as an excuse for poor behaviour, and only when he first found out about his diagnosis.

*Dominic: "[my friends] think that I'm... a bit violent sometimes."*

*Ms Morrison: "...they do a lot for attention."*

### Anger

Five pupils, six parents and one SENCo linked ADHD with anger. There were no clear links between pupils that talked about anger and their different attributes e.g. ADHD symptoms or comorbidities. For one pupil, Ben, ADHD is exclusively about anger whereas for the other four, it is one of a range of symptoms. Pupils can feel frustrated and get 'wound up' by other pupils distracting or teasing them. Some pupils said they become angry when they are told off or punished. SENCo E said anger management might be needed by some pupils with ADHD.

*Ben: "...I think it's just this thing what makes you like, angry."*

*Ms Chambers: "I also think he gets frustrated a lot because he gets angry quite often. He has quite a short fuse."*

### Cognitive functioning difficulties

All pupils, six parents and one SENCo mentioned (and demonstrated, in the case of some pupil participants) cognitive functioning difficulties including problems with memory, reflection, prediction, generating ideas, following instructions and completing school work. Of these, memory difficulties were mentioned by the most participants, which one parent linked to inattentiveness, and was reflected in the timeline activity, when some pupils could not recall much from their past. Four pupils either described problems with learning or reported significant learning problems on Conners 3. Seven pupils had difficulties reflecting on their behaviour or imagining the unknown. This tended to be, but was not limited to, pupils that also have a diagnosis of ASD, perhaps reflecting the ASD trait of inflexibility of thought. Four parents and one SENCo said young people with ADHD see or assimilate things in a different way.

*Elliot: "I forget a lot of things."*

*SENCo C: "...young people...whose brain is wired in a slightly different way in terms of how they assimilate what they're doing and how it's ordered in their head."*

### I/ he cope(s) better as he gets older

Six pupils said their behaviour and success in school or behaviour had improved over time. Five parents and four SENCos felt young people with ADHD learned strategies that meant they were better able to cope with ADHD symptoms as they got older. One parent thought her son being more socially aware also had an impact and had talked about the possibility of not using the ADHD label anymore. However, two SENCos spoke about parents wanting ADHD to be 'fixed' and having to explain they cannot do that.

*Dominic: "I'm calming down."*

*SENCo A: "...as they get older they learn strategies and tricks to manage what they've got"*

### Social relationships

Eight pupils, all parents and three SENCos discussed social difficulties. Some were linked directly to ADHD such as being: socially excluded because they were often in trouble at school; teased for not listening in class; seen as annoying; or frustrated by peers that distract them. Others were not necessarily linked to ADHD. The six pupils with comorbid ASD all mentioned or demonstrated social skills difficulties, such as not knowing what to do at break-time, and some peer problems were seen as typical of secondary school, including bullying. Two SENCos said pupils with ADHD required intervention to understand how their symptoms can impact on others. Mr Wade explained hyperactivity means his son speaks so fast it can be difficult to understand what he is saying.

However, all pupils also spoke about having positive peer relationships. Harry and Owen thought their friends would describe them in more favourable terms than parents and teachers would. Despite not liking 'the other people' at school, Dominic said he has a girlfriend and 'forty-two friends'. To some, their friendships are important. In the vignette activity, Owen advised the young man who had just been told he has ADHD to tell his close friends how he feels, which suggests he can confide in his friends about ADHD. SENCo C found pupils tend to form friendships with peers with similar difficulties. Similarly, three pupils mentioned having friends with ADHD or autism.

*Harry: [How would your parents describe you in three words?]*

*"Annoying, annoying, annoying."*

*Alfie: "The reason I like coming to school is because I'm seeing friends."*

### Emotional difficulties

All parents and one SENCo discussed emotional difficulties. Some were linked directly to ADHD such as self-esteem and being upset by symptoms. For example, Ms Kirk said her son was once extremely upset by being too distracted to do homework and Ms Arnold described how, in primary school, her son did not feel understood nor safe because he was often in trouble. For others, it is unclear how much their emotional difficulties are caused by ADHD or other problems such as learning difficulties. For example, Ms Morrison said her son does not like school because he finds it difficult.

*Ms Arnold: "...every day he would start pulling his hair, and it coincided with him being able to visually see the school gates."*

### **4.2.3 The label**

Participants reported positive and negative aspects to a young person being given the label of ADHD. It is perceived by some adult participants to be unclear because of the heterogeneity of symptoms.

#### I am not normal

Two of the nine pupils described the opposite of having ADHD as being 'normal'. The vignette activity allowed five pupils to express negative feelings in relation to ADHD when asked how the young man might feel after being told he has ADHD. For example, they said the boy in the photograph might be feeling sad, upset, worried, confused, angry, shocked and annoyed. Will thought some aspects of life would be easier without ADHD.

*Ryan [vignette activity; the boy might be thinking]: "I've got a disability now, I'm sad."*

#### I am (he is) no different

Seven pupils, seven of the eight parents and two of the six SENCos talked about how ADHD does not make a young person different and described positive aspects. Will said having ADHD is a 'perk'. Positive aspects of ADHD included:

- being honest, curious, inquisitive and competitive;
- having practical intelligence;
- having lots of energy;
- eagerness to learn;

- ability to argue a point of view;
- being 'bright kids'; and
- always having music playing in their head.

Several pupils could not think of any ways having ADHD made their day different to that of others. Most said their friends do not think ADHD is an issue. Only one pupil was conscious about peers knowing about his ADHD. All pupils described themselves and said others would describe them in positive terms including intelligent, sporty, creative, funny, friendly, kind, happy, and brave.

All pupils except one had high standards for themselves in school or aspirations for the future including wanting to gain qualifications, be a teacher, gamer, footballer or mechanic, and travel the world. The pupil that did not know what he wanted to do was having a difficult time in school and moved to a specialist provision some time later. All pupils described subjects they found harder and ones they did well in, indicating they had had a balanced view of their strengths and difficulties.

*Ryan: "It doesn't make you any different... you're the same person who you were before you knew, you just know now."*

*Dominic: "You just feel so more energised and more active..."*

*Ms Fuller: "I don't see [my son] as he's got ADHD, ASD, 'cos [sic] all my children are different... I don't see him as his label..."*

### Understanding myself

Six pupils felt it was useful for them to be diagnosed with ADHD. This was partly so they understood themselves and so teachers knew about their difficulties. However, Owen did not think it was useful or good to find out about ADHD but did not explain why. Harry and Alfie were indifferent to knowing about their diagnosis.

*Ryan: "Yeah, because now I've actually got a reason for why I shout at people when it gets later in the day."*

### Stigma

One pupil spoke about the stigma of ADHD and did not want his peers to know about his diagnosis. He attended grammar school and following specialist intervention, thought he maybe no longer had ADHD, which was also reflected in his Conners 3 responses. Two others felt judged by others because of behaviours linked to ADHD symptoms. Ryan and Patrick would rather not ask for help because of what others



might think. In Patrick's class, pupils groan when he puts his hand up because he has missed something due to his inattention.

Six parents and one SENCo talked about stigma being linked to several factors including the child often being in trouble at school, the young person not wanting to be different to others, assumptions school staff and professionals can make and support offered. For example, Ms Morrison explained her son's school had initially said they could not meet his needs based on his diagnoses. Mr Fuller felt stigma came about because of a culture that does not embrace individualism and ADHD being an 'invisible' disorder. Mr Wade felt it was due to stigma regarding all mental health conditions. Ms Arnold said being given the label had a bigger impact on her son than any other aspect of having ADHD. Pupils wanting to be the same means it can be difficult to put support in place. Ms Arnold felt some parents do not want to talk about ADHD and this can mean children do not get a diagnosis.

*Patrick: "I just didn't want anyone to know I had ADHD."*

*Mr Fuller: "I think there's such a stigma attached to it that nothing else does."*

#### Future worries

Two parents and one SENCo said they worried about prospects for young people with ADHD. This included concerns about job options and leaving the safe school environment. Two pupils also worried but about typical issues such as exams and getting a job.

*SEnCo B: [college or an apprenticeship is] "...a challenge for a student with ADHD... because it's a change in environment, it's not as safe a place as when you're in school..."*

#### Is misunderstood and unclear

Three pupils, two parents and one SENCo were not completely sure what ADHD was, though they could describe symptoms. Six parents and one SENCo mentioned 'naughty boy syndrome', which means some dismiss young people with ADHD as naughty children that simply need better behaviour management strategies. Two parents had been given mixed information about whether ADHD is a life-long or childhood condition. Two SENCos said some parents expect symptoms to be 'fixed'.

All parents and five SENCos spoke about the label of ADHD being misunderstood by others, or not giving a clear picture of a young person's difficulties, nor what support

they need. Misunderstandings impact on the length of time before diagnosis, families being believed and school staff's understanding and willingness to implement intervention. For example, Ms Kirk explained her son's difficulties to a previous SENCo, who replied, 'He'll be fine, I think they just put it on most of the time.'

Five parents and four SENCos felt ADHD was under-diagnosed. SENCos reported having many more pupils with ASD than ADHD, which does not match national prevalence rates (Beau-Lejdstrom et al., 2016; Taylor et al., 2013).

*Ms Arnold: "...as a parent of a child who has ADHD, I still don't really understand it, you just... manage it the best way that you can."*

*Mr Wade: "...we had been saying all that time that there was something there and no-one listened."*

### Challenges to inclusion

Adult participants discussed factors linked to ADHD, including challenging behaviour and pupils being distracted or frustrated by others, which mean inclusion in mainstream secondary school can be challenging. Some pupils also mentioned these factors but did not link them to inclusion. Four parents said moving classrooms, more difficult work and having different teachers made secondary more difficult than primary school and can exacerbate symptoms.

Three parents said secondary schools were reluctant to put certain interventions or strategies in place, such as one-to-one TAs, movement breaks and kinaesthetic resources. One pupil participant moved to a specialist provision some time after he was interviewed because the school could no longer meet his needs. For students on medication, not taking it can mean their behaviour is unacceptable and they are kept out of class or excluded.

*SENCo B: "You're trying to be as inclusive as possible, but by being inclusive, it's challenging that student."*

*Mr Wade: "But they've done pretty much everything they could here, really. And it hasn't worked but that's not because of them, that's because of who [my son] is."*

#### 4.2.4 Blurred lines

Understanding ADHD as a stand-alone disorder is difficult because of the high rate of comorbidity and impact of family context.

##### Comorbidities

Only one pupil briefly mentioned ASD despite six having a comorbid diagnosis. All parents reported their son had comorbidities, meaning no pupil participants had 'pure' ADHD. One of the six SENCOs said ADHD pupils often needed interventions for other difficulties, including literacy and numeracy.

Parents saw some autistic traits as separate to ADHD, including disliking change, inflexible behaviour and taking things literally. More commonly, ASD symptoms crossed over with ADHD to cause problematic behaviours including an obsession with food, risky or inappropriate behaviour, hoarding, difficulty maintaining friendships, not understanding social boundaries, and not responding to delayed gratification. For three pupils, their ASD diagnosis came much later than their ADHD diagnosis. One parent said ADHD could be a feature of the autistic spectrum.

One parent had explored developmental delay and her son was seeing a Neuro-Developmental Therapist, which she and her son reported was working well. She had told her son 'retained reflexes' was the real issue and he could 'get rid of' his ADHD label once his reflexes were switched off. She added 'getting rid' of the ADHD label was motivating her son to change his behaviour.

*Mr Wade: "...the ADHD will keep him going and going and going and going until he hits that wall when he loses something and then the ASD will kick in."*

*Ms Kirk: "He's got ASD and ADHD so it's difficult, they cross over... you don't know which is which really."*

##### Family context

Six of the nine pupils mentioned potentially difficult family circumstances, and data from parent participants revealed factors pupils did not mention e.g. parental suicide, parental drug addiction, mental health problems in the family and siblings with SEN. Four of the eight parents spoke about traumatic experiences and one felt a combination of home and school factors may have impacted on her son. Four of the six SENCOs felt an ADHD diagnosis can sometimes be explained by family context.

One pupil that was not able to live with his mother said it impacted on him in school but five pupils mentioned life events such as divorce and absent parents without any visible emotion attached. Parents were better able to reflect on the impact these issues may have had on the pupils. For example, one parent mentioned several factors she felt could have had a role in her son's challenging behaviour, including living with her parents, not focusing on social skills, and not being stretched in school. However, another parent felt school staff attributed ADHD symptoms to her son's father's death and did not consider ADHD.

*Ms Arnold: "...I don't think people look at the behaviours and all the different factors that could be causing them. I think it's really quick to say ADHD, put it in that box. This is what CAMHS do."*

*SENCo E: "And sometimes I wonder if it's wrongly diagnosed, in that it might be more poor parenting or poor strategies at home..."*

#### **4.2.5 ADHD means medication**

Medication use was strongly linked with ADHD.

##### ADHD means medication

Six of the nine pupil participants were taking medication and inextricably linked having ADHD with taking it. There was a sense of being required to take medication and none talked about wanting to stop. Pupils often mentioned medication when asked what ADHD is. One parent was advised by a local charity and CAMHS that her son would need medication in secondary school. Parents and SENCos reported pupils that take medication tend to stay on it, despite most acknowledging its effectiveness decreases. Only one SENCo talked about pupils refusing medication. Two of the six SENCos said when pupils take medication, school staff take on the role of monitoring behaviour and reporting changes to parents or CAMHS.

*Ryan: [What is ADHD?] "It means that every morning I have to take tablets and I have to do the same thing every night"*

*Ms Arnold: "...they said, 'It's very uncommon that a child will get through secondary school without being medicated.'"*

### Main treatment

Medication is the main treatment offered for ADHD. One pupil, who was not taking medication, was aware CAMHS did not offer other treatment options. The two parents that decided not to use it with their sons were discharged from CAMHS. One parent that was discharged felt abandoned. One SENCo and one parent felt this was because of a lack of knowledge about how else to support young people with ADHD. One parent explained her son started taking medication after a request for counselling was turned down.

*Ms Booth: "...from that day onwards, since I refused the medication, I haven't had any help whatsoever from anybody."*

*Mr Wade: "maybe...you would presume if someone just has ADHD, chuck some tablets in them and they'll be alright. It doesn't always work [laughs]."*

### The drugs usually work

Pupils that take medication agreed with parents and SENCos that it usually works, though four parents acknowledged medication does not work for everyone and its efficacy can decrease over time. All participant groups said it can improve a range of symptoms including concentration, impulsivity and hyperactivity, and this in turn impacts positively on behaviour, learning and friendships. No pupils questioned the effectiveness of medication. Ms Kirk said medication had an immediate positive effect and described it as a 'wonder drug'. However, medication can wear off and this can mean parents have to deal with behaviour issues at home.

All SENCos said medication can be effective and they usually notice when pupils have not taken it. Pupils forgetting to take medication can be frustrating for school staff and mean pupils are seen as unmanageable without it. Two SENCos felt the responsibility of adherence to medication is an issue and could be a child protection concern if parents are not meeting their child's needs. Two SENCos said time on medication can be a 'window of opportunity' for teaching pupils coping strategies.

*Mr Fuller: "It's like yin and yang, night and day. The best thing we've ever done for [my son] was get him medicated."*

*SEnCo A: "...we get the beautiful little children that come in from nine till three... when that medicine wears off either side, the parents are having an eternal battle."*

### Side effects

No pupils and only two parents mentioned experiencing side effects (sleep problems and becoming withdrawn). Another parent had balanced the possibility of side effects, including stunted growth, with the benefits he saw and concluded taking medication was the best decision for his son. Five SENCOs talked about side effects and these could be severe, including depression, aggression and suicidal thoughts. For two SENCOs, the side effects were so concerning they would not give their own child ADHD medication if they were diagnosed and another had disagreed with a parent's decision to continue with their child's medication when he became unresponsive and 'lost his personality'.

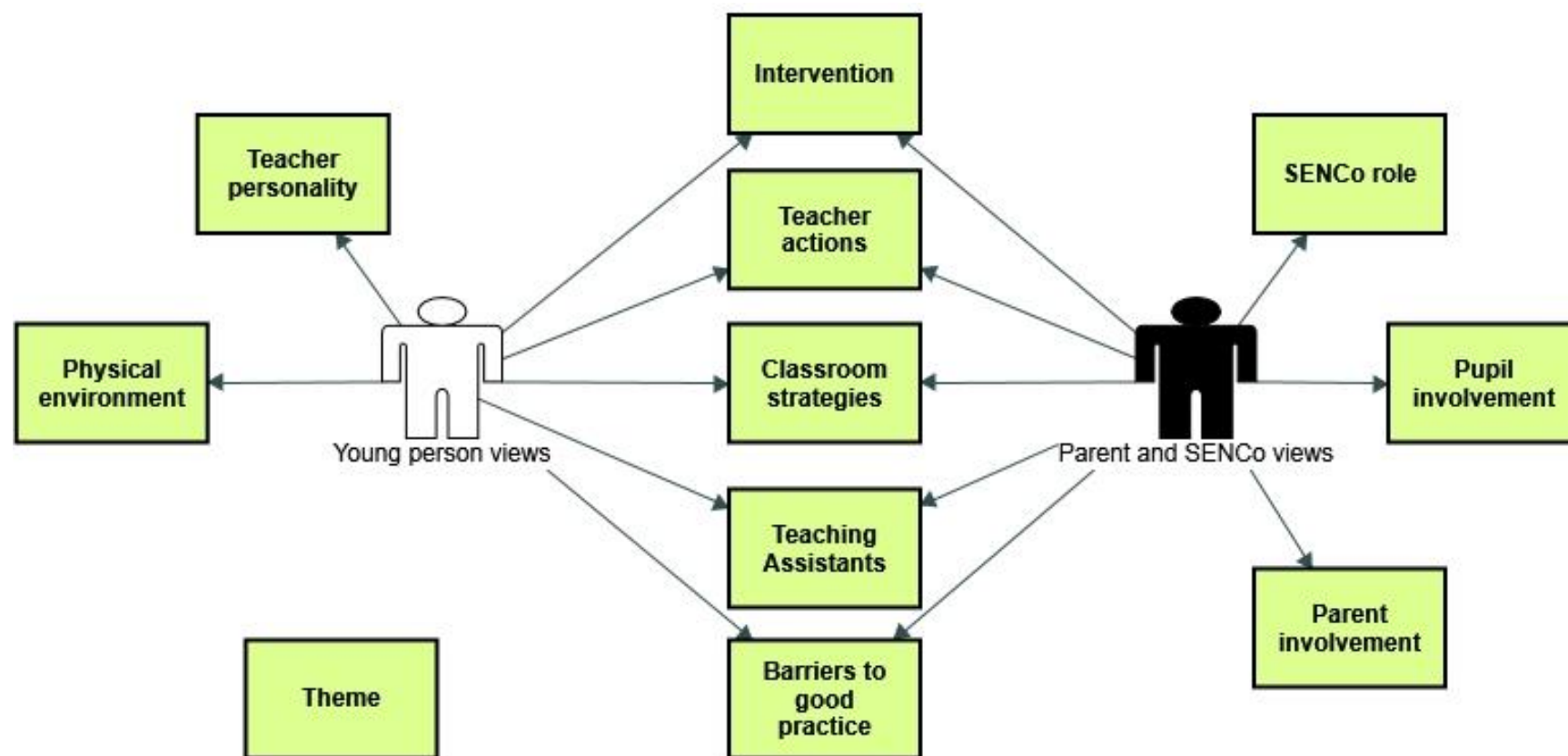
*Ms Chambers: "[medication] made him quite like a zombie... there was no personality there. He was just tired and withdrawn."*

*Mr Fuller: "...do you want [my son] to be able to... concentrate or are you worried about he's not going to grow an inch more? What is it you want?"*

### **4.3 Views on good practice when supporting young people with ADHD**

Five main themes that all participant groups contributed to were developed from the thematic analysis, a further two themes were just for pupil participants and three themes for parent and SENCO participants (see Figure 4.2). More detailed thematic maps with themes and subthemes can be found in Appendix 9.19.

Figure 4.2: Thematic map for views on good practice when supporting young people with ADHD



### 4.3.1 Interventions

All participant groups talked about a range of interventions they thought worked well for young people with ADHD.

#### Calming activities and support

Calming activities were the most commonly mentioned intervention. Students said listening to music (Ryan), drawing (Ben), origami (Dominic), or fidget toys (Patrick) would be useful. Feelings were mixed on the efficacy of mindfulness: Patrick said it would be helpful, whereas Harry thought not because it was 'boring'. Four parents and three of the six SENCos found giving students things to keep their hands busy, including colouring, origami and fiddle toys, helped keep them calm.

All SENCos recognised young people with ADHD may need emotional support and each school had its own systems for this. Six parents said their sons have someone to talk to in school, including TAs, the SENCo or a counsellor. They all felt this was positive. However, two parents were not happy with emotional support available for their sons. Interventions mentioned as good practice included emotion coaching, having a quiet place to go at break-time, anger management, mindfulness, mentoring and Lego Therapy. One SENCo developed an intervention with her EP that incorporated mindfulness and psychoeducation. However, at the time of interview, the intervention had not yet been evaluated.

*Ms Arnold: "...you cannot underestimate the power of just meeting with him twice a week to get him to talk."*

*SEnCo A: "we... explain to [pupils] what happens when they get stressed and anxious and frustrated and just help them to learn techniques to calm down."*

#### Specialist intervention

Two of the nine pupils and one of the eight parents were enthusiastic about specialist interventions, including NDT, Nurture Group and use of ADHD role models, stating that they worked well. One parent spoke about a specialist ADHD course her son had attended through a charity in a different LA. The main impact of this was her son seeing more severe ADHD symptoms in the other attendees, which gave him an understanding of how his classmates might feel about him. She felt it had helped his self-esteem because he was not 'the naughty one'.

*Pupil: [Nurture Group is] "Really helpful. It calms me down."*



*Pupil: [regarding NDT] "...since I've done it, there is a definite change... I've been more positive, I've got better at school..."*

### Gaps in skills

Some SENCoS said pupils with ADHD often need interventions that focus on gaps in skills seemingly unrelated to ADHD e.g. social skills, literacy and numeracy. Two pupils attended such interventions and reported they were effective. For one, this positive feedback was unusual because he did not like to be different to his peers.

*SENCo B: "I wouldn't say that there's a specific group, intervention or one-to-one for ADHD. It's more there are students inevitably that fit those groups based on their needs."*

### EP gives deeper understanding

One pupil was seeing an EP for motivational interviewing sessions so he would be more open to other intervention. He said he was happy to work with her, which was one of the only times this pupil said an intervention made a difference to him.

All the schools buy-in EP time. Four SENCoS talked about using their EP for a range of work for pupils with ADHD including one-to-one with pupils, training, parent work, assessment, and casework when they feel 'stuck' or because CAMHS recommendations were not appropriate to the setting. SENCo E explained her EP always meets with parents and often uncovers previously unknown information that then informs intervention. Also, it works well that the EP is in school every week.

Six parents said working with an EP had been useful when contributing towards an EHCP, for their knowledge of ADHD or understanding typical development. Ms Arnold suggested EPs should have a role in teachers' planning so it takes account of SEN.

*Ms Morrison: "...their input I think's quite good. When they actually sit back and watch the child."*

*SENCo A: "...Samantha's amazing. Samantha [EP] works with me to come up with the strategies that work for us..."*

### EHCP changed things for the better

Three parents whose sons had recently received EHCPs felt it had made a big difference to the support their son received and success in school. There was a sense that before the EHCP, their sons were struggling and parents did not think school took their difficulties seriously and as soon as they received the EHCP, everything was

better. It meant their sons were seen by a range of professionals, got one-to-one support and staff awareness of difficulties and strategies increased.

However, the two parents whose sons have had an EHCP since primary school felt the support had decreased in secondary and their sons were getting less than they were entitled to.

*Ms Kirk: "...he was having real troubles, but since they've put all the help in, it's made a big difference... with friendships, with the attention for learning, the support, it's everything..."*

*Ms Morrison: "...he doesn't get his full hours... But then there should be support in that class for him or anybody who's got a statement."*

#### Trial and error

All SENCos talked about needing individualised strategies for pupils with ADHD, depending on their specific strengths and difficulties. This meant a trial-and-error approach was required to see what worked well for each pupil. Three SENCos spoke about taking pre- and post-measures to ensure intervention is working for the pupil.

*SENCo E: "...it's 'This is David... what does he need? Well he might benefit from that'. Rather than 'Oh, he's got ADHD, that's what he's gonna [sic] have'."*

#### Any help helps

Five parents (including one via questionnaire) said they were grateful for any support they received and found it all helped. Some suggested it was rare support was offered.

*Mr Wade: "I think most of [the professionals] have... been helpful."*

*Mr Fuller: "...we're so used to not getting... any sort of support, you could literally roll out a turd on a stick and it could be like helpful [laughs]."*

### **4.3.2 Classroom strategies**

Some classroom strategies were mentioned, mostly by pupil participants.

## Seating

Participants had mixed views on where they, or pupils with ADHD, should sit in class. Pupil views included: having space but sitting next to friends (Will, Elliot and Ben); sitting by themselves (Ryan); sitting in groups rather than long rows (Alfie, Patrick and Dominic); and sitting near the front (Elliot). Harry said sitting away from distractions was not useful for him.

Two SENCos said optimal seating was different for each pupil but for the majority with ADHD, the front was best. SENCo B said the best arrangement was somewhere with space and easily accessible so the teacher can support the pupil with work. Also, being close to the door so the pupil can go for a break if needed. However, SENCo D felt sitting near a door or window would be too distracting so would avoid that.

*SENCo F: "...where... the pure focus point is just in front."*

## Differentiated curriculum

Four pupils and two SENCos talked about breaking tasks down into small steps. The SENCos suggested this could be done with a checklist and used with the whole class, thus benefitting the pupils with ADHD that do not want to look different.

Will and Owen said having less writing to do or having more time to complete it would be useful in some subjects. They both said they have bad handwriting so this could have been their concern rather than ADHD. Ben and Ryan disagreed, saying less writing would not be useful for them in any lesson.

Harry's worst teacher made him do "*all my work*." Dominic wanted teachers to give him easy work but could not describe what this would be. One parent said teachers should try not to 'bombard' pupils with ADHD with information.

However, Patrick did not want to appear different to his peers and felt he should do what everyone else was so it was not too much 'hassle' for teachers to do extra planning.

*Harry: "But when I did the work, it was all like... shortened...  
Basically like five questions in one. So, it was just easier."*

*Ryan: "I like to try to complete all the work."*

*SENCo B: "...we've found [checklists] quite useful because it's not  
such a big amount of information, it's a clear start, a clear finish, in*

*this time, and you're going to get a break afterwards. It's that knowing."*

#### Time out

Three of the nine pupils said having a time out card was useful in some lessons but not others. This depended on how stressful or overwhelming they found the lesson. These pupils had talked about being distracted by other pupils and finding it frustrating so the strategy is likely to alleviate that stress. One of the eight parents said using a 'time out' card had been effective at primary school.

*Will: [In maths] "It helps. 'Cos [sic] like if it's a bit overwhelming... then I could [use] it."*

#### Movement breaks

One parent and one SENCo said pupils with ADHD benefit from movement breaks. Pupil participants did not mention this.

*SENCo B: "...get the students up and moving about... It works."*

### **4.3.3 Teacher actions**

Pupils talked about what their ideal, favourite and worst teachers do and rated strategies as to their effectiveness in different lessons. Parents and SENCos described good practice for teachers supporting young people with ADHD.

#### Differentiated behavioural expectations

Six of the nine pupils mentioned differentiated behavioural expectations including giving rewards, understanding ADHD symptoms and not punishing pupils for them, and letting pupils do 'whatever they want'. Patrick thought rewards should be given for effort not just attainment.

Six of the eight parents strongly felt teachers should have a good understanding of their child's strengths and difficulties and tailor their approach to these. An awareness of ADHD is key to this. For example, Ms Arnold said staff should be aware her son has significant difficulty with listening to whole-class input but his competitiveness can be used to get him to do work. Two parents reported teachers are not always aware of their son's difficulties, to the extent some do not know about their ADHD diagnosis.

*Will: "Like when I fidget, they ask me to sit still... I can control it but it's like a bit hard sometimes."*

*Ms Chambers: "...to be aware of the condition. Because a lot are seen as children that just want to mess about..."*

### Calm and in control

Five pupils wanted a teacher that was calm and this meant not shouting or telling them off. Patrick's ideal teacher would give him chances instead of jumping straight to punishment. Four pupils said it was important teachers can control the class so they are better able to concentrate. Three of these had said a time out card would be useful so seemed to be particularly impacted by their peers' behaviour. Elliot's ideal classroom had security cameras so pupils were protected from bullying. This is interesting because there is a traditional view that pupils with ADHD are 'naughty boys' yet they prefer teachers with strong boundaries and students that behave. However, Dominic did not think having a calm teacher would be that useful, but did not elaborate as to why.

Two of the six SENCos talked about teachers being firm but flexible, calm, and managing their responses to students.

*Ben: "...when I get angry, they like, make it worse by telling me off more and shouting at me."*

*SENCo E: "The pupils we've had with ADHD are most settled in the classes where... what I would call strong staff or good on behaviour management, but also they're a bit more flexible as well."*

### Make learning fun

Four pupils said they wanted teachers to make learning fun. Ways to do this included linking work to things the pupil likes, discussing modern and relevant topics and learning new things. Dominic's ideal teacher likes to have fun, yet a fun teacher was only useful for him in one lesson (maths).

*Patrick: [teachers need to] "...try and get the kids to learn and enjoy learning instead of just keep punishing them..."*

### Checking-in

Four pupils, three parents and one SENCo said it is helpful for teachers to check-in with pupils, to make sure they are on task and explain things to them. This should be

subtle so the pupil does not feel they are being marked out as different but would support their inattention. For example, Ms Arnold suggested the teacher should check-in with several pupils. However, Harry said teachers checking-in with him did not make a difference.

*Elliot: [Is checking-in with you helpful?] "Sometimes. 'Cos [sic]... I don't wanna [sic] get distracted."*

### Relationship

Three pupils talked positively about teachers that believe in them, have high expectations, let them know they are doing well and do not give up on them. Harry's worst teacher "...don't like kids"; he said he could tell when this was the case.

*Elliot: "He wants people to be from here [gestures] to there [gestures higher]."*

### Consistent personnel

Three pupils mentioned teachers leaving or changing in a negative light, suggesting they would prefer to have the same teachers. All three had comorbid ASD, which could reflect the ASD trait of inflexibility.

*Owen: "We keep getting too many supply teachers. And they're all weird."*

### Specialist strategies

Three parents felt teachers need ADHD training to better understand it because there is a general lack of knowledge. One parent was a teacher and said SEN was only 'touched on' during initial teacher training and many strategies were for primary-aged children. Four parents said usual behaviour management strategies are not enough and ADHD-specific strategies are required.

*Ms Morrison: "I don't think a lot of teachers actually understand Autism or ADHD."*

### School-specific training

Three SENCos said CAMHS recommendations are broad strategies that do not consider the young person's setting, which is frustrating for them. The SENCo of a grammar school said it was problematic that ADHD training she attended assumed pupils would be at a low level academically. Three SENCos said they would use either

their EP or the local PRU for ADHD training because they know the setting and students well.

*SENCo A: "...some of the [CAMHS] recommendations can be impossible to meet in a mainstream secondary school."*

*SENCo D: "...[training] would be best coming from her [EP] because then you could do the sort of general 'what is ADHD?' and then she could do a specific for that child."*

#### Time for data and strategies

Two SENCos said staff being allocated time to look at data and strategies worked well for all SEN pupils. This corroborates parents reports that staff need a better understanding of their sons' strengths and difficulties. If a pupil is struggling and not responding to an intervention that has been put in place, SENCo B and colleagues would observe the pupil throughout a full day.

*SENCo B: "...you follow them and see... is there a particular style lesson they like? Is it all the lessons that they're doing really well in is because the teacher's really active, engaging, fast-paced? And the ones they're struggling in is because there's too many words on the board for example, or there's no activities, no breaks in there."*

#### **4.3.4 Barriers to good practice**

All participant groups identified barriers to implementing strategies and intervention in school for pupils with ADHD.

##### I do not want to talk to teachers

Seven of the nine pupils said they had never asked for anything different to help them or talked to teachers about the way they like to learn. Ryan would not ask teachers for help because of what others would think about him. Six pupils were choosing not to tell their teachers about their learning preferences, despite being given the opportunity. Two pupils said they would talk to teachers and felt they would be listened to.

*Ryan: "...if other people think it's easy and I think it's hard then I'll be like, I probably shouldn't mention that... I don't want them to think I'm dumb..."*

*Ben: "I'm not gonna [sic] tell my teachers anything."*

#### Not wanting to look different

Three pupils and three of the eight parents said they/their son did not want to look different to their peers and this could be a barrier to intervention. SENCo D talked about a pupil that was embarrassed to use resources no-one else had. This means there is a delicate balance between providing support for young people with ADHD and not impacting on their self-esteem by making them seem different. A further four parents said their son will not ask for help or give their views because they do not want to draw attention to their difficulties. Three parents suggested ways to support pupils in class without making it obvious, such as small physical prompts to refocus a pupil.

*Elliot: "...I wanna [sic] be like every single person in the class."*

*Mr Fuller: "...he doesn't like the fact that it's different and that's the one thing he doesn't want."*

#### Rigid learning environment

Three parents spoke about their sons finding it difficult to respond to an inflexible school environment. They would prefer more practical, hands-on learning in the classroom. Ms Arnold had found school were unwilling to let her son have movement breaks, which had been a successful strategy in primary school. Two of the six SENCos said it can be difficult to get teachers to put recommended strategies into place. The other four SENCos did not say teachers were unwilling to implement strategies.

*Mr Fuller: "...the education system we've got now, is purely academic... if you put [my son] in a class where you're taking apart an appliance and reassembling them... he'd be top of the class."*

*SENCo E: "...teachers' priorities are exam results, that's how they're judged... And I'm asking them to do another thing."*

#### Issues with services

All parents and SENCos spoke about a range of issues with local services.

Lack of funding in schools and for external services was brought up by six parents and four SENCos. For two parents, it meant their sons could not attend their preferred schools because the council would not fund either the transport or specialist residential school. Mr Wade felt services in general helped but there is a limit to what they can do



because of funding. Ms Arnold had noticed a reduction in the number of professionals working in SEND services.

Four SENCOs explained lack of funding can prevent schools from providing the support they would like to, including TAs, outside services and staff training.

Six parents and six SENCOs mentioned gaps in services including: CAMHS only offering medication for ADHD; there being no parenting groups or courses; and no support for one young person's obsession with eating. Ms Chambers sought advice from CAMHS but was directed to a website which she said was not helpful. One SENCO said parents could be frustrated by being told to go to a website and another said some parents do not have internet access. NICE guidelines (2018) recommend several interventions for young people with ADHD and their families not currently available in LA X, including CBT, teacher training and parent groups. Three parents said they had not seen an EP regularly. One parent had noticed a high turnover of staff in social services, CAMHS and the EP service.

Three parents thought services were slow, including getting a diagnosis, respite from social services or an EHCP. One parent had been waiting over six years for respite. Three SENCOs said it takes time to bring in external professionals and then put their recommendations in place. However, traded services seemed to be more reliable.

Poor communication about or between services was mentioned by five parents. This meant parents acted as the 'middle person' between services and school, or did not know what support they were entitled to. Ms Chambers felt this led to inequality and said she had only received information about support through friends and a local SEN charity. Ms Arnold would like to see CAMHS provide information about alternative therapies.

*SENCO A: "...it feels like they get the diagnosis and then it's back to the schools to manage it."*

*Ms Kirk: "...things take so long. I know they're understaffed and there's such a long waiting list for everything but it doesn't help the children."*

*SENCO E: "... the fact we buy into things makes it easier for us... I think having [our EP] is the biggest thing in there."*

### ADHD not a priority

In LA X, ASD is perceived to be more of a priority than ADHD. Two parents said taking part in this research was the first time the focus had been on ADHD and not ASD. Three SENCos said there were not the level of services available for pupils with ADHD as there were for ASD e.g. parent support groups, specialist teachers.

Six parents felt ADHD not being a priority meant their sons had struggled at school. Mr Fuller said it was linked to stigma and, as parents, they had been made to feel like 'moronic parents' and 'hypochondriacs' when pushing for support in primary school. Two parents felt their sons' difficulties were ignored because they performed well academically. Ms Kirk said teachers do not prioritise reading information about SEN pupils because they are too busy, again highlighting the need for appropriate time allocation for staff. Three parents felt a delayed diagnosis meant strategies were not put into place until later and so had less chance of being effective. One parent felt his son's challenging behaviour was not taken seriously, even though his son can hurt others.

Five SENCos felt ADHD was not a priority because there were few pupils with a diagnosis. SENCo D explained some schools would not necessarily put pupils with ADHD on their SEN register. Five SENCos said support, especially having a TA in class or a learning mentor, is only guaranteed with an EHCP.

*Mr Wade: "It's very strange talking about the ADHD on its own."*

*SENCo C: "I'm not aware of any specific support in LA X for kids with ADHD."*

### **4.3.5 Teaching assistants**

All participant groups discussed the effectiveness of TA support and ways this should be implemented.

#### Working towards pupil independence

Two of the nine pupils found it useful to have a TA in class or sat next to them, Ryan in all lessons and Owen in some lessons. Elliot said it was useful in technology but not other lessons because he did not want to look different. Patrick said the TA could "...keep track of what you're doing", but did not rate it highly as an effective strategy for every lesson. Dominic did not think a TA would be useful in any lesson.

Four of the six SENCOs said TAs should be supporting pupils towards independence and, in line with the DISS project (Blatchford et al., 2009), had moved away from the 'Velcro TA' approach where a TA is always by a pupil's side. This can involve going around the class providing 'scaffolded learning', giving reminders, helping students stay on task and be organised, and taking data on what the pupil has done independently and where he needed help. Two of the eight parents agreed with this, saying the TA should just check-in with their sons to help them stay on task and explain the work when needed. However, SENCO E said TA support is not always helpful in secondary school and is dependent on the pupil.

*SENCO B: "...some students, whether it be ASD or ADHD... they want their space, they don't want to feel different. So, it's very much a check-in, make sure, question, maybe update their whiteboard. Move away, let them have the chance to be independent..."*

#### Dedicated one-to-one

Two pupils with a high level of TA support in class rated it positively. Two pupils that could use TAs as scribes and readers said it was useful for them in some lessons, e.g. when having to write under pressure. Both these pupils were doing well academically in school. Six parents (one via questionnaire) reported their son had a one-to-one TA in class and it worked very well and two more said it had been effective at primary school. Two parents (one via questionnaire) said they would like their son to have more one-to-one support in class and no parent said they wanted less.

One parent said the secondary school were reluctant to put one-to-one support in place, despite her son having an EHCP. She felt her son was struggling with school work and a one-to-one would be able to explain it to him better.

*Ms Kirk: "...they've put all this one-to-one help in, his grades are coming back up, he's able to concentrate..."*

*Ms Morrison: "All they keep saying is 'Well, they're grown up now, they don't need to have one-to-ones'. I mean, 'Well, where is their support?' is my attitude."*

#### Ensuring safety

One SENCO spoke about the need for TAs to be in certain lessons with pupils with ADHD for safety reasons because of impulsive or hyperactive behaviour e.g. woodwork or science experiments.

*SENCo C: "...where they were a bit lackadaisy or saws or swinging things around, the TA was much more attached to those ones where that was a risk... not because they wanted to be risky but just... didn't think of those consequences..."*

#### SEN expert

Three SENCos said TAs tend to have more training than teachers on SEN including ADHD and can be the ones to put strategies in place. Two SENCos felt TAs alleviate some pressure on teachers by having SEN and pupil-specific knowledge. In one school, TAs are allocated time to share this knowledge with teachers.

*SENCo B: "That [training] was just for the teaching assistants... Then we look actually at teaching assistants to drive that forward... in lessons."*

#### **4.3.6 Physical environment**

This subtheme was only related to pupil views. Pupils named a range of ways they would like their school to be different. No adult participants mentioned the physical environment, but were not directly asked about it.

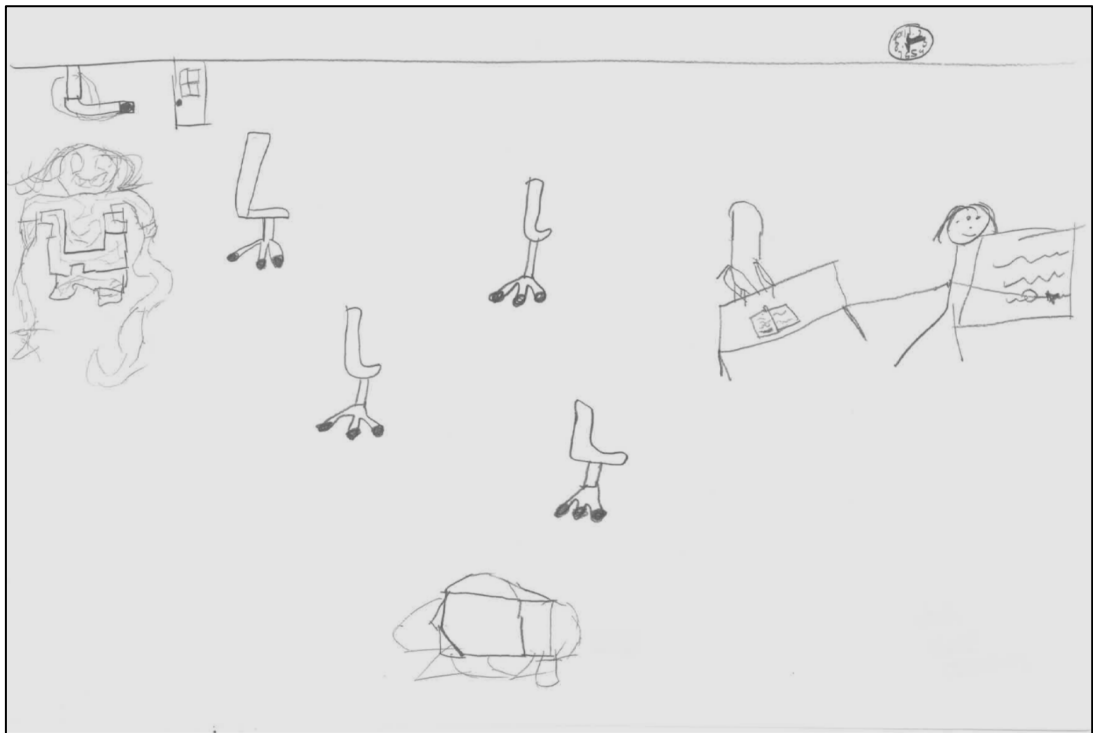
Most aspects of the physical environment the pupils described would not specifically benefit ADHD including: a more aesthetically pleasing school (six of the nine pupils); more comfortable seating (four pupils); better or cheaper food (three pupils); and air-conditioning (one pupil with sensory sensitivities). Seven pupils wanted access to resources like phones, computers and books, but Owen did not want to look different to his peers so rejected special resources. Harry would like to do all his work on technology and have no teachers.

Some features speak to the need to alleviate energy and can be linked to the movement breaks that two adult participants suggested: having more space (four pupils), and being able to engage in physical activity or sport (four pupils).

*Owen: [I do not like] "Sitting down in these rock-hard chairs and teachers get nice chairs."*

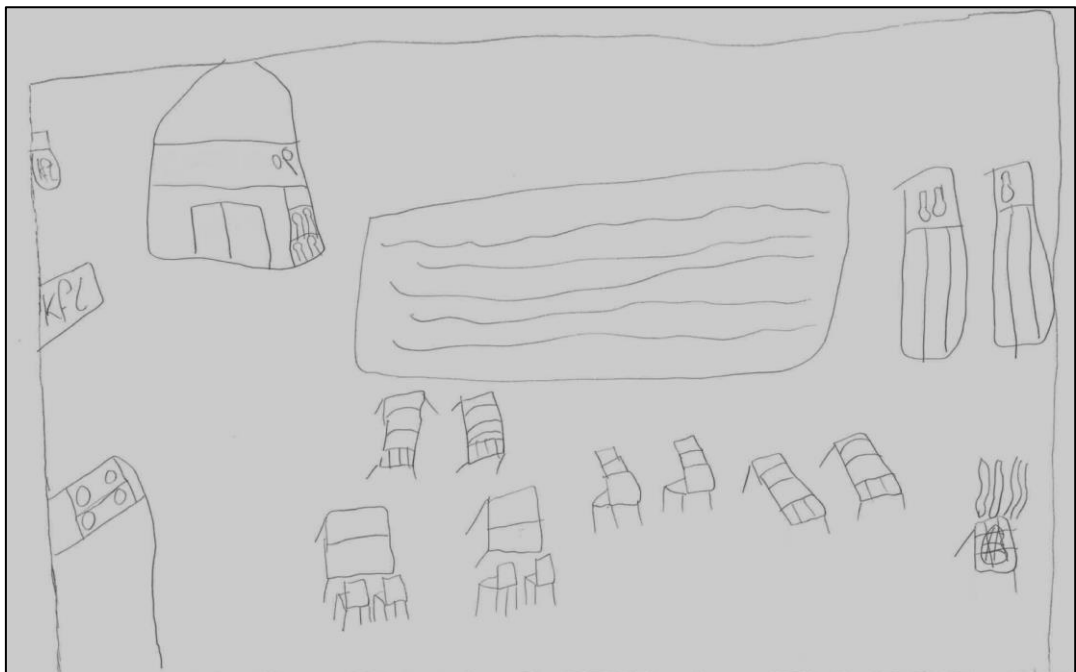
*Dominic: [ADHD means] "I just run, have to run."*

Figure 4.3: Elliot's ideal classroom



Elliot's ideal classroom featured a display on the wall, reading corner and security camera to protect from bullying. It had comfortable chairs and lots of space.

Figure 4.4: Ben's ideal classroom



Ben's ideal classroom had a KFC, barbeque and candy shop. There is also a cinema and bowling alley. Everyone has a pillow and can choose to have a table to themselves or sit next to someone. Outside the classroom is a football pitch.

Figure 4.5: Elliot's ideal school

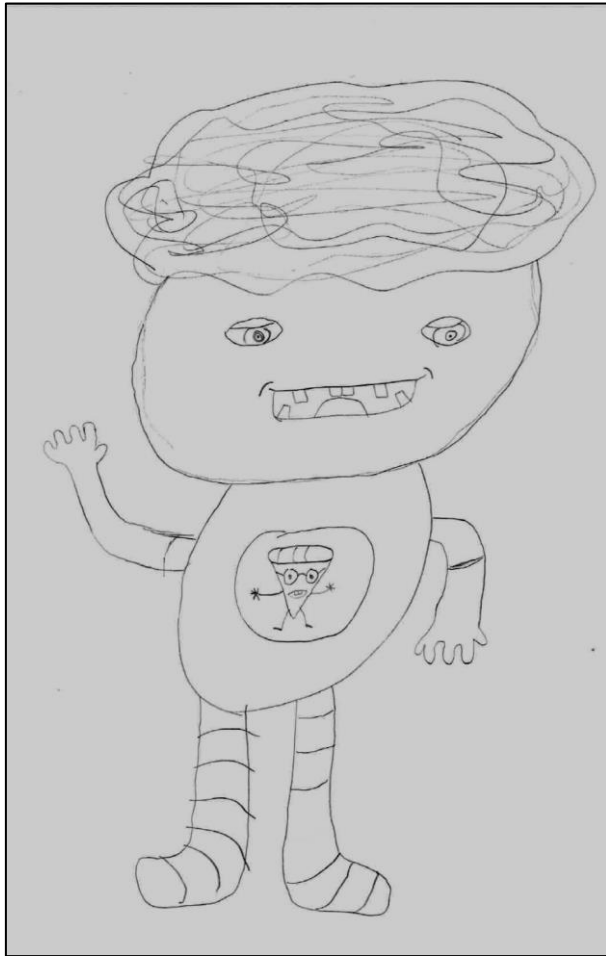


Elliot's ideal school has lots of different things to look at including graffiti work, ancient sculptures and decorations. The inside of the school is all brand new.

#### **4.3.7 Teacher personality**

This subtheme was only related to pupil views. Pupils described their ideal and favourite teachers, and some talked about their worst teacher or teachers they did not like. The most frequently desired descriptions were a warm personality, followed by being funny, sporty, and quirky. Ben's drawings and answers indicate he would also like a teacher that was trustworthy, wise and strong.

Figure 4.6: Ben's ideal teacher



Ben's ideal teacher was a 'crazy scientist' who does 'crazy scientist projects' that can result in explosions. He is cheerful, happy, strong, playful and clever. He is also wise and artistic.

Figure 4.7: Ben's worst teacher



Ben's worst teacher was a snake-like character who 'slithers' and is sly. His hands were 'chopped off' because he stole things. He has a tail that grows every time he tells a lie and he does not care about his students.

Figure 4.8: Elliot's ideal teacher



Elliot's ideal teacher was a man. Whenever Elliot is good in the lesson, the teacher takes him out to do an activity such as Lego or football. He works with Elliot and is in all of Elliot's lessons. He is very sporty and likes to dress smartly.

Figure 4.9: Dominic's ideal teacher



Dominic's ideal teacher likes to have fun and is very sporty. He is not strict and gives Dominic easy work.



#### 4.3.8 SENCo role

Adult participants discussed the importance of the SENCo role in relation to supporting pupils with ADHD. Pupils did not talk about SENCos but were not specifically asked about them, and a lot of a SENCo's work is behind-the-scenes coordination.

##### SEN knowledge

Five of the eight parents said SENCo knowledge of ADHD and SEN was important. Two of these parents felt the SENCo's knowledge impacted on other staff's understanding, resources and strategies. Mr and Ms Fuller said the SENCo understands their son and his difficulties and this had made a positive difference.

Three of the six SENCos said their role involves supporting teachers to understand what is going on for a pupil and cascading data and recommendations. SENCo D observes staff to ensure they are implementing appropriate strategies. SENCo B was building a knowledge base on the school's computer system about different areas of SEN and said he is "...*constantly driving and championing the SEN flag*". Three SENCos regularly run training for staff which may include ADHD or relevant behavioural management strategies. However, two SENCos said their understanding of ADHD was limited. SENCo E said this was because the label is unclear (see 'The label', section 4.2.3) whereas SENCo F felt as a school, they were not sure what ADHD meant or how to support it.

*Ms Kirk: "I think it's whoever's at the top, the understanding follows through. So, it just depends who you've got."*

*SEnCo A: [I am] "...the guru that everyone comes running to and I really haven't got that much information."*

##### Coordinating support and communication

SENCos with an 'open door' policy for parents were spoken about in glowing terms. All but one SENCo said they were in regular contact with parents of students with ADHD. One referenced the SEND Code of Practice (DfE & DoH, 2015), which puts parent and pupil views at the heart of support. Three SENCos said they provided emotional support to students when needed. SENCo D said she creates an 'ADHD success plan' with the pupil and parent/s which outlines factors, strategies and interventions to consider so the environment and teachers are appropriately prepared for the student.

Five SENCos talked about coordinating advice and support from external agencies and within school. SENCo E added part of her role was managing the amount of

intervention in place because professionals tend to want to put too much in place at once.

For four parents, the SENCo is a source of support for them. They said their SENCo worked in the best interests of their sons and was a channel of communication between parents and teachers. Ms Kirk felt SENCos in general had become more pro-active, whereas in the past she had found they did not 'do much' and were 'set in their ways'. However, three parents had little contact with their SENCo; they received less feedback about how their sons were doing, were not sure what the SENCo role was and did not know what their son's targets were.

*Ms Booth: "...if anybody helps [my son], it is her [SENCo] trying to get... the message across to all the other teaching staff on behalf of me and him."*

*SENCo C: "...[parents] feel like... they can ring me, they can email me, I will answer."*

#### **4.3.9 Pupil involvement**

SENCos and parents spoke about pupil involvement in planning and reviewing their support. Pupils did not talk about this, except to say they do not like to talk to teachers about it.

##### Motivation to change

Two of the six SENCos talked about interventions to increase pupil motivation to follow school rules or change. One school used their EP to do motivational interviewing with a pupil with ADHD because they felt intervention would not have an impact if the pupil did not want to change. The other intervention involved placing pupils in teams that earned points and prizes for following school rules.

*SENCo E: "...you try and get them in a place so they accept the need to change... to get him into a place ready... to do an intervention, rather than just sort of thinking, 'Oh, yeah, I'll do this, but... it don't [sic] mean anything to me'."*

##### Feedback on support

Three of the eight parents said it was difficult to obtain their sons' views on the support they have. This improved for one once he started having one-to-one support. One

parent felt it was because her son did not want to draw attention to his difficulties. For the other two parents, it was more about the type of person their sons are.

Three SENCoS said it worked well to create learning profiles with pupils which are then sent to teachers. Some SENCoS sought regular feedback from pupils on how they feel their intervention is going and how they apply it in class. However, one SENCo said pupils were generally passive so gaining pupil voice was challenging.

*SENCo E: "...[pupils will] often say what they think you want to say... there needs to be work on giving them the skills to be able to give their opinions."*

*Ms Chambers: "He doesn't like to say anything. I have to push him to say things."*

#### Setting targets

Three SENCoS said pupils set and reviewed their own targets. This could either happen across all pupils or for those with 'Individual Education Plans'. SENCo A explained this meant students were taking more responsibility. She felt it worked better with practice and as pupils became more mature. SENCo B felt the effectiveness depended on the tutor running the target-setting session.

*SENCo A: "But when they get used to doing it, I think by the time they get to GCSE, it does work quite well for them."*

#### **4.3.10 Parent involvement**

Parents and SENCoS talked about the importance of parental involvement in their child's support and what this should look like. Pupils did not say anything in relation to this area, but as with the 'SENCo role' theme, is not something one would expect them to reflect on and they were not specifically asked.

#### Parent as expert

Four of the eight parents talked about being the first to suspect ADHD and how they 'pushed' for a diagnosis. Three felt they knew more about their child's symptoms than professionals. Parents also said they can offer suggestions for strategies they know have worked well in the past. However, they often cannot control what happens for their child in terms of school support.

Five of the six SENCoS spoke about the importance of parental involvement, for example, for multi-agency work to be successful, at annual reviews, when an EP is involved and to reinforce strategies at home.

*Ms Fuller: "I don't need a book to tell me about ADHD, I live with him..."*

*Ms Booth: "...we've just got to go with the flow whether we agree with it or not, that's the hardest part."*

*SENCo A: "We don't hold annual reviews unless we can get parents in."*

### Regular updates

Parents appreciate, or would like to have, regular updates from school about how their son is doing. One parent's son has 'team around the child' meetings every six weeks because she receives respite from social care. She felt the regular meetings were good practice. Two parents said they only tend to hear from school when their sons have been in trouble. They felt this has impacted on their son's self-esteem and it would help if parents received good news as well as bad. One SENCo also acknowledged this would be good practice.

*Ms Chambers: "I think it would be good for [my son]'s self-esteem. To hear what he's doing well at as well."*

*SENCo E "...if parents were involved earlier when things were going well, maybe they wouldn't get to the point where things go wrong."*

### Parenting strategies

Three parents had been on a parenting course several years ago and learned about strategies to use at home. For example, Ms Booth said the most useful strategy was giving alternative options instead of saying 'no'. However, one parent had found the strategies had worked for his other children but not his son with ADHD, so felt parents needed ADHD-specific training.

*Ms Arnold: "...for any parents who are getting a diagnosis, you can't underestimate how important boundaries are."*

*Mr Wade: [the parenting course was] "...great for what they were doing and for every average child who's being naughty. But not someone with ASD and ADHD. It didn't work at all."*

### Respite

Outside of school support, three parents spoke about needing respite but only one received it. One of these parents was unable to work and his life was very restricted because his son was on a reduced timetable. Also, it was particularly difficult because his son did not sleep for long and he worried what his son would do when awake at night. Another of these parents felt she received no respite because refusing medication meant she had no avenue to find out about support available to her and her son.

*Parent: "...we need the break. I have him every day... eight, nine hours... And there's no let up almost. For him and for us."*

*Ms Booth: "...since I refused the medication I haven't had any help whatsoever from anybody."*

## **4.4 Summary of findings**

This study explored perceptions of ADHD from the viewpoints of young people with ADHD, their parents and school SENCOs. The findings showed ADHD is complex and its symptoms can impact negatively on young people's behaviour, self-esteem, social relationships, emotional regulation and ability to learn. But these are not a given, for example, some pupil participants are doing well in school and all reported good friendships. Positive aspects of ADHD were also mentioned and some described it as just an extra dimension to who they are. Participants did not fully subscribe to one construct of ADHD over others but had different, sometimes contradictory views on what ADHD means to them. ADHD has a unique impact on each individual.

All pupil participants had comorbid diagnoses or difficulties, most commonly ASD, and many had experienced difficult family circumstances. ADHD is often just one dimension to take into account when planning support for a pupil.

Medication is inextricably linked to ADHD: young people that take it feel they need it and tend to stay on it for a long time. Those that do not take it are discharged from CAMHS and parents are left to find support themselves.

This research also sought views on what good practice is when supporting young people with ADHD. Several interventions and strategies, both specialist and ones that can be implemented as a matter of routine, were identified by participants as having been successful in their experience, but a key finding was what works well is different for every individual with ADHD, irrespective of the type and severity of symptoms experienced, so a tailored, trial-and-error approach is best. This links to the finding that ADHD is heterogeneous.

Several issues with services in LA X were identified, meaning families and schools felt there was more that could be done to support ADHD. Adult participants felt ADHD was not taken seriously in LA X and this could lead to negative outcomes for young people with ADHD and their families. EPs were seen to hold good knowledge about ADHD and being well placed to develop intervention plans.

Pupils with ADHD often do not want to appear different to their peers and this can be a barrier to intervention and gaining their views. However, pupil participants sometimes offered different or new perspectives to the adults. Their views matter because intervention cannot be effective if they are not happy with it.

When carrying out interviews with pupil participants, several tools were used and assessed for ease of use for the interviewer and quality of response from the participant. It was felt the tools helped sustain participants' attention. The drawn 'ideal/worst teacher' activity was judged to prompt the best quality of response and could all be used with little or no training. However, due to the heterogeneity of ADHD, a range of tools should be employed and, as with intervention, selected based on the individual's strengths and needs.

The findings have implications for young people with ADHD, and their families and school staff, who may want to see how others perceive ADHD in order to further their understanding of it. They can also look for strategies and interventions to implement. A trial-and-error approach based on individual needs is suggested as good practice. From this research, school staff should also be able to see how important their relationships with pupils with ADHD and their parents are, and a range of ways they can seek pupil voice is outlined.

The findings suggest there are reasons to question the value of the label of ADHD including: heterogeneity of symptoms; stigma; young people not wanting to look different; lack of understanding about what ADHD is; and few specialist strategies being identified. Timimi (2015), a leading critic of the ADHD label, has argued these factors and others including the medication of children based on culturally-constructed

pathology, mean giving children a diagnosis of ADHD can lead to negative outcomes so we should move away from its use.

However, the findings also suggest there are reasons to keep the label including: parents wanting recognition of ADHD needs; access to medical treatment, which is usually effective, and support in school; helping young people to understand themselves; and participants demonstrating a good understanding of diagnostic criteria. A leading proponent for the ADHD label has argued there is a large body of research supporting the existence of the disorder, and the reasons critics use to question its validity could be applied to all psychiatric and numerous medical disorders (Barkley & Coendorsers, 2004).

#### **4.4.1 Researcher reflections on the findings**

Several findings were surprising to me, in terms of my expectations and their difference to findings in previous research including:

- The large amount of strategies being identified as effective.
- Young people did not question the need for medication. This may have been because the participants did not experience significant side effects and some struggled to reflect on their behaviour.
- The strength of the association young people made between ADHD and medication.
- The cognitive dissonance demonstrated by participants who held opposing beliefs about what ADHD meant to them.
- There were no clear links between participant characteristics and the beliefs they held about ADHD and strategies they found to be effective.

The activities used with pupil participants were helpful in sustaining their attention and building rapport. Different tools worked better with different pupils, depending on their strengths and needs e.g. Harry said he could not remember what he had done yesterday, never mind last year when shown the timeline task, which demonstrated his difficulty with reflection and memory.

## **5 Chapter 5: Discussion**

This chapter contains a discussion of the key findings in relation to previous research and current guidelines on ADHD in three areas: perceptions of ADHD, good practice and use of tools to gain pupil views.

### **5.1 Perceptions of ADHD**

#### **5.1.1 Heterogeneity**

Participants reported a wide range of symptoms and severity of these symptoms, meaning ADHD was experienced differently by each individual. Most adult participants said the label of ADHD does not give a clear picture as to a young person's strengths and difficulties, and the support they require. Previous research has also pointed to the importance of treating ADHD as a heterogeneous condition, including Wåhlstedt, Thorell, and Bohlin (2009), who quantitatively assessed children and found different profiles of neuropsychological functioning (inhibitory control, working memory, reaction time and delay aversion) and comorbidity (Oppositional Defiance Disorder, internalising problems and poor academic achievement) have differential impacts on ADHD symptoms. Kendall (2016) also summarised the impact of ADHD is unique to each individual. Consequently, ADHD is a heterogeneous disorder and the unique impact on the individual needs to be assessed at an individual level.

Although the experience of ADHD was heterogeneous, overall, participant groups reported diagnostic symptoms of ADHD to a similar frequency, for example, nearly all mentioned hyperactivity and inattention, and impulsivity was less commonly reported. This differs from Wiener et al.'s finding (2012) children with ADHD report significantly less ADHD-related symptoms than their parents but corresponds with Sikirica et al.'s conclusion (2015) adolescent reports generally matched their parents regarding impacts of ADHD. This could be because of cultural differences; Wiener et al.'s study was Canadian, whereas Sikirica et al.'s was European and included British views. Here, pupils may be repeating what they have heard from their parents, e.g. in school or CAMHS meetings, and so young people's understanding of their ADHD comes from their parents. Likewise, it could be that parents here are in tune with their child's experience of ADHD.

Participants described additional difficulties that are in line with previous reports: cognitive functioning difficulties (Kendall, 2016); social and emotional problems



(Sikirica et al., 2015); and behavioural and emotional regulation, particularly of anger (Singh, 2012). Pupil reports largely matched their parents. The findings provide further evidence for Wong et al.'s conclusion (2018) ADHD impacts on many and varied aspects of a young person's life. These symptoms may be interlinked and mean inclusion in mainstream secondary classes can be challenging. For example, cognitive functioning difficulties might be driving problems with self-regulation, and these issues, and the consequences thereof (e.g. being reprimanded) might lead to frustration and anger. If there were more understanding of ADHD and support for these difficulties in the classroom, perhaps frustration and anger could be reduced. Singh et al. (2010) found UK pupils with ADHD felt teachers assumed their behaviour would be more challenging than their peers, an assumption borne out by these findings.

Participants described or demonstrated misunderstandings about ADHD held by themselves, school staff or the general public. This could be due to the heterogeneity of the disorder and often has negative consequences such as diagnosis being delayed or school staff dismissing family concerns. This corresponds with Sikirica et al.'s Europe-wide study (2015), which found obtaining an ADHD diagnosis is difficult for the majority of parents and because of this, they can be blamed for their child's behaviours. This elucidates the need for a better and more widespread understanding of ADHD, in order for it to be taken more seriously, and to prevent delays in diagnosis.

No pupil participants had 'pure' ADHD. They all had at least one comorbid diagnosis or difficulty, most commonly ASD. NICE guidelines (2018) acknowledge the symptoms of ADHD can overlap with those of other disorders and state practitioners should try to differentiate the level of impairment specifically due to ADHD, to guide the treatment plan. However, this study demonstrates it can be difficult to categorise symptoms to disorders. Parents explained how comorbidities crossed-over with ADHD and impacted on their sons e.g. risk-taking behaviour, attention-seeking behaviour or social difficulties. For some, their ASD diagnosis came much later than their ADHD diagnosis. This could indicate ADHD symptoms change over time and present more like ASD behaviours. One parent felt ADHD could be a feature of the autistic spectrum. Accordingly, a young person's individual strengths and difficulties should be regularly reviewed in order to provide appropriate support.

Many pupil participants had experienced difficult family contexts. Pupils did not reflect on the impact of these, however they were not directly asked to. Parents described how these factors impacted on their sons e.g. emotional wellbeing, social skills difficulties and behavioural regulation. This corresponds with Wong et al.'s finding (2018) some parents attribute their child's difficulties to family factors. Some SENCos

referenced 'poor parenting' as an explanation for some ADHD diagnoses, which is more in line with the idea of 'naughty boy syndrome' than the impact of traumatic experiences. Family context may exacerbate or cause ADHD symptoms and so should be taken into account when planning support for a young person with ADHD.

### **5.1.2 ADHD means medication**

ADHD is inextricably linked to medication use by pupils because they felt they had to take it. This corresponds with Singh et al. (2010), whose participants said they needed ADHD medication. However, the authors and others (e.g. Ferrin et al., 2012) had also reported adolescents were more likely to question the ongoing need for medication, something not found in this research. This may have been because the pupils that were taking medication agreed with parents and SENCos that it usually works. Participants said it improved core ADHD symptoms and this in turn impacted positively on behaviour, learning and friendships. This is consistent with Kendall (2016) and Walker-Noack et al. (2013), where young people reported medication was beneficial but does not take away ADHD symptoms completely. However, medication can wear off, or young people forget to take or run out of it, and this can mean parents and school staff have to deal with behaviour issues. This fits with Travell and Visser's (2006) comparison that ADHD medication to ADHD symptoms is as aspirin is to toothache: they mask the symptoms but do not cure it.

Parents and SENCos talked about medication being a long-term commitment because young people that go on it tend to stay on it. Pupils did not give opinion on this, although some said they had been taking it for a long time and felt they needed to keep taking it. This confirms Beau-Lejdstrom et al.'s finding (2016) 60% of those taking ADHD medication were still taking it after 2 years and suggests in LA X, this figure could be higher.

Few pupil or parent participants mentioned side effects. This differs from previous research that found medication can cause a young person to question their moral identity (Singh, 2012) and worry about side effects (Brinkman et al., 2012; Ferrin et al., 2012). One parent had balanced the possibility of stunted growth with the benefits he saw and concluded taking medication was the best decision for his son. This is in line with Wong et al.'s finding (2018) that endorsement of medication does not imply parents are not aware of possible negative effects.

A large-scale study of the cost-effectiveness of the main ADHD treatments (Jensen et al., 2005) found medication management combined with behavioural intervention was

most effective but medication management alone was most cost-effective. Importantly, in a follow-up study by the MTA (Swanson et al., 2017), it was found extended use of medication was not associated with reduction of symptoms into adulthood. However, in LA X, medication is the main treatment offered for ADHD. The two parents interviewed that decided not to use it with their sons were discharged from CAMHS. This is contrary to NICE guidelines (2018 para.1.5.13), which state medication should only be offered if symptoms persist after parents have received ADHD information and group-based support. There is no group-based ADHD support available in LA X, meaning the current practice in place is not optimal.

### **5.1.3 Discourses and constructs**

Previous ADHD literature has taken different views on the causes of and treatment for ADHD: biomedical, social-cultural and bio-psychosocial. Alongside this, qualitative research has found young people with ADHD subscribe to one, or a blend of, three constructs of ADHD: as a personality trait, medical disorder or minor concern (Brady, 2014; Charach et al., 2014). However, Singh (2012) found perceptions of ADHD fell into either 'performance' or 'conduct' niches, with the conduct niche being more prevalent in the UK.

In the current research, rather than subscribing fully to one discourse, participants seemed to understand ADHD as a mixture of two or three constructs. For example, Will, who described ADHD as a 'perk' (personality trait), also said he could not control his fidgeting (medical disorder). This is consistent with Brady's UK study (2014), where young people with ADHD neither fully accepted nor rejected the medical discourse. Except in Singh (2012), the studies where young people aligned with one construction over others were carried out in countries other than the UK, meaning perceptions of ADHD are influenced by cultural context. In the UK, ADHD is understood to be a complex disorder that amalgamates several constructions identified in previous research.

The blending of ADHD constructs and heterogeneous impact of ADHD, comorbidities and family context are consistent with the bio-psychosocial perspective, where ADHD is perceived to be a complex interaction between biological and social-environmental factors (Wheeler, 2010), and Bronfenbrenner's bioecological model (2005), which demonstrates that biopsychosocial characteristics, the environment, time, interactions between these factors, and processes within them, all influence a person's

development and behaviour. Therefore, a wide range of factors need to be taken into account when developing support for a young person with ADHD and their family.

More than half the pupils and parents linked ADHD to anger, with no clear links between this construct and other participant attributes. Singh (2012) also described ADHD as a 'disorder of anger and aggression', especially in the UK. Unlike in Singh's study, participants did not say they used ADHD as an excuse for poor behaviour. This could be because Singh's UK participants were on average, two years younger than in this study. The parent views are consistent with the findings of a doctoral dissertation (Robinson, 2017), in which British parent perspectives of ADHD focused on anger and aggression. The high prevalence of conduct problems being described in this sample reflects previous studies that found pupils with ADHD perceived themselves as deviant and said ADHD symptoms contributed to disciplinary problems at school (Ljusberg, 2011; Sikirica et al., 2015). There are echoes of this finding with ADHD historically being thought of as 'naughty boy syndrome'. NICE guidelines (2018, para.1.2.1) advise young people diagnosed with conduct disorder may have increased prevalence of ADHD compared with the general population. Anger and conduct problems are an issue for many, but not all, young people with ADHD so should be considered when developing a support plan.

The accounts of all participants, except one pupil, about what ADHD is fit with its diagnostic core symptoms (NICE, 2018). This is further evidence for previous research which has found most young people with ADHD identified themselves as exhibiting its symptoms and the majority of parent reports are in line with DSM criteria (Sciberras et al., 2010; Wong et al., 2018). Participants had a good understanding of ADHD diagnostic criteria, which in turn is in line with the symptoms they experience.

All pupils seemed to have a balanced view of their strengths and difficulties, which does not fit with the theory of 'personal illusionary bias' which predicts pupils with ADHD would report they were performing better than they are (Charach et al., 2014). This balanced understanding of strengths and difficulties was also demonstrated in several pairs of contrasting sub-themes including: young people saying they are 'not normal' but also 'no different'; the label bringing an understanding of self but also stigma; and all participant groups reporting negative and positive aspects of ADHD. Previous research has also found young people acknowledge both positive and negative attributes of ADHD and themselves (Bringewatt, 2015; Sciberras et al., 2010). This balanced perception of the disorder is enduring despite its heterogeneity.

Most pupil and parent participants identified positive aspects of ADHD, an area which has only recently featured in research and has an emerging evidence base (Wong et

al., 2018). Two previous studies reported the same strengths of increased energy and drive, creativity, and needing less sleep (Mahdi et al., 2017; Walker-Noack et al., 2013). Participants in this study added ADHD also means being bright, honest, curious, eager to learn and competitive, having practical intelligence, and being able to argue their point. These could be harnessed in the classroom e.g. by using more hands-on activities, encouraging debates and setting competitive challenges.

Most pupils felt the label of ADHD was useful which attests to previous studies that have shown diagnosis brings empowerment, feelings of relief and an improvement in teachers' attitudes (Bringewatt, 2015; Kendall, 2016). The label was more useful to young people than SENCOs, who felt the label was not useful because of the heterogeneity of symptoms. This contrasts with Moore et al.'s finding (2017) that school staff saw the value in labelling ADHD to provide access to support and understanding. This difference may be because Moore et al. interviewed a range of school staff, whereas this study focused on SENCOs, who have a more strategic and less hand-on role.

Stigma had been experienced by most parents and was linked to several factors, including assumptions school staff can make and support offered. This corresponds with previous research, which found the majority of parents reported stigmatising experiences leading up to their child's diagnosis of ADHD (dosReis et al., 2010). However, only one pupil discussed stigma associated with the label which is little evidence for previous research that indicates some children with ADHD feel stigmatised (Moldavsky & Sayal, 2013; Wiener et al., 2012). Pupils in this study were not directly asked about stigma so may have experienced more than they reported.

In line with the finding the label can bring both understanding and stigma, NICE guidelines (2018) state professionals should discuss the positive and negative impacts of receiving a diagnosis with young people and their family.

## **5.2 Good practice**

### **5.2.1 Working with young people as individuals**

Overall, most interventions being used were seen as effective and SENCOs advocated a trial-and-error approach, which is in line with the finding ADHD is heterogeneous. This corresponds with Moore et al.'s finding (2017) school staff use a range of broad strategies to support pupils with ADHD and make individual adaptations based on strengths and needs. Some SENCOs said a good way to do this was by creating a

'learning profile', which was also reported as a useful strategy in Moore et al.'s study (2017).

Fewer strategies were mentioned by participants that seemed to be ADHD-specific than ones that would work for pupils with any SEN. These included:

- calming activities (e.g. drawing, fiddle toy);
- ADHD psycho-education course;
- ADHD role models;
- teachers understanding ADHD and adjusting behavioural expectations accordingly;
- movement breaks;
- engaging in physical activity; and
- TA support in lessons where impulsive behaviour could be risky.

All these strategies have been mentioned in previous research, except for the use of TAs to monitor risky behaviour (Kendall, 2016; Moore et al., 2017; Singh et al., 2010; Walker-Noack et al., 2013). NICE guidelines (2018, para.1.6.1) promote the benefits of a healthy lifestyle and regular exercise. The three pupils that did not mention having differentiated behavioural expectations also met criteria for Oppositional Defiance Disorder on Conners 3, which could mean these pupils are disobedient more often and so the teacher's expectations matter less to them. Otherwise, participant attributes did not seem to link with the strategies they mentioned.

Pupil descriptions of their ideal teacher would likely be appreciated by all students e.g. warm, funny and trustworthy. These descriptions are consistent with previous findings (Gibbs et al., 2016; Ljusberg, 2011; Wiener & Daniels, 2016). Traits that differed from previous literature were: sporty, quirky and wise. Similarly, most interventions and strategies identified would likely benefit students with other types of SEN, including:

- social skills, literacy or numeracy interventions;
- good pupil-teacher relationship;
- making learning fun;
- teacher being calm and in control;
- consistent personnel;
- teacher checking-in with pupils to keep them on track;
- differentiated curriculum e.g. breaking tasks down into small steps;
- use of rewards;
- choice of seating;
- time out card;

- comfortable, nice environment (e.g. chairs, space, temperature);
- access to food;
- access to resources e.g. technology;
- TA support;
- pupil involvement in planning for support and targets;
- NDT; and
- Nurture Group.

This wide range of intervention is in line with NICE guidelines (2018, para.1.5.2), which state psychological, behavioural and educational needs must be addressed. There were no clear relationships between pupil participant attributes (such as ADHD symptoms, medication use, comorbidities, attainment or family context) and the intervention, strategy or teacher personality trait they talked about, except for 'gaps in skills' which involved pupils who were below expected levels academically and 'consistent personnel' which was mentioned by pupils with comorbid ASD, reflecting the ASD trait of difficulty with change.

Most parents were grateful for any kind of help put in place for their sons and some suggested it was rare support was offered, which is consistent with previous research (Baric et al., 2015; Singh et al., 2010). Parents seem to be right to welcome any support; this research and Gaastra et al. (2016) indicate all intervention types are likely to result in positive outcomes and does not necessarily need to be 'ADHD-specific'. Similarly, Moore et al. (2017) found UK school staff draw on a range of strategies to include pupils with ADHD in the classroom but these strategies did not necessarily target ADHD symptoms nor were evidence-based ADHD interventions. Rather, they were flexible to the needs of the individual student. However, the authors argued there was a lack of knowledge about evidence-based interventions, for example, daily report cards, something not mentioned by participants in this study either. This could be due to a lack of ADHD training in schools. EPs are well placed to share evidence-based practice with schools and families through consultation and training.

All interventions suggested by participants can be found in previous research (see Appendix 9.20 for more information). When pupils and adults talked about the same intervention or strategy, they were largely in agreement. This contradicts Bussing, Koro-Ljungberg, Gurnani, et al.'s conclusion (2016) young people with ADHD are less willing to consider interventions than the key adults in their lives and Singh et al.'s (2010) report that few participants spoke about helpful non-pharmaceutical interventions.

Participants in this research did not report intervention fosters inequality, as was found in Bussing, Koro-Ljungberg, Gagnon, et al.'s research (2016). This is a positive indication the concept of equal opportunities is well understood in the UK.

### **5.2.2 Issues with services**

All parents and SENCos spoke about a range of issues with local services. These included lack of funding, which is linked to gaps in services and poor continuity; and services being slow, linked to poor communication. Similarly, Wong et al. (2018) found parents of young people with ADHD say there is little information given about what they can expect in terms of symptoms and treatment.

NICE guidelines (2018) recommend several interventions for young people with ADHD and their families not currently available in LA X, including CBT, teacher training and parent groups. Previous research has also highlighted concerns psychological treatment is not available due to a lack of funding, meaning medication is often the only option for many families (Brady, 2014; Hill & Turner, 2016). It would be highly beneficial for young people with ADHD and their families if LA X offered more support, especially through CAMHS, who only offer medication after diagnosis. Whilst medication is effective and less costly in the short-term, previous research has shown its efficacy decreases over time (Swanson et al., 2017). CBT and teacher training may be available to schools in LA X through their EP, but this depends on the amount of EP time they buy-in and school priorities. However, investing in them would increase the chances of treating the underlying causes in a sustainable manner, and consequently being more cost-effective for the state. NICE guidelines (2018, para.1.4.11) say young people with ADHD have *“above-average parenting needs”*. Parent support and education groups are a significant gap in LA X and means parents feel somewhat abandoned after diagnosis. These findings suggest LA X should review the services available to young people with ADHD and their families and ensure they are in line with NICE guidelines and local need.

### **5.2.3 Not wanting to look different**

The most common barrier to implementing intervention in school was pupils not wanting to talk to teachers about the way they learn or ask for something different. However, previous research indicates it is important to consider the child's view when planning their support (Moldavsky & Sayal, 2013; Sciberras et al., 2010) and guidelines



suggest this should happen regularly (NICE, 2018). Accordingly, schools should look for new ways to seek pupil views (see 'Gaining young people's views' section below).

Some pupils and parents said they/their son did not want to look different to their peers and this can be a barrier to intervention. This stigma is well documented in previous research (e.g. Bringewatt, 2015; Bussing, Koro-Ljungberg, Gagnon, et al., 2016) and means there is a delicate balance between providing support for young people with ADHD and not impacting on their self-esteem by making them seem different. It is good practice to provide support in the least obvious way, for example, teachers could subtly tap students on the shoulder as a cue to re-focus their attention. It was also suggested the amount of intervention in place at one time needs to be managed.

Most pupil participants and their parents felt their behaviour and success in school had improved over time and suggested this was because they were more aware of peer perceptions of them and learned coping strategies. This supports Gibbs et al.'s conclusion (2016) adolescents with ADHD did not want to appear to be different and so were reinforced by better managing their behaviour. Because ADHD profiles change over time, a pupil's needs should be reviewed regularly to reflect their current strengths and difficulties, and desired support for behavioural management.

#### **5.2.4 EP role**

Participants that talked about working with an EP said they were useful. The only issue raised was not seeing them enough. Parents and SENCos said EPs have a unique role because they have good knowledge about ADHD and know the school setting well, so can give practical, achievable recommendations, and deliver appropriate training. NICE guidelines (2018, para.1.2.5) state young people with ADHD may be referred to an EP. Hill and Turner (2016) reported EPs are well placed to support the development of tailored interventions for young people with ADHD and are aware of the impact of contextual factors on young people's behaviour. This complements the finding a pupil's individual strengths, difficulties and circumstances need to be explored in order to provide individualised intervention. EPs are experienced in working in this way.

Parents were often ill-informed about support available in LA X. NICE guidelines (2018, para.1.4.4) recommend young people with ADHD and their families should be told about sources of information, including support for education. This could be an EP role, depending on the model of service delivery in a LA, because they have a good overview of the local context and evidence-based intervention.

### **5.2.5 Greater recognition of ADHD needs**

Parents and SENCos felt ADHD was often not a priority meaning young people with ADHD can struggle in school. In LA X, ASD was perceived to be more of a priority and has more services and support available. SENCos felt this was because there are few pupils with an ADHD diagnosis. One said schools do not always put pupils with ADHD on the SEN register. Yet, ADHD is associated with academic failure (Anixt et al., 2016; Bussing, Koro-Ljungberg, Gagnon, et al., 2016); can be incredibly disruptive at an individual, classroom and family level (Walker-Noack et al., 2013); and has been estimated to cost UK society £100,000 per case due to the use of health services, educational provision, and lower lifetime earnings (Khong, 2014). Forty-five percent of this is for the extra costs of educational provision, which supports the finding in this research that most of the burden for ADHD management falls on schools. Therefore, greater recognition of ADHD needs, along with appropriate and effective support earlier on, is not only beneficial for the young person with a diagnosis, but for fellow peers, teachers, parents and society.

When ADHD is taken seriously, positive outcomes are reported. For example, two parents whose sons had recently received EHCPs felt it made a big difference to their support and success in school. There was a sense that before the EHCP, their sons were struggling and the school did not take their difficulties seriously and as soon as they received the EHCP, everything was better. However, the two parents whose sons have had an EHCP since primary school felt the level of support had reduced in secondary, and their sons were getting less than they were entitled to. More needs to be done to support pupils before an EHCP is needed and the level of support provided in secondary school needs to be monitored to ensure it is consistent with EHCP provision.

Some parents felt teachers need ADHD training to better understand it because there was a general lack of knowledge amongst staff. They felt usual behaviour management strategies were not enough and staff needed ADHD-specific strategies. Indeed, Singh (2012) found knowledgeable teachers are instrumental in helping children with ADHD. Teachers' lack of knowledge and training regarding ADHD is repeatedly evidenced in studies from UK, Canada, Australia and USA (Kendall, 2016; Wiener & Daniels, 2016). However, the current research has found most strategies that are seen as good practice are not ADHD-specific. Whether ADHD-specific strategies are more effective than non-specific ones could be an area for further research. Training would be useful

in helping teachers to understand ADHD symptoms and behaviours and ways to support pupils.

Parents felt SENCos are important and can influence teacher's knowledge and willingness to implement strategies. Kendall (2016) recommends more input regarding ADHD in initial teacher training, but does not address what could be done for practicing teachers. This could be achieved through the SENCo who has specialised knowledge.

SENCos said they often seek parent and pupil views when planning intervention. Parents and SENCos talked about the importance of parental involvement. Parents saw themselves as experts in their son's difficulties and felt they could help the school by suggesting strategies. However, for this to happen, they needed more communication with school about issues earlier on. The SENCo role as coordinator of support and point of communication for families and pupils is congruent with UK law (DfE & DoH, 2015) and NICE guidelines (2018, para.1.5.3), which state treatment decisions should be regularly discussed with young people with ADHD and their families. Previous research has shown families with a child with ADHD develop skills and strategies to live with ADHD (Moen et al., 2014), so it is likely parents would be able to suggest strategies to schools. Also, young people have reported their parents know more about ADHD than teachers (Walker-Noack et al., 2013). The SENCo role is key, especially regarding communication and relationships with parents and pupils.

Parents wanted to be given regular updates that include good news, not just bad. In a synthesis of systematic reviews, Moore et al. (2015) found daily report cards received the most consistently positive feedback as an intervention for ADHD pupils. This would be a way parents could receive more regular and positive feedback. No participants mentioned the use of daily report cards, which is consistent with findings they are infrequently used (Martinussen et al., 2011). EPs could promote the use of this intervention.

Three parents spoke about needing respite but only one received it. One parent was unable to work and his life was restricted because his son does not sleep much and was on a reduced timetable. This was reflected in previous research that found some parents had to stop working or reduce their hours to care for their child with ADHD (Sikirica et al., 2015). Similarly, Moen et al. (2014) concluded daily life in families with a child with ADHD is steered by the difficulties of the child and all family members need to be supported so problems do not become significant. LA X are not providing such respite to all families that require it.

Two SENCos said it can be difficult to get teachers to put recommended strategies into place. This attests to Singh et al.'s study (2010), which reported UK pupils with ADHD felt teachers used ADHD as an excuse to avoid making changes in the classroom. However, another study found teachers were more willing to implement interventions for pupils with a label than without (Ohan et al., 2011). The other four SENCos did not say teachers were unwilling to implement strategies so there is stronger evidence for Ohan et al.'s (2011) finding. Two parents said schools had rigid learning environments when perhaps being more flexible would better support their sons e.g. more practical learning. Similarly, Prosser (2008) outlined how traditional pedagogical practices required students to have skills at odds with ADHD symptoms e.g. sitting silently. Some teachers may need support to consider if their classroom and pedagogy fit with the strengths and needs of ADHD pupils. EPs would be well placed to do this work.

### **5.3 Gaining young people's views**

#### **5.3.1 Tools used**

A separate analysis was carried out to rate the activities used with pupil participants because they are infrequently employed and could be useful for those working with young people with ADHD (see Appendix 9.17). The tools were reviewed by the researcher as to their ease of use and quality of response from participants so professionals working with young people with ADHD can judge which tools they might use. Seeking pupil views is important, reflected by recent UK legislation including the Children and Families Act 2014 and the SEN Code of Practice (DfE & DoH, 2015), which place a duty on LAs to put the views of young people and their families at the heart of decisions regarding their education, health and care.

The young people that participated in this research discussed their views on ADHD, their experiences and support they had received in depth. Interviews lasted between 33-84 minutes, which is an extended time, especially for pupils that struggle with attention. However, the tools were helpful in sustaining their attention. Drawing the ideal/worst teacher and classroom were rated as giving the best quality of responses but took the longest time to complete. This was based on the 'Ideal Self' tool developed by Moran (2012) and was successfully used by Wiener and Daniels (2016) with adolescents with ADHD. This tool may have enabled deeper discussion because drawings provided a reference point that may have felt less personal to the participants.

The quality of response to the different tools varied by participant, which given the heterogeneity of ADHD and comorbidities of participants is to be expected. For example, some participants with ASD struggled with tasks that required imagination e.g. Ryan's ideal classroom was "*...just a classroom with tables and a white board.*" Tools should be selected based on the individual strengths and needs of the young person, and several methods should be used with each pupil.

### **5.3.2 Importance of pupil views**

The importance of seeking pupil views has been demonstrated in this research because pupils sometimes offered different perspectives on what ADHD is and effective strategies not discussed by adult participants. For example, many more pupils than SENCos equated ADHD with anger and pupils were more likely to see ADHD as a 'personality quirk'. Also, pupils talked about the importance of a comfortable classroom and teachers having high expectations for them, which no adult participants mentioned. The way pupils spoke about medication offered new insights, as many saw it as inextricably linked to having ADHD.

Previous research into the feasibility and willingness of young people to engage in intervention argued student views should be included when developing interventions, to lower the risk of them being resisted by pupils (Bussing, Koro-Ljungberg, Gagnon, et al., 2016; Bussing, Koro-Ljungberg, Gurnani, et al., 2016). Some SENCos talked about the importance of including pupil views because if they are not motivated to change, intervention will not make a difference. Gaining pupil views on their strengths, difficulties and what works well for them would effectively aid the development of tailored intervention based on their individual profile.

### **5.3.3 Difficulty gaining pupil views**

A common barrier for good practice was pupils not wanting to talk to teachers about their support or to ask for something different. This corresponds with previous findings that school adaptations can lead to pupils being teased and feeling insecure (Walker-Noack et al., 2013). The current research demonstrates using a range of tools is effective in gaining pupil views.

Eight of the nine pupils completed Conners 3 questionnaires (Conners, 2008a) after their interview but their scores did not always match how they explained ADHD

qualitatively. This difference could be a weakness of qualitative research, in that what is reported depends on what the participant thinks of at the time of interview. On the other hand, it could be a weakness of a quantitative measure's ability to truly reflect a pupil's experience of their own disorder. Using both qualitative and quantitative methods to assess a young person's ADHD symptoms results in a richer picture because one method may identify aspects the other has missed. This is an important finding for professionals assessing a young person's needs for diagnosis or intervention.

## **5.4 Summary**

The present research captured the views of pupils, parents and professionals, on their experience of ADHD in mainstream schooling, and best practice. A discussion of the limitations of the study can be found in Chapter 6. Recommendations are made for those that support young people with ADHD and future research in Chapter 7.

## **6 Chapter 6: Limitations**

In this section, the limitations of the study are described.

### **6.1 Sample**

The overall sample size for each participant group was small and this reflected difficulties with recruitment, which was partly due to low prevalence of ADHD in LA X. All pupil participants were male because no female pupils met criteria in the schools that participated. Seven of the nine pupil participants were white British meaning the transferability of these findings to other ethnic populations should be questioned.

The profile of pupils that participated may have been skewed towards young people that were relatively untroubled in school. For example, in one school, some pupils with ADHD were unable to participate because they were excluded at the time of data collection.

Six pupil participants had comorbid ASD and this may have impacted on the findings. Often, these young people are excluded from research but important findings were identified in relation to the impact of these other difficulties and they are relevant because a large percentage of young people with ADHD are estimated to have at least one comorbid diagnosis (Stefanatos & Baron, 2007). Though interview questions focused on ADHD, we cannot say with certainty which findings are as a result of ADHD, and which might be a consequence of comorbid difficulties.

The views of other professionals, such as teachers, CAMHS professionals or EPs, may have added other perspectives.

### **6.2 Methodology**

All but two participants were only interviewed once. This means all findings are based on their thoughts on the day of interview, which may have been impacted by factors including mood and current context. My relationship with participants and attributes such as my gender, age and ethnicity will have impacted on participants and what they said in an unknown quantity. However, I feel a strength in my approach was using skills I apply as an EP including attunement and reflection on language used.

Pupil participants were invited to give feedback on initial findings through a website but only one did so. Arranging to do this in person may have yielded more feedback and

could be incorporated into future research design to increase validity. One Conners questionnaire was not returned and the parents of two pupil participants were not interviewed, meaning the data could be more complete.

Participants were asked about challenges they face, which included arguably emotive and personal topics. It can be difficult to share this with a person you have never met and this may have impacted on the data. Conversely, sometimes it can be easier to say some things to someone from outside of everyday life. For example, pupils may have found it easier to tell me things they did not like about their school than to a teacher. Effort was made to use different tools to reduce anxiety.

Conners 3 self-report questionnaires were used but have been criticised because there is little research into its validity and reliability and it has been found to assess general psychopathology rather than ADHD specifically (Gianarris et al., 2001). Also, a study into the relationship between self-reported impulsivity and behavioural measures of it found no relationship between the two (Barnhart & Buelow, 2017).

In this research, what is deemed good practice in terms of support for young people with ADHD is based on participants' experience with and exposure to intervention. Findings on strategies/interventions were not triangulated with quantitative data on their effectiveness.



## **7 Chapter 7: Future directions and conclusion**

In this section, the key findings from Chapters 4 and 5 are summarised. Then, implications are discussed for those that support young people with ADHD and recommendations made for future research.

### **7.1 Future directions**

#### **7.1.1 Recommendations for Educational Psychologists**

This research demonstrated EPs are well placed to support young people with ADHD, their families and school staff because they have a good understanding of the specific LA and school context, are knowledgeable about ADHD, and work at and between different ecosystemic levels to ensure individual needs are met in all key areas of the child's life.

Recommendations for how EPs might better support young people with ADHD are shown in Table 7.1, in relation to Bronfenbrenner's bioecological model (2005). This framework reflects the systems and factors that influence a person's development and behaviour and the different levels of EP work. The systems and factors overlap and interact with each other, so each recommendation is not rigidly fixed within an aspect of the PPCT model.

LA X has a traded EP service and most schools have weekly EP input. In England, the level of EP delivery in schools varies by LA, which means inequality of access to services. Therefore, the extent to which EPs can implement these recommendations will be dependent upon location.

Table 7.1: Recommendations for EP work with respect to Bronfenbrenner's bioecological model

<b>PPCT aspect/ system</b>	<b>Recommendations</b>
<b>TIME:</b> Chronosystem.	<ul style="list-style-type: none"> <li>• Inform key stakeholders ADHD symptoms and relationships may change over time.</li> </ul>
<b>CONTEXT:</b> Macrosystem, exosystem, mesosystem, microsystem.	<ul style="list-style-type: none"> <li>• Help schools to think about how their environment and pedagogy fits with these pupils, not the other way around.</li> <li>• Promote the positive impact of ADHD and use of role models to help tackle stigma.</li> <li>• Help schools to secure support e.g. EHCP, CAMHS referrals.</li> <li>• Work with CAMHS and local charities to provide support and training to young people with ADHD and their families.</li> <li>• Work with community services to include young people with ADHD in social and sporting activities.</li> <li>• Raise the profile of ADHD in the LA.</li> <li>• Signpost families to other services they can access.</li> <li>• Promote the importance of peer and teacher-pupil relationships for young people with ADHD.</li> <li>• Support schools with data-sharing practices e.g. so teachers do not discipline students for ADHD symptoms.</li> <li>• Promote the importance of meeting Maslow's hierarchy of needs in schools e.g. comfortable seating, better food.</li> </ul>
<b>PROXIMAL PROCESSES:</b> Good practice, understanding of ADHD.	<ul style="list-style-type: none"> <li>• Carry out direct work with pupils with ADHD e.g. motivational interviewing, gaining their views.</li> <li>• Provide a better explanation of ADHD to young people that includes helping them to resolve their confused feelings of being normal and different at the same time and identify positive aspects.</li> <li>• Provide tailored training in schools to promote understanding of challenges faced by pupils with ADHD and their families, and ways to support them.</li> <li>• Support SENCos to manage the amount of intervention in place at one time for each pupil.</li> </ul>
<b>PERSON:</b> Demand, resource and force characteristics.	<ul style="list-style-type: none"> <li>• Carry out consultations with parents and school staff, and assess and observe pupils in order to develop a better understanding of the specific impact of ADHD, strengths, comorbidities and family circumstances on the pupil and their family. Based on this, support key stakeholders to develop an individualised, evidence-based intervention plan.</li> <li>• Be aware of pupil motivation as a factor in intervention efficacy.</li> <li>• Support schools in seeking and using pupil and parent views e.g. developing a range of tools, analysis of data, reviewing support (trial-and-error approach).</li> <li>• Help schools to deliver support for pupils' emotional wellbeing and regulation.</li> </ul>

### **7.1.2 Recommendations for LA X**

Participant accounts suggest there are gaps in services in LA X, especially regarding parent support/education programmes and availability of respite, so these should be developed as a matter of urgency. The LA could also develop programmes using ADHD role models or mentors to more positively support young people with ADHD.

Information about the support young people with ADHD and their families are entitled to and can access should be readily available to key stakeholders. Parents of young people with an EHCP felt their child's support reduced in secondary when compared to primary school. This should be monitored by the SEN team, for example, at annual reviews.

When young people receive a diagnosis of ADHD, they would benefit from a fuller description of what it is, and positive and negative possible impacts. Participants felt recommendations made by CAMHS for schools and families were inadequate.

Young people with ADHD in LA X that choose not to take medication are discharged by CAMHS. A review of what CAMHS in LA X offer in terms of intervention and support for ADHD needs to be reviewed.

### **7.1.3 Future research directions**

Based on the key findings and limitations of this study, the following recommendations are made for future research:

- This research focused on one English LA. Replicated research in other LAs could highlight differences between areas and provide further knowledge and understanding.
- Employing a sample size with a wider representation of participant factors such as comorbidity, gender and ethnicity would allow for further exploration of group differences and may yield different findings.
- Further qualitative or mixed-method research including teacher, TA, EP and CAMHS practitioner views would perhaps provide other perspectives and suggestions for good practice.
- The good practice highlighted in this research could be explored using mixed or quantitative methods to further strengthen the findings about the effectiveness of the interventions suggested. Also, comparing ADHD-specific

strategies to more general ones would explore whether 'special' interventions are needed.

- Seeking child views on the impact of having ADHD alongside comorbid diagnoses would triangulate the adult perceptions found here.
- Further research could investigate whether ADHD symptoms change over time and become more akin to ASD.
- The SENCo role was viewed as important to teacher knowledge and understanding of ADHD. This could be explored to see if such a relationship exists.
- The question of whether the ADHD label is useful has not been fully resolved; the findings suggest reasons for and against it.

## **7.2 Conclusion**

This research is timely because it has coincided with new NICE guidelines for ADHD being published (NICE, 2018) and awareness of the need to include young people and parent views being at the forefront of education.

The findings of this research highlight the complexity of ADHD, heterogeneity of its symptoms and pros and cons of the impact of the label on young people and their families. Strategies and interventions have been suggested as good practice but a trial-and-error, tailored approach is needed to account for an individual's strengths and difficulties. These strategies and interventions are not always ADHD-specific and are likely to benefit pupils with a range of SEN, and perhaps typically developing pupils more broadly. Teachers, TAs, SENCos, EPs and CAMHS professionals all have an important role to play in helping young people with ADHD and their families and LA support has found to be lacking in several areas. Tools to gain pupil views were used and described so they can be used by school staff or other professionals including EPs. A range of tools should be used and selected based on the young person's strengths and needs. This project has added to the evidence-base about the experience of ADHD and how best to support it from the viewpoints of adolescents and key stakeholders. It has highlighted areas where knowledge and support is lacking, and promoted the voice of young people with ADHD.

This research has also impacted on my practice as an EP at an individual, whole-school and LA level in that I: am more confident in my explanation of what ADHD is (including positives) and the advantages and disadvantages of labelling ADHD; have a wider range of tools to gain young people's views; can make evidence-based

recommendations to schools; can provide holistic, tailored training to schools; have become involved with a public policy pressure group regarding ADHD medication; and plan to explore joint working with CAMHS and local charities in the future.

This research has been or will be disseminated via several routes:

- To participants: through a research report and website.
- To Trainee EPs and tutors: this research was presented at a conference at UCL Institute of Education in June 2018.
- To EPs in LA X: this research was presented at a team meeting in July 2018.
- Publication: one or more research articles will be submitted in the future.
- To COPE: COPE is a new public policy pressure group. The research was presented at their inaugural meeting at the House of Commons in June 2018.

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## 9 Appendices

### 9.1 Systematic search

Databases searched November 2016-April 2018:

- British Education Index (BEI)
- Child Development and Adolescent Studies
- The Cochrane Library
- ERIC (Education Resources Information Center)
- Medline
- PsycINFO
- ProQuest Education Journals
- SCOPUS
- Web of Science

Boolean search terms:

- ADHD OR “attention deficit hyperactivity disorder” AND
- views OR opinions OR perceptions OR beliefs AND
- child\* OR adolescents OR teenagers OR young people OR youth

Criteria:

- Qualitative or mixed methods
- Young people’s views about their ADHD sought

Table 8.1: Relevant papers from systematic literature search

Authors	Title	Year	Country	Participants
Ahlström and Wentz	Difficulties in everyday life: Young persons with attention-deficit/hyperactivity disorder and autism spectrum disorders perspectives. A chat-log analysis.	2014	Sweden	12 young people aged 15-26
Brady	Children and ADHD: seeking control within the constraints of diagnosis.	2014	UK	7 young people aged 6-19 and parent questionnaires

Brinkman, Sherman, Zmitrovich, Visscher, Crosby, Phelan and Donovan	In their own words: Adolescent views on ADHD and their evolving role managing medication.	2012	USA	44 young people aged 13-18
Charach, Yeung, Volpe, Goodale and dosReis	Exploring stimulant treatment in ADHD: Narratives of young adolescents and their parents.	2014	Canada	12 young people aged 12-15 and their parents
Gajaria, Yeung, Goodale and Charach	Beliefs about attention-deficit/hyperactivity disorder and response to stereotypes: Youth postings in Facebook groups.	2011	N/A Facebook postings	Aged 13-21, unknown number of participants
Honkasilta, Vehmas and Vehkakoski	Self-pathologizing, self-condemning, self-liberating: Youths' accounts of their ADHD-related behaviour.	2016	Finland	13 young people aged 11-16
Kendall	'The teacher said I'm thick!' Experiences of children with attention deficit hyperactivity disorder within a school setting.	2016	UK	12 young people aged 10-15
Ljusberg	Children's views on attending a remedial class because of concentration difficulties.	2011	Sweden	10 young people aged 10-12
Mahdi, Viljoen, Massuti, Selb, Almodayfer, Karande, de VriesLuis Rohde, and Bölte	An international qualitative study of ability and disability in ADHD using the WHO-ICF framework.	2017	Brazil, India, Saudi Arabia, South Africa and Sweden	76 participants including 25 children aged 7+, their family members, caregivers, or others closely involved in their life
Moen, Hall-Lord and Hedelin	Living in a family with a child with attention deficit hyperactivity disorder: A phenomenographic study.	2014	Norway	4 young people aged 8-17 and their families



Moldavsky and Sayal	Knowledge and attitudes about ADHD and its treatment: The views of children, adolescents, parents, teachers and healthcare professionals.	2013	N/A- review	N/A- review
Sikirica, Flood, Dietrich, Quintero, Harpin, Hodgkins, Skrodzki, Beusterien and Erder	Unmet needs associated with attention-deficit/hyperactivity disorder in eight European countries as reported by caregivers and adolescents: Results from qualitative research.	2015	France, Germany, Italy, the Netherlands, Norway, Spain, Sweden, UK	28 adolescents (aged 13–17) and 38 caregivers
Singh, Kendall, Taylor, Mears, Hollis, Batty and Keenan	Young people's experience of ADHD and stimulant medication: A qualitative study for the NICE guideline.	2010	UK	16 young people aged 9-14
Singh	A disorder of anger and aggression: Children's perspectives on attention deficit/hyperactivity disorder in the UK.	2011	UK	82 young people aged 9-14
Singh	VOICES: Voices on identity, childhood, ethics and stimulants. Children join the debate.	2012	UK and USA	151 young people aged 9-14
Walker-Noack, Corkum, Elik, and Fearon	Youth perceptions of attention-deficit/hyperactivity disorder and barriers to treatment.	2013	Canada	25 youths (aged 10-21)
Wiener and Daniels	School experiences of adolescents with ADHD.	2016	Canada	12 young people aged 14-16
Wong, Hawes, Clarke, Kohn and Dar-Nimrod	Perceptions of ADHD among diagnosed children and their parents: A systematic review using the common-sense model of illness representations.	2017	N/A- Systematic search	N/A- review

## 9.2 Ethical approval form

**Institute of Education**

### Ethics Application Form: Student Research

Anyone conducting research under the auspices of the Institute (staff, students or visitors) where the research involves human participants or the use of data collected from human participants, is required to gain ethical approval before starting. This includes preliminary and pilot studies. Please answer all relevant questions in terms that can be understood by a lay person and note that your form may be returned if incomplete.

For further support and guidance please see accompanying guidelines and the Ethics Review Procedures for Student Research <http://www.ucl.ac.uk/srs/research-ethics-committee/ioe> or contact your supervisor or [researchethics@ioe.ac.uk](mailto:researchethics@ioe.ac.uk).

**Before completing this form you will need to discuss your proposal fully with your supervisor(s). Please attach all supporting documents and letters.**

*For all Psychology students, this form should be completed with reference to the British Psychological Society (BPS) Code of Human Research Ethics and Code of Ethics and Conduct.*

Section 1 Project details					
a.	Project title	Exploring young people with ADHD's experiences of secondary school and good practice in the schools supporting them			
b.	Student name	Emma Flack			
c.	Supervisor/Personal Tutor	Emily Farran and Vivian Hill			
d.	Department	Psychology & Human Development			
e.	Course category (Tick one)	PhD/MPhil	<input type="checkbox"/>	EdD	<input type="checkbox"/>
		MRes	<input type="checkbox"/>	DEdPsy	<input checked="" type="checkbox"/>
		MTeach	<input type="checkbox"/>	MA/MSc	<input type="checkbox"/>
		ITE	<input type="checkbox"/>		
		Diploma (state which)	<input type="checkbox"/>		
		Other (state which)	<input type="checkbox"/>		
f.	Course/module title	Doctorate in Professional Educational, Child and Adolescent Psychology			
g.	If applicable, state who the funder is and if funding has been confirmed.	N/A			
h.	Intended research start date	March 2017			
i.	Intended research end date	June 2018			

j.	Country fieldwork will be conducted in <i>If research to be conducted abroad please check <a href="http://www.fco.gov.uk">www.fco.gov.uk</a> and submit a completed travel insurance form to Serena Ezra (<a href="mailto:s.ezra@ucl.ac.uk">s.ezra@ucl.ac.uk</a>) in UCL Finance (see guidelines). This form can be found here (you will need your UCL login details available): <a href="https://www.ucl.ac.uk/finance/secure/fin_acc/insurance.htm">https://www.ucl.ac.uk/finance/secure/fin_acc/insurance.htm</a></i>	UK
k.	Has this project been considered by another (external) Research Ethics Committee?	
	Yes <input type="checkbox"/>	External Committee Name:
	No <input checked="" type="checkbox"/> ⇒ go to Section 2	Date of Approval:
<p><b>If yes:</b></p> <ul style="list-style-type: none"> <li>– Submit a copy of the approval letter with this application.</li> <li>– Proceed to Section 10 Attachments.</li> </ul> <p><b>Note:</b> Ensure that you check the guidelines carefully as research with some participants will require ethical approval from a different ethics committee such as the <a href="#">National Research Ethics Service (NRES)</a> or <a href="#">Social Care Research Ethics Committee (SCREC)</a>. In addition, if your research is based in another institution then you may be required to apply to their research ethics committee.</p>		

## Section 2. Project summary

### Research methods (tick all that apply)

Please attach questionnaires, visual methods and schedules for interviews (even in draft form).

- |   |  |
|---|--|
| <input checked="" type="checkbox"/> Interviews        | <input type="checkbox"/> Controlled trial/other intervention study                             |
| <input type="checkbox"/> Focus groups                 | <input type="checkbox"/> Use of personal records   |
| <input checked="" type="checkbox"/> Questionnaires    | <input checked="" type="checkbox"/> Systematic review ⇒ if only method used go to Section 5.   |
| <input type="checkbox"/> Action research              | <input type="checkbox"/> Secondary data analysis ⇒ if secondary analysis used go to Section 6. |
| <input type="checkbox"/> Observation                  | <input type="checkbox"/> Advisory/consultation/collaborative groups                            |
| <input checked="" type="checkbox"/> Literature review | <input type="checkbox"/> Other, give details:  |

Please provide an overview of your research. This should include some or all of the following: purpose of the research, aims, main research questions, research design, participants, sampling, your method of data collection (e.g., observations, interviews, questionnaires, etc.) and kind of questions that will be asked, reporting and dissemination (typically 300-500 words).

### Background to the research

Attention deficit hyperactivity disorder (ADHD) is one of the most common childhood disorders and has a significant impact on children and families. School can be difficult for pupils with ADHD and it is associated with academic failure. However, little training is offered to school staff regarding special educational needs in general and even less so for ADHD specifically. There is a lack of ADHD research that seeks pupil views on their experience of UK secondary school and what helps them.

### Research questions

- What is good practice for secondary schools supporting young people with ADHD?
- How do young people with ADHD experience secondary school in the UK?

### Aims of the study

This research will aim to give disadvantaged young people a voice regarding their diagnosis of ADHD

and the support they receive in school. It will widen our understanding of ADHD and how it impacts adolescents within a mainstream secondary school environment.

This research will inform school staff of strategies that young people with ADHD, school SENCOs and parents perceive to be effective and so can be referenced by school staff and EPs when designing intervention for pupils with ADHD. This research will help professionals to see that young people have an understanding of their needs and what helps them and so should seek pupil views. The tools I use with pupil participants could be used to gain the views of young people when developing or reviewing their support in school.

#### Methodology

- I will approach SENCOs or head teachers in all secondary schools in LAX to take part. If the school agrees, I will send information sheets and consent forms to all pupils in the school that have ADHD as their primary need and their parents/carers (attached).
- A questionnaire will be sent to each parent identified with an invitation to take part in an interview (attached).
- Interview the SENCO from each school that agrees to participate.
- Interview parents that agree to participate.
- Interview pupils when both they and their parents provide informed consent. Interviews will be comprised of verbal questions and short activities (see interview schedule attached).
- All interviews are semi-structured so that the questions are flexible and anything interesting the interviewee says can be followed up (interview schedules attached).

#### Reporting

The research will be written up as a 35,000 word (+/- 10%) thesis. A research brief will also be written. This will be shared with the schools that take part and any participants that would like a copy. It is possible that the research will be published in journals in the future. The university will hold a copy of the thesis in their library and include a summary in university publications.

### Section 3 Participants

Please answer the following questions giving full details where necessary. Text boxes will expand for your responses.

a.	Will your research involve human participants?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/> ⇒ go to Section 4
b.	Who are the participants (i.e. what sorts of people will be involved)? Tick all that apply.		
	<input type="checkbox"/> Early years/pre-school <input type="checkbox"/> Ages 5-11 <input checked="" type="checkbox"/> Ages 12-16 <input type="checkbox"/> Young people aged 17-18	<input type="checkbox"/> Unknown – specify below <input checked="" type="checkbox"/> Adults please specify below <input type="checkbox"/> Other – specify below	
	<p><b>NB:</b> Ensure that you check the guidelines (Section 1) carefully as research with some participants will require ethical approval from a different ethics committee such as the National Research Ethics Service (NRES).</p> <p>Parents of the young people and SENCOs (Special Educational Needs Co-ordinators) from the schools the young people attend.</p>		
c.	If participants are under the responsibility of others (such as parents, teachers or medical staff) how do you intend to obtain permission to approach the participants to take part in the study? (Please attach approach letters or details of permission procedures – see Section 9 Attachments.)		

	Approach parents via the school SENCo; information sheet and consent form for parents; information sheet and consent form for young people; information sheet and consent form for SENCos.
d.	<p>How will participants be recruited (identified and approached)?</p> <p>I will email or telephone the SENCo or head teacher at every secondary school in LA X and if they agree to participate, will send consent forms and information sheets to every pupil that has ADHD as their primary need and to their parent/carers. I will also give an information sheet and consent form to the SENCos.</p>
e.	<p>Describe the process you will use to inform participants about what you are doing.</p> <p>Information sheets and consent forms for parent/carers, pupils and SENCos (attached). I will provide my contact details in case they have any questions. I will re-state the aims of the research and address ethical issues at the start of each interview (see interview schedules, attached).</p>
f.	<p>How will you obtain the consent of participants? Will this be written? How will it be made clear to participants that they may withdraw consent to participate at any time?</p> <p><i>See the guidelines for information on opt-in and opt-out procedures. Please note that the method of consent should be appropriate to the research and fully explained.</i></p> <p>Opt-in written consent forms and information sheets for each participant (attached). For pupil participants, I will also seek the consent of their parent/carers.</p> <p>I will re-state ethical issues such as withdrawal of consent and not having to answer all questions at the start of each interview (see interview schedules). During interviews, if I feel that the participant feels uncomfortable or upset in any way, I will remind them that they can stop the interview at any time and withdraw from the research.</p>
g.	<p><b>Studies involving questionnaires:</b> Will participants be given the option of omitting questions they do not wish to answer?</p> <p>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>If NO please explain why below and ensure that you cover any ethical issues arising from this in section 8.</p> <p></p>
h.	<p><b>Studies involving observation:</b> Confirm whether participants will be asked for their informed consent to be observed.</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If NO read the guidelines (Ethical Issues section) and explain why below and ensure that you cover any ethical issues arising from this in section 8.</p> <p></p>
i.	<p>Might participants experience anxiety, discomfort or embarrassment as a result of your study?</p> <p>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>If yes what steps will you take to explain and minimise this?</p> <p>I will tell participants and remind them at the start of and during interviews that anything they say will not be able to be linked to them, that I will not name them, the school or the local area and that for any question, they can choose not to answer it or ask for the interview to be stopped at any time. If appropriate, I will reassure participants and explain that the aim of the research is to explore what it is like to have ADHD in school and to further schools' understanding of how best to support pupils with ADHD. I will identify someone in the school that the student participants</p>

	can talk to afterwards if they have any negative feelings and provide my contact details to all participants for if they have any concerns or questions. If <b>not</b> , explain how you can be sure that no discomfort or embarrassment will arise? <input type="text"/>
j.	Will your project involve deliberately misleading participants (deception) in any way? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
	If <b>YES</b> please provide further details below and ensure that you cover any ethical issues arising from this in section 8. <input type="text"/>
k.	Will you debrief participants at the end of their participation (i.e. give them a brief explanation of the study)? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
	If <b>NO</b> please explain why below and ensure that you cover any ethical issues arising from this in section 8. <input type="text"/>
l.	Will participants be given information about the findings of your study? (This could be a <u>brief summary</u> of your findings in general; it is not the same as an individual debriefing.) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
	If <b>no</b> , why not? <input type="text"/>

#### Section 4 Security-sensitive material

Only complete if applicable

Security sensitive research includes: commissioned by the military; commissioned under an EU security call; involves the acquisition of security clearances; concerns terrorist or extreme groups.

a.	Will your project consider or encounter security-sensitive material?	Yes <input type="checkbox"/> *	No <input checked="" type="checkbox"/>
b.	Will you be visiting websites associated with extreme or terrorist organisations?	Yes <input type="checkbox"/> *	No <input checked="" type="checkbox"/>
c.	Will you be storing or transmitting any materials that could be interpreted as promoting or endorsing terrorist acts?	Yes <input type="checkbox"/> *	No <input checked="" type="checkbox"/>

\* Give further details in Section 8 Ethical Issues

#### Section 5 Systematic review of research

Only complete if applicable

a.	Will you be collecting any new data from participants?	Yes <input checked="" type="checkbox"/> *	No <input type="checkbox"/>
b.	Will you be analysing any secondary data?	Yes <input type="checkbox"/> *	No <input type="checkbox"/>

\* Give further details in Section 8 Ethical Issues

If your methods do not involve engagement with participants (e.g. systematic review, literature review) and if you have answered **No** to both questions, please go to Section 10 Attachments.

### Section 6 Secondary data analysis Complete for all secondary analysis

a.	Name of dataset/s		
b.	Owner of dataset/s		
c.	Are the data in the public domain?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
		If no, do you have the owner's permission/license? Yes <input type="checkbox"/> No* <input type="checkbox"/>	
d.	Are the data anonymised?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
		Do you plan to anonymise the data?	Yes <input type="checkbox"/> No* <input type="checkbox"/>
		Do you plan to use individual level data?	Yes* <input type="checkbox"/> No <input type="checkbox"/>
		Will you be linking data to individuals?	Yes* <input type="checkbox"/> No <input type="checkbox"/>
e.	Are the data sensitive (DPA 1998 definition)?	Yes* <input type="checkbox"/>	No <input type="checkbox"/>
f.	Will you be conducting analysis within the remit it was originally collected for?	Yes <input type="checkbox"/>	No* <input type="checkbox"/>
g.	If no, was consent gained from participants for subsequent/future analysis?	Yes <input type="checkbox"/>	No* <input type="checkbox"/>
h.	If no, was data collected prior to ethics approval process?	Yes <input type="checkbox"/>	No* <input type="checkbox"/>

\* Give further details in Section 8 Ethical Issues

If secondary analysis is only method used and no answers with asterisks are ticked, go to Section 9 Attachments.

### Section 7 Data Storage and Security

Please ensure that you include all hard and electronic data when completing this section.

a.	Confirm that all personal data will be stored and processed in compliance with the Data Protection Act 1998 (DPA 1998). (See the Guidelines and the Institute's Data Protection & Records Management Policy for more detail.)	Yes <input checked="" type="checkbox"/>
b.	Will personal data be processed or be sent outside the European Economic Area?	Yes <input type="checkbox"/> * No <input checked="" type="checkbox"/>
* If yes, please confirm that there are adequate levels of protections in compliance with the DPA 1998 and state what these arrangements are below.		
<div style="border: 1px solid black; height: 15px; width: 100%;"></div>		
c.	Who will have access to the data and personal information, including advisory/consultation groups and during transcription?	
	Me (all data) and my supervisors, Vivian Hill and Emily Farran (anonymised data).	
<b>During the research</b>		
	Where will the data be stored?	
d.	Recordings and transcriptions will be stored securely on my personal laptop and external hard-drive. Paper data (questionnaires and consent forms) will be stored in a locked document storage box.	

Will mobile devices such as USB storage and laptops be used?		Yes <input checked="" type="checkbox"/> • No <input type="checkbox"/>
• If yes, state what mobile devices: Personal laptop and external hard-drive.		
e.	• If yes, will they be <u>encrypted</u> ? Yes	
<b>After the research</b>		
f.	Where will the data be stored? Personal laptop and external hard-drive (digital data) and locked document storage box (paper data)	
g.	How long will the data and records be kept for and in what format? They will be kept for five years. If The interview recordings and transcripts will be stored on the laptop described above as coded files so that they cannot be connected to the research participants. The paper data will be stored in a locked document storage box.	
h.	Will data be archived for use by other researchers?	Yes <input type="checkbox"/> • No <input checked="" type="checkbox"/>
• If yes, please provide details. <input type="text"/>		

### Section 8. Ethical issues

Are there particular features of the proposed work which may raise ethical concerns or add to the complexity of ethical decision making? If so, please outline how you will deal with these.

It is important that you demonstrate your awareness of potential risks or harm that may arise as a result of your research. You should then demonstrate that you have considered ways to minimise the likelihood and impact of each potential harm that you have identified. Please be as specific as possible in describing the ethical issues you will have to address. Please consider / address ALL issues that may apply.

*Ethical concerns may include, but not be limited to, the following areas:*

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li>- Methods</li> <li>- Sampling</li> <li>- Recruitment</li> <li>- Gatekeepers</li> <li>- Informed consent</li> <li>- Potentially vulnerable participants</li> <li>- Safeguarding/child protection</li> <li>- Sensitive topics</li> </ul> | <ul style="list-style-type: none"> <li>- International research</li> <li>- Risks to participants and/or researchers</li> <li>- Confidentiality/Anonymity</li> <li>- Disclosures/limits to confidentiality</li> <li>- Data storage and security both during and after the research (including transfer, sharing, encryption, protection)</li> <li>- Reporting</li> <li>- Dissemination and use of findings</li> </ul> |
|---|--|

Informed consent will be gained from:

- The pupil being interviewed
- The pupil's parent/carer (for the pupil to be interviewed)
- The member of staff being interviewed
- The parent/carers who complete the questionnaire
- The parent/carers that are interviewed

Each participant will be asked if they would like a copy of the research briefing and will be sent a copy if they so wish.

To make sure what each participant says cannot be linked with them in any way, pseudonyms will be used in the write-up of the study. Recordings and transcripts will be coded so that no names are stored in the same place as the data. Data will be stored in encrypted, password-protected files on



one laptop and one external hard-drive that only the researcher has access to. Paper data (consent forms and parent questionnaires) will be stored in a locked document storage box.

I will ensure they participants know they do not have to answer every question, that they can stop the interview at any time and can withdraw from the study at any time (the deadline for withdrawing consent will be the end of September 2017 to allow for the write-up). I will conduct the interviews in a private room where no-one else can hear what is being said. I will ask for permission from the participant to record the interview. If the participant does not agree to being recorded, I will ask permission to take written notes. I will monitor the participants throughout the interview and will reassure them they can stop the interview if they appear uncomfortable in any way.

I will inform the participants that nothing that they say will be attributed to them. I will not tell the school, the pupils or the pupil's parents what they said. I will anonymise any quotes in the write-up. The only time I will tell someone else what is said is if any safeguarding issues arise. This will be explained to the participants before the interview starts.

An adult in the school will be identified with the SENCo, whom the pupil can talk to at any time after the interview if the interview makes them feel embarrassed, uncomfortable or anxious in any way. The pupil will be told this at the beginning and end of the interview. All participants will be given my contact details. If any participant becomes upset or distressed during an interview, I will reassure them and suggest a break or to end the interview. I will stay with the participant until they are not upset or, in the case of pupil participants, are with another adult who can help them.

I will ask the parents and the SENCo if the pupil is aware of their diagnosis of ADHD before meeting with the pupil. The pupil will not be asked or told about their diagnosis if they are not already aware of it. I will ask the SENCo if the pupil has any sensitivities around the support they receive in school or their difficulties and amend the interview questions if so required, for example omitting the questions about difficulties the pupil has.

#### Section 9 Further information

Outline any other information you feel relevant to this submission, using a separate sheet or attachments if necessary.

#### Section 10 Attachments Please attach the following items to this form, or explain if not attached

a.	Information sheets and other materials to be used to inform potential participants about the research, including approach letters	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
b.	Consent form	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
	<i>If applicable:</i>		
c.	The proposal for the project	Yes <input type="checkbox"/>	No <input type="checkbox"/>

d.	Approval letter from external Research Ethics Committee	Yes <input type="checkbox"/>	No <input type="checkbox"/>
e.	Full risk assessment	Yes <input type="checkbox"/>	No <input type="checkbox"/>

### Section 11 Declaration

	Yes	No
I have read, understood and will abide by the following set of guidelines.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
BPS <input checked="" type="checkbox"/> BERA <input type="checkbox"/> BSA <input type="checkbox"/> Other (please state) <input checked="" type="checkbox"/> HCPC		
I have discussed the ethical issues relating to my research with my supervisor.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
I have attended the appropriate ethics training provided by my course.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<p>I confirm that to the best of my knowledge:</p> <p>The above information is correct and that this is a full description of the ethics issues that may arise in the course of this project.</p>		
Name	Emma Flack	
Date	11.03.2017	

Please submit your completed ethics forms to your supervisor.

### Notes and references

### 9.3 Information from CAMHS in LA X

#### Referral and assessment procedures

- Referral to CAMHS by the SENCo is usually the first step. The time between referral and assessment for ADHD is usually a few months.
- There must be evidence of a parenting intervention and appropriate strategies being used in school before a referral will be accepted. Some schools have found it difficult to find any parenting courses.
- Questionnaires are completed by parent/s and school. If the questionnaires indicate the child has displayed ADHD symptoms in at least two different settings for six months, the child is invited for a QB Test, a computer-based assessment that evaluates the core symptoms of ADHD (Qbtech AB, 2013). Then, the child and parent/s attend a 2-hour appointment with an ADHD Practitioner. School staff are invited but do not usually attend. Finally, a decision on diagnosis is made with a Psychiatrist. After the diagnosis decision, a practitioner meets with the parent/s.
- The practitioners estimated the prevalence rate in LA X is below the national average, at around 1%. They see a high proportion of white boys and struggle to reach Asian and Romany families. The majority of the population in LA X is Asian whilst less than 1% is Romany (X Borough Council, 2013), which suggests there may be under-diagnosis of ADHD in Asian families in LA X.
- CAMHS provide a Tier 3 specialist outpatient service and do not currently offer any psychological or behavioural intervention.

#### Practitioner views on good practice

- The practitioners estimated around 10% of referrals are inappropriate. Sometimes, this is because the child's symptoms are more aligned with another disorder such as ASD or Dyslexia or because of family issues.
- The practitioners would like better and earlier referrals and for more children and their families to receive early intervention. They felt some children should attend special schools that deliver intensive behavioural interventions with highly trained staff. The practitioners thought some school staff adjust their responses on questionnaires to make the child's behaviour seem better than it is because they do not agree with medicating ADHD or do not want to be unkind to the child. Sometimes, questionnaires are completed by someone who does not know the child well enough.

- The practitioners said approximately 95% of children diagnosed with ADHD in LA X are taking medication. Families that refuse medication are usually discharged. Yet, the practitioners stressed medication is only effective alongside intervention.
- A good rapport with school staff is needed so the practitioners can effectively monitor how the child is responding to medication.
- The practitioners would like to have more input in schools, but this would require a big change in infrastructure and some young people do not want their peers to know about their ADHD. They sometimes find information about required strategies does not always reach teachers.

## **9.4 Selection of activities for pupil interviews**

A systematic search of studies that gained the views of pupils with SEN using activities, and not just interviews/ focus groups, was carried out in January 2017.

Databases searched:

- British Education Index (BEI)
- ERIC
- PsycINFO

Boolean search terms (in abstract):

- SEN OR “special educational needs” AND
- views OR opinions OR perceptions OR beliefs AND
- child OR adolescent OR children OR teenager

Criteria:

- Peer reviewed journal articles Nov 2010-Jan 2017.
- Articles that gain views from children and young people with SEN.

Fifteen articles were identified. Activities used in these studies were then rated as to their appropriateness for this study, in terms of the research aims and likely strengths and difficulties of the pupil participants. The activities used in this study were selected from those rated as ‘green’ (see next page).

Green methodologies	Amber methodologies	Red methodologies
<ul style="list-style-type: none"> <li>• Participatory methods: young people are empowered to make decisions about how they participate in the research.</li> <li>• Write Post-it Notes: 'things I like about school' on one colour, 'things I don't like' on another colour.</li> <li>• Drawing activities with discussion.</li> <li>• Graffiti wall: could use Google docs.</li> <li>• The decision-making pocket chart: grid to rate how useful different strategies/ interventions are in different lessons.</li> <li>• Ideal school, classroom, teacher, and opposites.</li> <li>• Document analysis: ask participants to bring examples of work.</li> <li>• Questions using Personal Construct Psychology.</li> <li>• Timeline or 'Life path' of life with key moments re: schooling and ADHD.</li> <li>• The pots and beans activity: jar of beans and 6 pots with different labels with strategies on. Put up to 3 beans in depending on usefulness.</li> <li>• 'Partially completed drawing'- participant completes it. Perhaps picture of child who has just been diagnosed with ADHD- add speech and thought bubbles and emotions.</li> <li>• Three comments</li> </ul>	<ul style="list-style-type: none"> <li>• Participants draw balls, with pre-determined topics written on them, from a bag, and decide whether or not to discuss the topic.</li> <li>• Diamond ranking: what is most important to the young person.</li> <li>• 'Traffic light' system, where pupils give a yellow card if s/he does not want to answer a question or a red one if s/he wants to end the session altogether.</li> <li>• Use photographs and sort into categories e.g. 'like', 'ok' and 'dislike'. Then probe further to understand the reasons underpinning likes and dislikes.</li> <li>• Draw hands and write 5 things that make a good teacher on one and good classroom on the other.</li> <li>• Missing words game: complete a sentence.</li> <li>• Blob trees- to show how young people feel about themselves in the classroom/ school.</li> <li>• Make a poster.</li> <li>• Take photos of activities and discuss them in interviews</li> <li>• Q methodology: rank statements from most agree to most disagree. Needs specialist computer package to analyse.</li> <li>• Scaling questions.</li> </ul>	<ul style="list-style-type: none"> <li>• Pictured surveys: questionnaires designed by children.</li> <li>• Drama activities- better for groups.</li> <li>• Participant observation (doesn't get views).</li> <li>• Self-description grid.</li> <li>• Forum theatre/ production of a short film: ethical considerations, time.</li> <li>• Kinetic family drawing.</li> <li>• Walking interview: the young person shows me around their school and I ask about what is important to the pupil in the school and what are the most useful/helpful things that happen in the classrooms.</li> <li>• Talking mats.</li> <li>• Movement evaluations: young person stands on a line according to their evaluation e.g. does having a TA help? Better for group, might not have the space.</li> <li>• Photo voice: lot of resources and multiple visits needed.</li> <li>• School situation pictures.</li> <li>• Child Attachment interviews.</li> <li>• Wikis, blogs, podcasts: lot of resources needed</li> <li>• Portrait gallery: to explore feelings.</li> <li>• Discussion of photos of classrooms.</li> <li>• Questionnaires with visuals, pictures, simple text.</li> <li>• Direct scribing: e.g. timeline/ life story written out or made on computer.</li> </ul>

## 9.5 Pilot of activities for pupil interviews

I have given the pupils I piloted the activities with the following pseudonyms: Darius (Year 5 boy); Freddie (Year 4 boy); and Ali (Year 5 boy).

- Timeline/ life path: This was based on the 'life path' used by Tellis-James and Fox (2017) who found it aided thinking, facilitated narratives, helped to build rapport, reduced pressure, and positioned the young people as co-constructors. This worked really well with Darius. He could recall key moments in relation to school from nursery onwards and was reflective.
- Strategies chart: This was based on O'Kane (2008). O'Kane reported the grid allowed for a clear, visual impression and allows for comparison between charts. Using strategies suggested by the pupil placed them in the role of expert by asking what they found to be useful rather than imposing questions about interventions identified through previous research (Mertens, 2015). Ali added many more dots than I had suggested. I could avoid this happening again by having stickers ready with different amounts of dots on. I think it would be better to have a choice of 1-5 dots rather than 1-3 so it allows for a finer expression of the usefulness of the different strategies.
- Ideal teacher and classroom: This was based on Moran's ideal self (2012). Wiener and Daniels (2016) used the ideal classroom and ideal teacher in their research and found the method yielded rich information. Drawing can provide reference points for discussion (Beaver, 2011). Ali struggled with drawing his ideal classroom and ended up writing some large words on the paper. I think it would be better to offer the participants the choice of describing or drawing their ideal classroom. Freddie drew a picture of his ideal teacher and then described her to me. I added labels based on what he had said. He independently described her personality (funny), disposition (always happy) and identified actions (e.g. helps me when I'm confused, plays with me when I am lonely). I could extend this task by adapting questions from drawing the ideal self, such as 'What kind of person is this?', (Moran, 2012). I drew a stick figure for Ali's ideal teacher and wrote some of the descriptions he told me. Ali then added to the drawing and wrote some more words.
- Post-it Note activity: This was based on Pellicano et al.'s study (2014), where it was found this technique meant gaining a fuller picture of the young people's lives. Adderley et al. (2015) also used this method and reported it created a more relaxed relationship between researchers and participants. This worked well. Ali initially said he did not like school but then named several things that

he enjoys at school, giving a more balanced view to his main opinion of 'I don't like school'.

- Three comments: This was based on a Personal Construct Psychology technique to explore how a young person constructs their identity (Beaver, 2011). Ali found this difficult and just said others would describe him as a boy, is alive, lives in a house and is a human. However, I felt his motivation at this point was low because it was almost playtime and near the end of the session.
- Vignette: Bussing, Koro-Ljungberg, Gagnon, et al. (2016) argued vignettes have been successfully employed in research to elicit perceptions and opinions about ADHD. This was not piloted because the pupils either did not know about ADHD or did not have a formal diagnosis.

Amendments made to the activities following the pilot trials:

- Timeline/ life path: I took Darius' life path drawing as an example to interviews to show participants if they struggled to know what to draw/ describe.
- Strategies pocket chart: I used stickers with 1-5 dots on and a visual key.
- Ideal classroom, teacher and school: I gave participants the choice of drawing or describing them.
- Three comments: I took cards into the interviews with personality traits on to give participants ideas for descriptions people might use.



## 9.6 Information sheets and consent forms

For pupils:

Institute of Education



Dear



My name is Emma Flack (that's me on the right). I am training to become an Educational Psychologist. This means I work to help young people to be happy and successful in school. I am interested in hearing what students think about their school and learning.

I am carrying out some research in your school (and some others in LA X) to find out how school staff can best support students in their learning and school life. I want to share this information with other schools so that they have a better understanding of how to help pupils.

To do this, I am going to interview some pupils, parents and school staff. I believe that it is important to ask young people what they think so that schools can help them effectively. I hope that you choose to be involved but it is entirely up to you if you want to or not. If you would like to be interviewed, please fill in the form on the next page and return it to your form tutor by (Date). Your parents/ carers will also fill in a form to let me know that it is ok to talk to you.

If you agree to take part in the research, I will ask you questions such as:

- What do you enjoy in school?
- What is tricky or difficult for you in school?
- Are there any adults in school that you think do a great job?
- Have you been able to talk to your teachers about the ways you like to learn?

Also, we can do some short activities such as:

- Make a timeline of your life at school
- Draw or describe your ideal teacher, classroom and school
- Create a grid where you can rate the effectiveness of different strategies that teachers might use
- Design a poster

You do not have to answer every question I ask you, you can pass on any of the activities and you can stop the interview at any time. You can ask for your interview to be deleted and not used, at any time before [Date]. Anything you say during the interview will be kept confidential- your teachers and parents will not know what you have told me. When I write up the research, I will give you a different name so nobody knows which bits you said.

If you have any questions, you can ask your parents/carers or contact me at

Thank you for your time,  
Emma

Department of Psychology and Human Development  
Head of Department: Dr Jane Hurry  
UCL Institute of Education  
25 Webster Square, London WC1H 0AA  
+44 (0)20 7512 8000 [www.ioe.ac.uk/psd](http://www.ioe.ac.uk/psd)



Consent form

If you are happy to participate, please complete this consent form and return to your form tutor by [insert date].

	Yes	No
I have read and understood the information leaflet about the research	<input type="checkbox"/>	<input type="checkbox"/>
I agree to be interviewed	<input type="checkbox"/>	<input type="checkbox"/>
I am happy for my interview to be audio recorded (voice recording only)	<input type="checkbox"/>	<input type="checkbox"/>
I understand that if any of my words are used in reports or presentations they will not be attributed to me (no real names will not be used)	<input type="checkbox"/>	<input type="checkbox"/>
I understand that I can withdraw from the project at any time until [date], and that if I choose to do this, any data I have contributed will not be used	<input type="checkbox"/>	<input type="checkbox"/>
I understand that I can contact Emma Flack at any time	<input type="checkbox"/>	<input type="checkbox"/>

\_\_\_\_\_

Name \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_


\_\_\_\_\_

Researcher's name: Emma Flack

Signed \_\_\_\_\_

For parents:

Institute of Education



Dear Parent/ Carer,

I am a Trainee Educational Psychologist in LA X and I am writing to tell you about a research project that I am conducting in your son's school that forms part of the requirement of my doctoral course. The aim of my research is to investigate good practice for secondary schools in supporting pupils with Attention Deficit Hyperactivity Disorder (ADHD) and the school experience of pupils with ADHD.

I very much hope that you and your son would like to take part. This information sheet will answer questions you might have about the project, but please don't hesitate to contact me if there is anything else that you would like to know.

Please explain the research to your child and discuss ~~whether or not~~ he wants to take part. I have not mentioned ADHD on the pupil information sheet in case your son is unaware of his diagnosis. I ask that he also signs a consent form and will remind him before the interview that he can drop out if he wishes with no negative consequences.


**Why are we carrying out this research?**  
The purpose of this research is to explore the school experience of young people with ADHD and to understand what works well in supporting these pupils. The aim is that the results can be used to share good practice across schools and increase teachers' understanding and awareness of ADHD, meaning that pupils with ADHD receive the right support.

**Why am I being invited to take part?**  
I have invited all secondary schools in LA X to take part in the research. The SENCo in each school that participates will be interviewed and I want to include as many young people with ADHD and their parents as possible. I believe it is important to gain the voice of young people so that intervention works well for them and as parents know their child best, your views are crucial. It is important for me to have a complete picture of the experience of pupils with ADHD so that they receive the right support.

**What will happen if I choose to take part?**  
You would complete the questionnaire enclosed and, if you agree, will also be interviewed either face-to-face or over the phone. The interview asks about your views about ADHD and good practice in schools, and will be no longer than 30 minutes. If you would like to be interviewed, please fill in your contact details on the consent form so that we can arrange a convenient time. You do not have to answer every question on the questionnaire or in the interview. If there is a question that you would prefer not to or cannot answer, just leave it blank.

**What will happen if my son takes part?**  
I will interview your son at school. I will ask some questions about his experience of school and what he feels helps him with his learning. I will also ask him to complete some short activities to

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gain his views (see the pupil information sheet for examples of questions and activities). I can carry out the interview over a few sessions if your son would prefer. I will ensure that your son knows that he does not have to answer every question that is asked and can stop the interview at any time. If your son is unaware of his diagnosis, I will not mention ADHD.

**Will anyone know if we have been involved?**

All information collected from parents, young people and school staff will remain confidential and anonymous. No individuals or schools will be identifiable when the findings are reported and I will not mention LA X. I will only pass on information if your son happens to say something that means that he is not safe.

**Could there be problems for me if I take part?**

I understand that sensitive topics may come up during the interviews. If you, or your son feels uncomfortable at any point, I will remind you/him that you do not have to answer all the questions, we can have a break or can stop the interview completely. I will let your son know who he can talk to in the school if he feels worried or upset by anything and you or your son can contact me at any time about the research. You, or your son can ask for your interview or questionnaire to be withdrawn from the study, at any time before the end of [Date].

**What will happen to the results of the research?**

The research will be written up as a 35,000-word thesis. A research brief will also be written. This will be shared with the schools that take part and any participants that would like a copy. You can indicate on the consent form if you would like one. The university will hold a copy of the thesis in their library and include a summary in university publications. It is possible that the research will be published in journals in the future.

Data will be retained for five years. Digital data will be password protected and stored on a laptop and external hard-drive. Questionnaires and consent forms will be kept in a locked document storage box. Transcriptions will be anonymised before they are shared with my supervisors.

**Do I have to take part?**

It is entirely up to you whether or not you choose to take part. I hope that if you do choose to be involved then you will find it a valuable experience. The aim of the research is to improve the school experience of pupils with ADHD and your contributions would help considerably with this.

**Thank you very much for taking the time to read this information sheet. If you would like to be involved, please complete the following consent form and return to your son's form tutor by [insert date].**

This project has been reviewed and approved by the UCL IOE Research Ethics Committee. If you have any further questions before you decide whether to take part, you can reach me at

Thank you for your time,  
Emma Flack



Consent form

If you are happy for you and/or your son to participate in the research, please complete this consent form and return to your son's form tutor by [insert date].

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| I have read and understood the information sheet about the research   | <input type="checkbox"/> | <input type="checkbox"/> |
| I agree for my questionnaire to be included in the research   | <input type="checkbox"/> | <input type="checkbox"/> |
| I understand that if any of my words are used in reports or presentations they will not be attributed to me.  | <input type="checkbox"/> | <input type="checkbox"/> |
| I understand that I can withdraw from the project at any time until [date], and that if I choose to do this, any data I have contributed will not be used | <input type="checkbox"/> | <input type="checkbox"/> |
| I understand that I can contact Emma Flack at any time  | <input type="checkbox"/> | <input type="checkbox"/> |
| I have discussed the information sheet with my child and agree that he may be interviewed.  | <input type="checkbox"/> | <input type="checkbox"/> |
| I would like to be interviewed as part of this research.  | <input type="checkbox"/> | <input type="checkbox"/> |

If yes- I can be contacted by phone/ email at \_\_\_\_\_

I would like to receive a copy of the research briefing when it is completed. If yes, please provide a postal or email address below

☐ ☐

Name \_\_\_\_\_

Son's name \_\_\_\_\_

Signed \_\_\_\_\_


Date \_\_\_\_\_

Researcher's name: Emma Flack

Signed \_\_\_\_\_

For SENCOs:

Institute of Education



Dear

My name is Emma Flack and I am a Trainee Educational Psychologist in LA X and am writing to tell you about a research project I hope to conduct in your school that forms part of the requirement of my doctoral course. This research looks at good practice for secondary schools supporting pupils with Attention Deficit Hyperactivity Disorder (ADHD) and the school experience of pupils with ADHD.

I very much hope that you would like to take part. This information sheet will try and answer any questions you might have about the project, but please don't hesitate to contact me if there is anything else you would like to know.

**Why are we doing this research?**  
The purpose of this research is to explore the school experience of young people with ADHD and to understand what works well in supporting these pupils. The aim is that the results can be used to share good practice across schools and increase teachers' understanding and awareness of ADHD. I feel there is little research that asks key people directly what they find works well. Your contribution would be crucial to increasing understanding of effective support.

**Why am I being invited to take part?**  
I have invited all secondary schools in LA X to take part in the research. I hope to interview as many SENCOs, young people with ADHD and their parents as possible.


**What will happen if I choose to take part?**  
I would interview you about your views regarding ADHD and good practice in schools. This is likely to be no longer than 60 minutes. You do not have to answer every question.

I would then pass on pupil and parent/carer information sheets and consent forms and ask that you give them to every pupil that has ADHD as their primary need.

**What will happen if pupils in my school and/or their parents take part?**  
I would hope to interview the pupils at school. I will ask some questions about their experience of school and what they feel helps them. I will also ask them to complete some short activities to gain their views too (the pupil information sheet gives examples of questions and activities). I may need to carry out the interview over a few sessions if the pupils would prefer. I will ensure that the pupils know that they do not have to answer every question that is asked and can stop the interview at any time. If a pupil is unaware of their diagnosis, I will not mention ADHD.

I will ask parents to complete a questionnaire. If they choose to be interviewed, I will arrange this with them directly. I will ask about their views on ADHD, good practice in schools and support they have received from other agencies.

Department of Psychology and Human Development  
Head of Department Dr Jane Murray  
UCL Institute of Education  
25 Woburn Square, London WC1H 0AA



**Will anyone know I/ we have been involved?**

All information collected from you, parents and young people will remain confidential and anonymous. No individuals or schools will be identifiable when the findings are reported and I will not mention LA X. I will only pass on information if a pupil happens to say something that means they are not safe.

**Could there be problems for me if I take part?**

I understand that sensitive topics may come up during the interviews. If you feel uncomfortable at any point, you can pass on the question, we can have a break or can stop the interview completely. You, or any other participant, can contact me at any time about the research.

**What will happen to the results of the research?**

The research will be written up as a 35,000-word thesis. A research brief will also be written. This will be shared with the schools that take part and any participants that would like a copy. You can indicate on the consent form if you would like one. The university will hold a copy of the thesis in their library and include a summary in university publications. It is possible that the research will be published in journals in the future.

Data will be retained for five years. Digital data will be password protected and stored on a laptop and external hard-drive. Questionnaires and consent forms will be kept in a locked document storage box. Transcriptions will be anonymised before they are shared with my supervisors.

**Do I have to take part?**

It is entirely up to you whether or not you choose to take part. I hope that if you do choose to be involved then you will find it a valuable experience. You can ask for your interview to be withdrawn from the study, at any time before the end of [Date].

**Thank you very much for taking the time to read this information sheet. If you would like to be involved, please complete the following consent form and return it to me.**

If you have any further questions before you decide whether to take part, you can reach me at

This project has been reviewed and approved by the UCL IOE Research Ethics Committee.

Thank you for your time,  
Emma Flack

Consent form

If you are happy to participate in the research, please complete this consent form and return to me as soon as possible.

	Yes	No
I have read and understood the information sheet about the research	<input type="checkbox"/>	<input type="checkbox"/>
I agree to be interviewed for the research	<input type="checkbox"/>	<input type="checkbox"/>
I understand that if any of my words are used in reports or presentations they will not be attributed to me.	<input type="checkbox"/>	<input type="checkbox"/>
I understand that I can withdraw from the project at any time until [Date], and that if I choose to do this, any data I have contributed will not be used	<input type="checkbox"/>	<input type="checkbox"/>
I understand that I can contact Emma Flack at any time	<input type="checkbox"/>	<input type="checkbox"/>
I would like to receive a copy of the research briefing when it is completed.	<input type="checkbox"/>	<input type="checkbox"/>

If yes, please provide a postal or email address below

\_\_\_\_\_

-----

Name \_\_\_\_\_

Signed \_\_\_\_\_

Date \_\_\_\_\_

-----

Researcher's name: Emma Flack

Signed \_\_\_\_\_



## **9.7 SENCo questions about pupil participants**

- Attainment at school, including progress from baseline.
- Socio-economic status e.g. free school meals or pupil premium?
- If taking medication
- Does he have a statement/ EHCP?
- Any comorbid diagnoses?
- Whether pupil knows about his/her label of ADHD and if so his level of sensitivity around it.
- Interventions and strategies being used with the pupil.
- Tips on how to approach pupil interview with individuals

## 9.8 Parent questionnaire

Your son							
Age of son _____	School year group _____						
Home language _____	Ethnicity _____						
How long has your son lived in LA X? _____							
At what age did your son receive his ADHD diagnosis? _____							
Who diagnosed your son? _____							
What subtype of ADHD is he diagnosed with? (Please <u>tick</u> )	<table><tr><td>Inattentive</td><td><input type="checkbox"/></td></tr><tr><td>Hyperactive-impulsive</td><td><input type="checkbox"/></td></tr><tr><td>Combined inattentive &amp; hyperactive-impulsive</td><td><input type="checkbox"/></td></tr></table>	Inattentive	<input type="checkbox"/>	Hyperactive-impulsive	<input type="checkbox"/>	Combined inattentive & hyperactive-impulsive	<input type="checkbox"/>
Inattentive	<input type="checkbox"/>						
Hyperactive-impulsive	<input type="checkbox"/>						
Combined inattentive & hyperactive-impulsive	<input type="checkbox"/>						
Does your son have any other diagnoses or learning difficulties?	Yes/No						
If yes, please specify _____ _____ _____							
Is your son aware of his diagnosis of ADHD?	Yes / No						
Does your son have a Statement of Special Educational <u>Needs</u> or EHCP (Education, Health & Care Plan)?	Yes / No						
If yes, how old was your son when this was first put into place? _____ _____							
Does your son take medication for ADHD?	Yes / No						
What factors influenced your decision about medication? _____ _____ _____ _____							

Support and services			
Has your son had any involvement with the following professionals/ services? If yes, what involvement have they had (e.g. assessment, advice, intervention, resources)?			
Have they been involved with your child?			
Professional/ service	YES	NO	What they did
Paediatrician			
Educational Psychologist			
Speech & Language Therapist			
Advisory Teacher			
CAMHS			
(local SEMH outreach service)			
Clinical Psychologist			
Psychiatrist			
Clinical Nurse			
Assistant Psychologist			
ADHD Service			
Diagnosis Support Service			
(Local SEN charity)			
ADDISS (National ADD Information & Support Service)			
Other (please specify)			
Other (please specify)			
Which of these services did you find most helpful? _____			
_____			
_____			

Following your son's diagnosis, did **you** receive support from any services? e.g. parenting classes, peer support, parent advisory service, (Local SEN charity), ADDISS Yes/ No

If yes, please specify \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If yes, how useful did you find this support? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What does your son's school do well in supporting him? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What could the school do to improve the support your son receives? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Thank|you for your time**

## 9.9 Interview schedules

### SENCO interview schedule:

Before recording:

- ✓ explain again why I am talking to them: research into good practice in secondary school for pupils with ADHD and the pupil's experience of school.
- ✓ explain confidentiality: no names will be mentioned in research, interviews stored securely
- ✓ say they don't have to answer any question they don't feel comfortable with and can stop at any time (even if it means deleting the interview when it's finished- up until DATE)
- ✓ ask if it is ok that the interview is recorded

Main question	Prompts	✓
What is your understanding of ADHD?	Definition	
	Life-long or not?	
	Over/ under diagnosed? Do you ever feel a diagnosis can be explained by other/ environmental factors?	
What is your opinion on medication?	Do you think it is effective?	
	Do you think it is necessary?	
	Under/over use of medication?	
	Does it change what makes an effective approach?	
	Are there any long-term challenges regarding pupils and ADHD medication?	
What are effective approaches to meeting the needs of pupils with ADHD?	In class?	
	Do you provide any 1:1/ small group support?	
	How are additional adults/TAs used to support ADHD needs?	
	SENCo role in relation to ADHD?	
	What factors do you take into account when developing support for a pupil with ADHD e.g. diagnosis type, common difficulties (social skills, motor coordination, working memory etc.), medication.	

	How do you adjust your approaches for individual pupils?	
	How often are TAs in lessons? How is that decided/ arranged?	
	How do you support pupils with the emotional effects of living with ADHD?	
	Are there any long-term barriers or challenges regarding meeting the needs of pupils with ADHD in school?	
What training/ professional development have you/ colleagues received for ADHD?	How useful?	
	Best thing about it?	
	Have you shared/ cascaded the training with colleagues in any way?	
	How has the training been put into practice?	
	Are there any long-term barriers or challenges regarding CPD about ADHD?	
Do any outside agencies provide support for ADHD?	Who	
	How often	
	Type of support	
	How useful	
	How are their recommendations put into practice?	
	What do you think of the support available in LA X?	
	Do you feel part of a multi-disciplinary team that plans interventions?	
	Are there any long-term barriers or challenges regarding multi-disciplinary work?	
How is progress monitored and information shared?	Shared with staff?	
	Who has access to it: i.e. all staff or just some?	
	Shared with parents?	
	Shared with pupils?	
	Shared with outside professionals?	
	How is the information used?	
	How is data used to inform intervention/ support?	
	How often reviewed?	

	Do you think the way you share information is effective/ useful?	
	Are there any long-term barriers or challenges regarding monitoring and sharing progress?	
How are parents/carers involved?	Support for them? How effective?	
	Annual review (if have statement/EHCP)? How useful?	
	How often is progress shared?	
	Are they aware of support school is providing?	
	Are there any long-term barriers or challenges regarding gaining and using parent views?	
What opportunities do pupils have to give their views?	Annual review (if have statement/ EHCP)?	
	Other times?	
	Is there a particular adult they would talk to?	
	How is this information used?	
	Is this effective?	
	Are there any long-term barriers or challenges regarding gaining and using pupil voice?	
Is there anything that we've not covered in terms of support or provision for pupils with ADHD?		

## Parent interview schedule:

Before recording:

- ✓ explain again why I am talking to them: research into good practice in secondary school for pupils with ADHD and their son's experience of school.
- ✓ explain confidentiality: no names will be mentioned in research, interviews stored securely
- ✓ say they don't have to answer any question they don't feel comfortable with and can stop at any time (even if it means deleting the interview when it's finished, up until DATE)
- ✓ ask if it is ok that the interview is recorded

Main question	Prompts	✓
What is your understanding of ADHD?	Definition	
	Life-long or not?	
	Over/ under diagnosed?	
How does ADHD impact on your son?	At home?	
	At school?	
	Socially/ with friendships?	
	Emotionally?	
What is your opinion on medication?	Do you think it is effective?	
	Under/over use of medication?	
What can schools do to meet the needs of pupils with ADHD effectively?	In class?	
	Using 1:1 or small group support?	
	Using TAs?	
	To support wellbeing and mental health?	
	In your experience, do schools have a good understanding of ADHD and how to support pupils with ADHD?	
	What barriers have you experienced in getting the right support for your son/daughter?	
Have you and/or your son received any support from services either in or out of school?	Who?	
	How often?	
	Type of support?	
	How useful?	



(see list on questionnaire)	Do you think the school puts professionals' recommendations into practice?	
	What do you think of the support available in LA X?	
	Are you in contact with the school SENCo? What is his/her role?	
	Are there any long-term barriers or challenges regarding accessing services?	
How is information about your child's progress shared with you?	How often?	
	Do you feel it is good practice?	
	Are there any long-term barriers or challenges regarding sharing progress?	
How are you involved in planning support and intervention for your son?	Annual review (if have statement/EHCP)? How useful?	
	Have you received any support from the school e.g. with managing behaviour at home, telling you about strategies that work well? How useful?	
	Are there any long-term barriers or challenges regarding the school gaining and using parent views?	
What opportunities does your son have to give his/her views in school?	Annual review (if have statement/EHCP)?	
	Other times?	
	Is there a particular adult they would talk to?	
	How is this information used?	
	Is this effective?	
	Are there any long-term barriers or challenges regarding gaining and using pupil voice?	
Is there anything that we've not covered in terms of support or provision for pupils with ADHD?		

## Pupil interview schedule:

### Before recording:

- ✓ explain again why I am talking to them: research into their experience of school/ learning. Ways in which teaching staff can best help them. Going to ask some questions and do some short activities.
- ✓ explain confidentiality: nobody will know what they said, no names used in research. Only time I would tell someone else would be if they said something that made me think they were not safe.
- ✓ tell pupil they don't have to answer any question/do any task they don't feel comfortable with and can stop at any time (even if means deleting the interview when it's finished, up until DATE)
- ✓ ask if it is ok that the interview is recorded

### RQ1: How do young people with ADHD experience their ADHD?

Questions		
What sort of things do you enjoy at school?	Which lessons?	
	Any clubs?	
What do you find more difficult or tricky in school?	Which lessons?	
	Particular kinds of work?	
	Anything else e.g. friendships, break-times?	
[If pupil knows about ADHD] Have you heard the term ADHD? What does it mean to you?	What is someone who has ADHD like?	
	Can you tell if someone else has ADHD? How?	
	What is the opposite of ADHD? What is someone who doesn't have ADHD like?	
	Do you think it was useful/good for you to know about having ADHD?	
	Do your teachers know? Has this changed how they work with you in any way?	
	Do your friends know? What do they think?	
	Has your ADHD changed over time?	
	In a typical day, how do you think having ADHD makes things different for you?	
[If taking medication] How has medication changed things for you?		
What are your hopes and aspirations for the future?		

Activities:		
Ask the participant to draw a timeline or 'life path' of their life with key moments related to school and ADHD and tell me about it.		
Vignettes: show a picture of a child/young person and tell the participant that the person in the picture has just been told they have ADHD.	<ul style="list-style-type: none"> <li>➤ What advice would you give to this boy/ girl?</li> <li>➤ What can the person expect to happen/ feel/ think?</li> <li>➤ This could be done as a drawing completion exercise, where the participant draws in thought or speech bubbles and feelings.</li> </ul>	
<p>Write Post-it Notes: things you like about school on one colour, things you don't like on another.</p> <p>These will be put together with what other pupils say and can give feedback.</p> <p>Email address:</p> <p>.....</p>		
Three comments: asking how others would describe the participant.		

**RQ 3: What do young people with ADHD think good practice is when supporting them in school?**

Questions		
Can you tell me about the best teacher you've had so far in this school?	What do you like about the way they teach?	
	Do they do special/different things to help you?	
	How would you like other teachers to be like them?	
	Is (the teacher's subject) one you do well in?	
Is there anybody else in school that stands out to you as doing a great job?	Could be teacher, TA, mentor etc.	
	What do you like/appreciate about them?	
When there are things you find difficult, can you tell teachers what	Do they check-in with you to make sure you can do the work ok?	
	Do you feel they would/ do listen to you?	

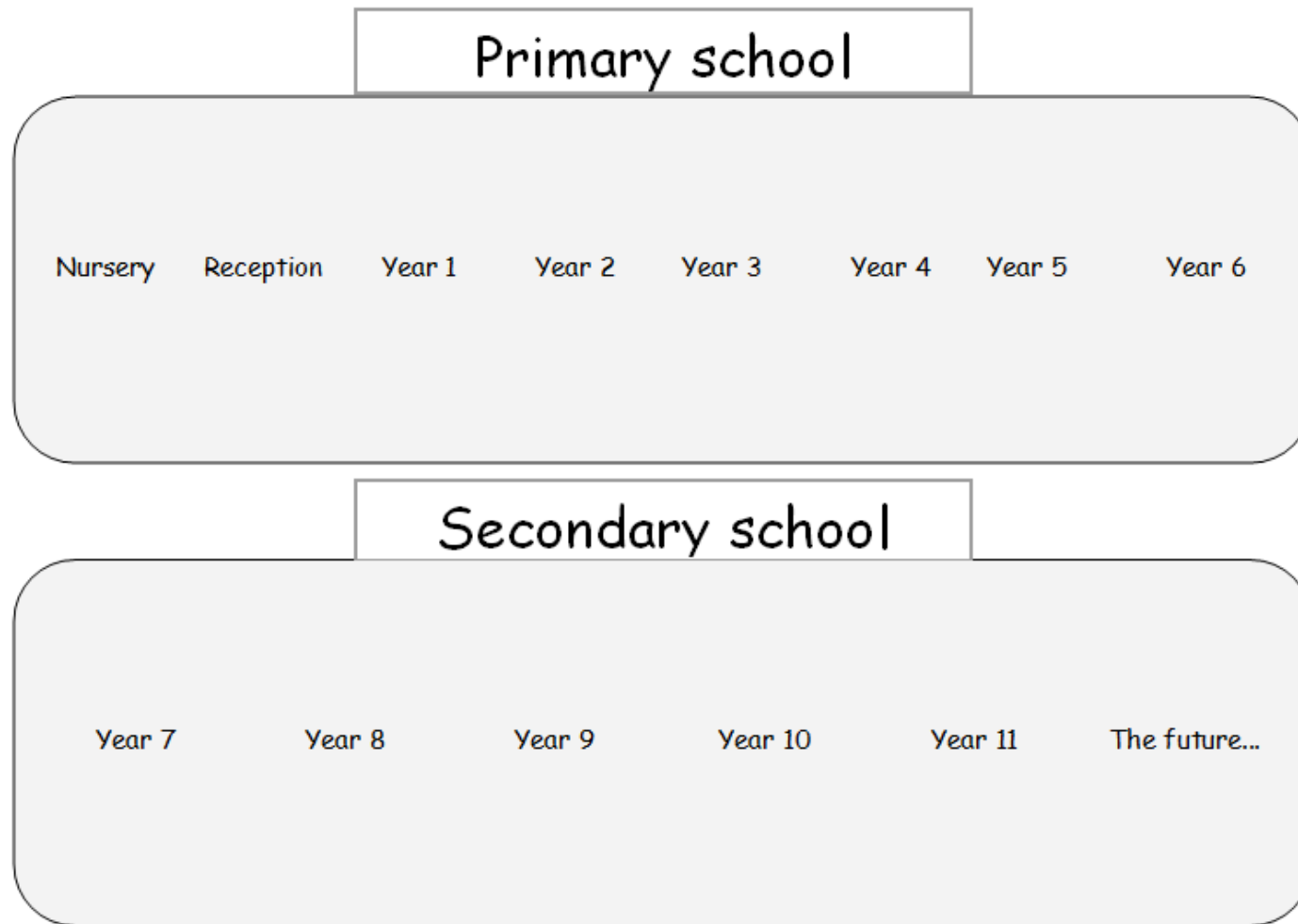
you need to make it easier?	Have you ever asked for something different to help you e.g. printed out slides, more time to write, extra breaks?	
	Are there times of the day or lessons where you are more focused/ engaged?	
Have you been able to talk to your teachers (or other school staff, or parents) about the ways you like to learn?	Have you ever been to an annual review (if has statement/ EHCP)?	
	Is there anything you would like to tell them?	
If intervention outside of class is taking place: I understand you've been getting X intervention for the last... Can you tell me about that	Can you give me some examples of things you've learned doing X intervention?	
	What do you think about doing X intervention? <ul style="list-style-type: none"> <li>➤ (probe) fed up because it means missing class/ having more work</li> <li>➤ (probe) pleased because it helps me with my work</li> </ul>	
Is there anything else that I've missed or not asked you about in terms of what helps you with learning?		
<b>Activities:</b>		
The strategy chart: construct a grid to rate how useful different strategies/ interventions are in different lessons.	<ul style="list-style-type: none"> <li>➤ What is it about this strategy that works/ doesn't work?</li> <li>➤ Do you think this (highly rated) strategy would help all pupils (with ADHD)?</li> </ul>	
Draw or describe ideal school, classroom and teacher. Perhaps draw the opposite of these too.	<ul style="list-style-type: none"> <li>➤ Can you tell me about what you've drawn?</li> </ul>	
Post-it activity (see table above)		

## 9.10 Pupil activities

Strategies chart (A3 size when used)

<div> <div>Lesson</div> <div>→</div> </div> <div> <div>↓</div> <div>Strategy</div> </div>	e.g. Maths				
e.g. Time out card					

Timeline activity (A3 size when used)

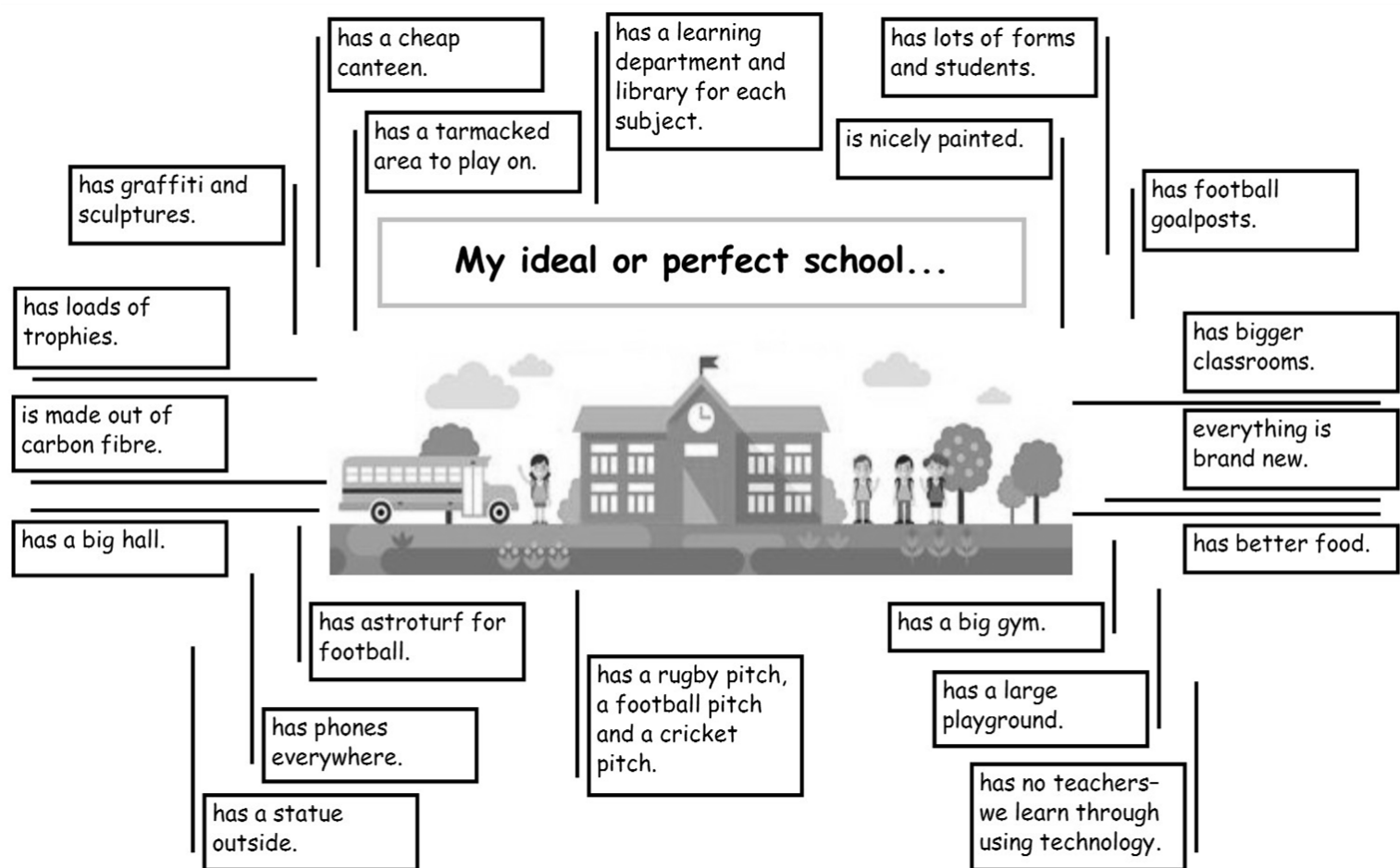


### 9.11 Interview lengths and details

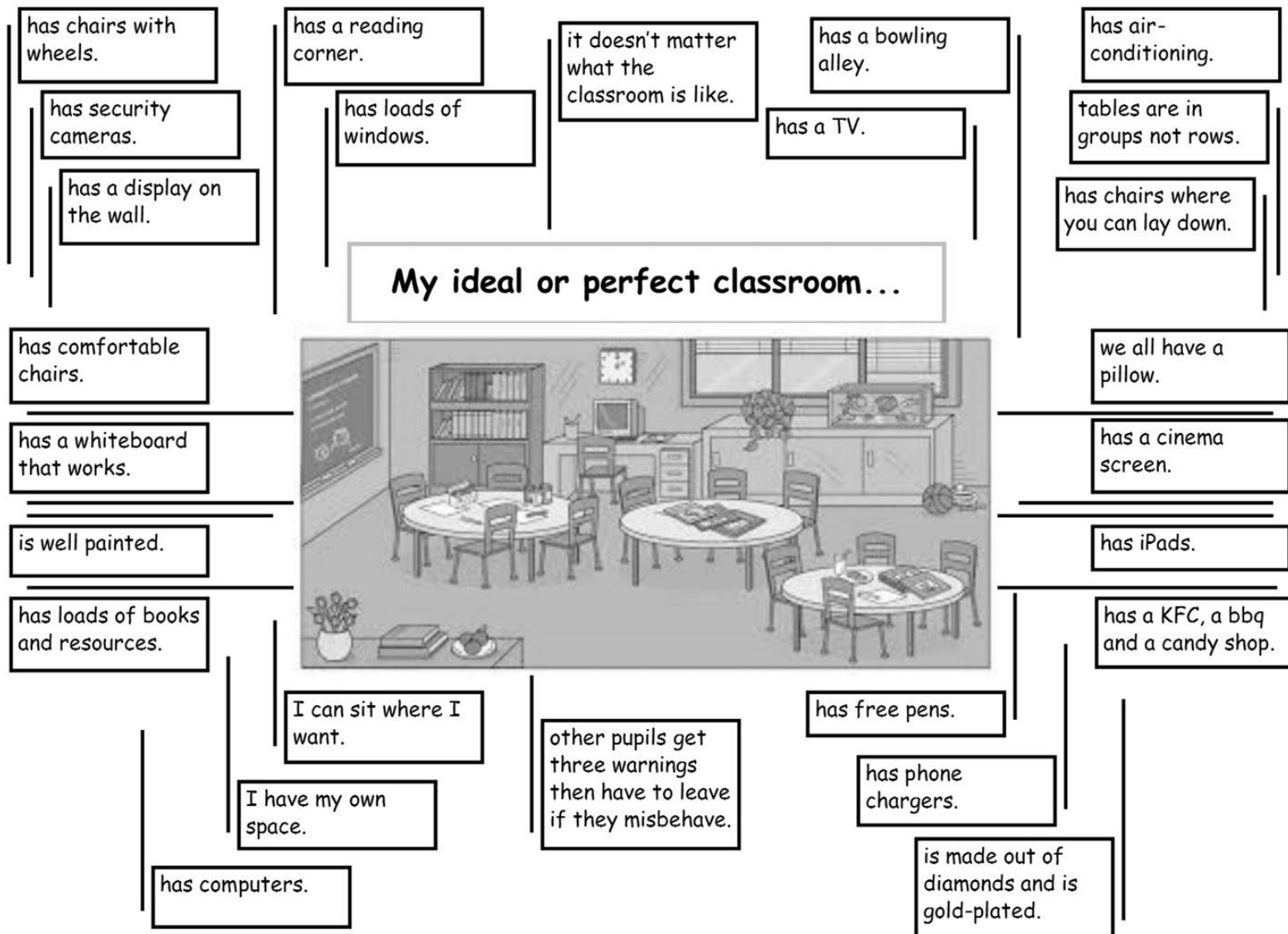
Name	Participant type	Method	Length of interview
SENCo A	SENCo	Face-to-face	46 minutes
SENCo B	SENCo	Face-to-face	68 minutes
SENCo C	SENCo	Face-to-face	76 minutes
SENCo D	SENCo	Face-to-face	41 minutes (over 2 sessions)
SENCo E	SENCo	Face-to-face	37 minutes
SENCo F	SENCo	Face-to-face	19 minutes
SENCo G	SENCo	Written	N/A
Alfie	Pupil	Face-to-face	65 minutes
Ben	Pupil	Face-to-face	67 minutes
Dominic	Pupil	Face-to-face	40 minutes
Elliot	Pupil	Face-to-face	54 minutes
Harry	Pupil	Face-to-face	33 minutes
Owen	Pupil	Face-to-face	80 minutes
Patrick	Pupil	Face-to-face	84 minutes
Ryan	Pupil	Face-to-face	75 minutes
Will	Pupil	Face-to-face	68 minutes (over 2 sessions)
Ms Arnold	Parent	Face-to-face	87 minutes
Ms Booth	Parent	Telephone	61 minutes
Ms Chambers	Parent	Telephone	24 minutes
Mr Fuller	Parent	Face-to-face	61 minutes (together)
Ms Fuller	Parent	Face-to-face	
Ms Kirk	Parent	Face-to-face	45 minutes
Ms Morrison	Parent	Telephone	21 minutes
Mr Wade	Parent	Face-to-face	43 minutes

## 9.12 Feedback website

Images on pupil feedback website. There was space for pupils to add any comments. Wherever possible, direct quotes were used on the pictures.







It gives you like your own personal touch and it's like an add-on to your personality

It's like a sort of a learning difficulty.

It's like a teacher's worst nightmare... I don't behave, I can't sit still at all. I literally shout

I can't sit still

I'm... a bit violent sometimes. I just get very annoyed really easily.

It doesn't make you a different person

I can get quite hyperactive. I've always got energy.

It's hard for me to control myself

Doing like silly things, messing about in class

You always have music playing in your head, no matter what

It means that every morning I have to take tablets and I have to do the same thing every night.

It's just this thing what makes you like, angry.

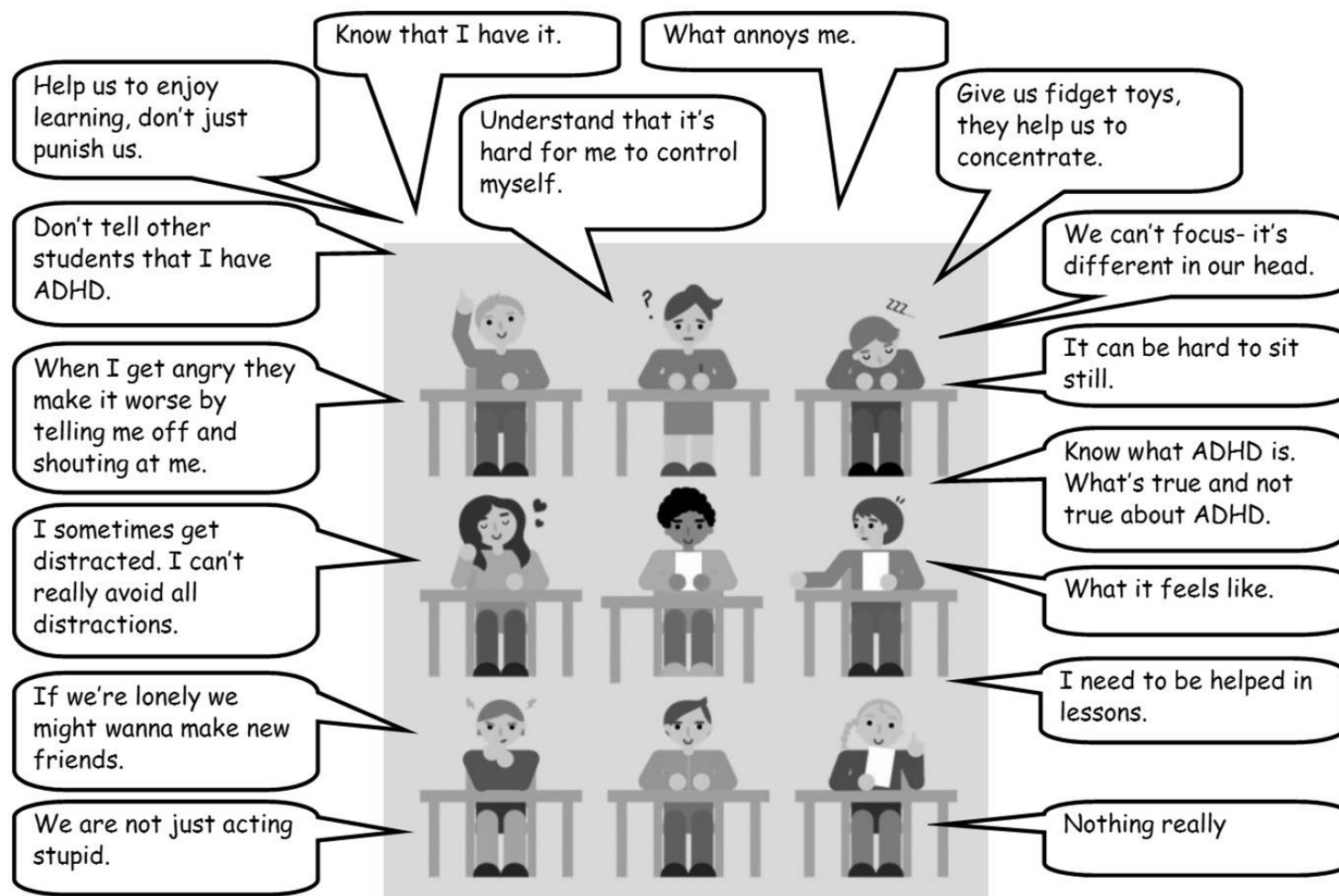
I sometimes get distracted.

Being a bit more hyperactive, and a bit more just crazy.

It's just if a child's brain is wired up a bit differently and they see things from a different angle that you see them from.



What is ADHD?



**What we wish teachers knew about ADHD**

lets me have longer to write.

understands me.

doesn't give a punishment straight away.

doesn't shout at me and is calm.

is laid back but firm.

is firm but fair.

makes the work more interesting for me.

is musical & artistic.

knows what annoys me.

is kind and nice.

walks around the classroom and helps people.

is funny, cheeky & playful.

### My ideal or perfect teacher...

has crazy scientist hair.

is not as stern on me.

is enthusiastic.

gives me easy work.

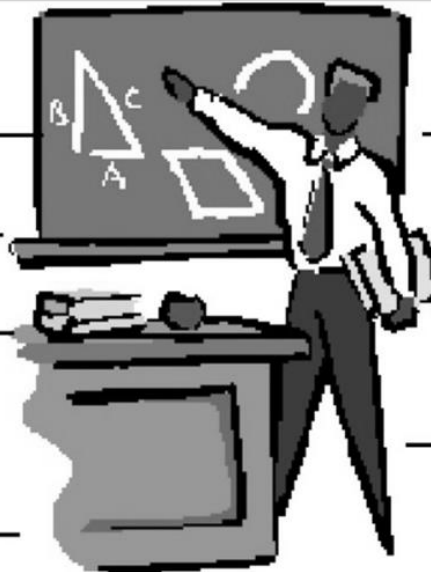
does whatever I say.

isn't bossy.

dresses smartly and is stylish.

gives me rewards.

is close to my age.



is cheerful and happy.

wants me to get higher grades.

is sporty.

gives me shorter work.

interacts with students.

is clever and wise.

is clear about what I need to do and how I need to behave.

doesn't moan.

lets me draw.

controls the class.

### 9.13 Other analysis methods considered

Method	What is it?	Why not?
Grounded theory	Theory is 'grounded' in the data and does not rely on previous constructs or theories. Theory developed using constant comparative analysis, theoretical sampling and theoretical coding. Is an approach, not just an analysis method. Is best suited to questions about influencing factors and social processes that underpin a phenomenon. Sample sizes are often larger (20-60) to better establish a theory.	<ul style="list-style-type: none"> <li>• I have a smaller sample size, especially per group.</li> <li>• Not necessarily looking for a theory, more exploratory.</li> <li>• ATA has elements of it that are useful for my research.</li> <li>• I want to compare my findings to previous research.</li> <li>• GT sidesteps reflexivity.</li> <li>• GT subscribes to a positivist epistemology.</li> <li>• GT focuses on social processes and not describing phenomena.</li> </ul>
Interpretative Phenomenological Analysis (IPA)	Aims to offer insights into how a given person, in a given context, makes sense of a given phenomenon. IPA is concerned with trying to understand lived experience and how participants make sense of their experiences. The researcher enters the participants' world by posing non-directive questions. Aims to capture experiences and meanings rather than people's opinion. Precise guidelines must be followed	<ul style="list-style-type: none"> <li>• I have a bigger sample size.</li> <li>• Deep interpretative aspect not needed.</li> <li>• I want to ask more directive questions so as to serve my research questions.</li> <li>• I look at opinion on interventions.</li> <li>• TA can have dual focus on individual cases and themes across cases.</li> <li>• Not flexible.</li> </ul>
Phenomenology	Looks at how individuals experience the world. The study of experience. Emphasizes the effects of research experience on the researcher. Much like hermeneutical analysis, but even more focused on the researcher's experience. Some use the term "phenomenology" to describe the researcher's experience and the idea this is all research is or can ever be.	<ul style="list-style-type: none"> <li>• ATA has elements of it that are useful for my research</li> <li>• Emphasizes idiosyncratic meaning to individuals, not shared constructions as much.</li> <li>• IPA can focus on researcher experience, I want to centralise pupil experience.</li> </ul>
Ethnography	Immersion in the target participants' environment to understand the goals, cultures, challenges, motivations, and themes that emerge. Rather than relying on interviews or surveys, you experience the environment first hand, and sometimes as a "participant observer."	<ul style="list-style-type: none"> <li>• I am using interviews.</li> <li>• Do not have the time required.</li> </ul>

Narrative	Weaves together a sequence of events, usually from just one or two individuals to form a cohesive story. Presented as a story (or narrative) with themes, and can reconcile conflicting stories and highlight tensions and challenges which can be opportunities for innovation.	<ul style="list-style-type: none"> <li>• I am using more participants.</li> <li>• I want more of an overview of a LA than one or two individual stories.</li> </ul>
Case study	Involves a deep understanding of a case through multiple types of data sources. A case can be an individual, an organisation, city, group of people, community, country, situation or incident. Can be explanatory, exploratory, or describing an event. Is in-depth and sharply focused.	<ul style="list-style-type: none"> <li>• Mine has aspects of a case study but will compare and contrast between participant groups using TA and ATA.</li> </ul>
Discourse analysis	Linguistic analysis of ongoing flow of communication. Find patterns of questions, who dominates time and how, other patterns of interaction. Interested in language as a social performance. Looks at patterns of meaning or language use across linguistic data sets. Is an approach to psychology, not just an analysis method.	<ul style="list-style-type: none"> <li>• My focus is not on use of language.</li> <li>• I look at what participants believe rather than how they say it.</li> <li>• DA is limited in its focus, which is just on use of language.</li> <li>• Does not easily translate into applied research/ recommendations.</li> </ul>
Content Analysis	Looks at documents, text, or speech to see what themes emerge. What do people talk about the most? See how themes relate to each other. Theory driven: theory determines what you look for. Rules are specified for data analysis.	<ul style="list-style-type: none"> <li>• This research is not about what participants repeat the most but stronger feeling about themes.</li> <li>• I want a deeper level of interpretation.</li> </ul>
Hermeneutic Analysis	Hermeneutics is making sense of written text; the theory of interpretation. Interpretation of texts in search of underlying socio-political meaning.	<ul style="list-style-type: none"> <li>• I am using interviews as main source of data.</li> </ul>

References: (Braun & Clarke, 2013; Mertens, 2015; Willig, 2001)

## 9.14 Analysis plan

Question	Answer
<b>What is the practical purpose of the analysis?</b>	<ul style="list-style-type: none"> <li>• Develop understanding of ADHD</li> <li>• Evidence for/against interventions and approaches</li> <li>• Evidence for/against student voice tools</li> </ul>
<b>What is the analytic purpose?</b>	<ul style="list-style-type: none"> <li>• Explore</li> <li>• Compare: between participant groups and factors where there are differences</li> </ul>
<b>How is analysis connected to RQs?</b>	The RQs will become overarching themes with several themes and sub-themes within them.
<b>What is my timeline?</b>	<ul style="list-style-type: none"> <li>• end of October 2017: all data collected</li> <li>• end of November 2017: all data transcribed (including pictures, activities)</li> <li>• December 2017 - end of March 2018: analysis</li> </ul>
<b>What resources do I have at my disposal?</b>	<ul style="list-style-type: none"> <li>• Main analysis done by me</li> <li>• Use NVivo for coding, themes, memos and comparison between participants</li> <li>• Report number of participants associated with each theme</li> <li>• Use supervisors and maybe another TEP for quality control check on coding and identifying themes</li> </ul>
<b>How large is my data set?</b>	<ul style="list-style-type: none"> <li>• 23 interviews</li> <li>• 9 parent questionnaires</li> <li>• 9 sets of information about student participants from SENCoS</li> <li>• CAMHS information (not analysed as such, just summarised in LA context section)</li> </ul>
<b>How heterogeneous are my data types?</b>	<ul style="list-style-type: none"> <li>• 1:1 or 1:2 interviews: parent and SENCo interviews are dialogue only, student interviews also have drawings/ pictorial data produced within the interviews</li> <li>• Each pupil has a parent questionnaire: provides context/background info</li> <li>• Each pupil has a SENCo interview and info from SENCo</li> <li>• 7 pupils have a parent interview (probably 1 more)</li> <li>• Codebooks: Same codebook for RQ 1-4 to enable comparison between groups</li> <li>• Rate tools used for RQ 5 on ease of use and effectiveness</li> </ul>
<b>Which data should I use for a particular analysis?</b>	Any data that relates to a RQ: should be the majority of the interview data
<b>Who is the audience for my analysis?</b>	<ol style="list-style-type: none"> <li>1. Doctoral thesis: up to 35,000 words</li> <li>2. Draft for peer-reviewed journal (need to decide which journal): use thesis and shorten.</li> <li>3. Shorter research briefing for parents, SENCo, students: use above and shorten again. Less technical language but same analysis can be used.</li> </ol>

## 9.15 Transcription, coding and theme development

### Example of transcription and coding

Grey row: Interviewer

White row: Ryan

Time	Transcript	Codes
	Okay. My research is about ADHD which you've heard of. What does it mean to you? What is ADHD?	
05.44	It means that every morning I have to take tablets and I have to do the same thing every night.	ADHD= medication Medication necessary
	So, you take them in the morning and then at night. And what do the tablets do for you?	
	Well, in the day time they help me concentrate and they stop me from punching people in the face and getting annoyed.	ADHD = inattention ADHD = anger Medication- positive
	Okay. So, they stop you getting annoyed. You said that in the day time, what about...?	
06.08	Night time just, it's just like a medicine that makes you drowsy, just so like I go to sleep faster.	Medication side effects
	Oh, so it helps you sleep as well, okay. What is a person that has ADHD like? What are they like?	
06.22	Without medicine, a bit crazy.	ADHD = crazy, no control, attention-seeking ADHD= medication
	A bit crazy, okay. Can you tell if someone else has got ADHD?	
	Sort of. It doesn't, it's not always ADHD but you can definitely tell.	ADHD = crazy, no control, attention-seeking



	How can you tell do you think? What is it?	
06.41	You can just tell they're a bit more hyperactive, and a bit more just crazy.	ADHD = hyperactive ADHD = crazy, no control, attention-seeking
	Okay. What do you think it's like to not have ADHD? What's the opposite of ADHD?	
	I don't know really.	Difficulty with imagination or reflection
	Okay.	
06.58	Before I knew I had it, I thought I was just very hyper, (laughs) so I don't know really.	ADHD = hyperactive
	Okay. And do you think it was useful that you found out that you had it?	
	Yeah, because now I've actually got a reason for why I shout at people when it gets later in the day.	ADHD = anger ADHD- knowing about it ADHD explains behaviour
	Okay, so it kind of explains things. Do your teachers know about it?	
07.27	Yeah. I think a lot of them do.	Teacher knowledge
	And do you think that changes the way they work with you?	
	Yeah. I know they, a lot of the cover teachers won't know because they're cover teachers.	Teacher knowledge Staff changes
	Yeah. And can you tell the difference then between a teacher that knows and a teacher that doesn't know?	
	Yeah, because a teacher that knows will punish you less if you get a bit more angry or a bit more frustrated.	Teacher knowledge Staff changes ADHD = anger Bad teacher Differentiated behavioural expectations

	Do your friends know?	
07.56	Some of them. Some don't believe me cos they're stupid, but they're not really friends.	Friends' views ADHD not real Peer relationships- negative
	And what about the friends that do know? What do they think?	
	They just know.	Friends' views
	Did you decide to tell them?	
	They've just learnt... really.	Friends' views
	And do you think your ADHD has changed over time in any way, as you've got older?	
	Not really. I've had to have different doses of medicine for it over the years. I know before I had to take my medicine I didn't wanna take it but you get used to it.	ADHD = medication. Medication necessary ADHD not changed with age

### Example of codebook development

Transcripts were initially coded using the following codes:

Name	Description	Sources	References
Strategies- negative or neutral view	Pupil dislikes a certain strategy or intervention. Pupil does not use a certain strategy or intervention. Pupil does not want to use a certain strategy or intervention. Pupil rates strategy as 1 - 3 on grid activity. Same for parent and SENCo views.	20	109
Strategies- positive view	Strategies that work. Strategies or interventions the pupil finds useful or effective or shows positive regard towards. Score of 4 or 5 on grid rating activity. Same for parent and SENCo views.	26	203

However, the number of references to different strategies and interventions was large within each code. Therefore, they were further split into the views (positive/ negative/ neutral) and the specific strategy or intervention. For example:

Name	Description
Time out- negative or neutral view	Participant reports they do not find using a time out card or being allowed to have short break outside classroom helpful or effective.
Fiddle toys- positive view	Participant reports using fiddle toys e.g. fidget spinners is a good strategy or is helpful.

### Examples from final codebook

Name	Description	Sources	References
ADHD = anger	ADHD means feelings of anger/ being aggressive/ being annoyed	13	44
ADHD = crazy, no control, attn seeking	Having ADHD means you are crazy or unable to control yourself or attention seeking	10	20
ADHD = different brain	ADHD means your mind is always going or have music always playing or think differently or see things differently or brain is wired differently	12	29
ADHD = hyperactive	ADHD means being hyperactive, not being able to keep still, always fidgeting.	19	69
ADHD = impulsive	ADHD means being impulsive, not thinking through the consequences of actions, being easily led.	10	22
ADHD = inattention	ADHD means it is difficult to concentrate or focus or pay attention or are easily distracted	19	50
ADHD = lifelong	ADHD is perceived to be a lifelong condition or is likely to be lifelong	14	18
ADHD = medication	ADHD means that you need to take medication	11	17
ADHD = naughty boy syndrome	Views that ADHD is 'naughty boy syndrome'. These views are held by people other than the participants	8	13

### Example of theme with corresponding codes

Research Question 1: Young people's experiences of ADHD

Themes	Sub-themes	Codes
Diagnostic symptoms	Inattention	<ul style="list-style-type: none"> <li>ADHD = inattention</li> </ul>
	Hyperactivity	<ul style="list-style-type: none"> <li>ADHD = hyperactive</li> </ul>
	Impulsivity	<ul style="list-style-type: none"> <li>ADHD = impulsive</li> </ul>
	Level of severity	<ul style="list-style-type: none"> <li>ADHD improved with age</li> <li>ADHD not changed with age</li> <li>ADHD worsened with age</li> </ul>
Personal experience of ADHD	Conduct problems	<ul style="list-style-type: none"> <li>ADHD = crazy, no control, attention seeking</li> <li>ADHD = naughty boy syndrome</li> <li>ADHD- an excuse</li> <li>ADHD explains behaviour</li> </ul>
	Anger	<ul style="list-style-type: none"> <li>ADHD = anger</li> </ul>
	Cognitive functioning difficulties	<ul style="list-style-type: none"> <li>Difficulty with imagination or reflection</li> <li>Memory difficulties</li> </ul>
	Social relationships	<ul style="list-style-type: none"> <li>Social difficulties</li> <li>Peer relationships- negative</li> <li>Peer relationships- positive</li> <li>Pupil-parent relationship- poor</li> <li>Pupil-parent relationship- positive</li> </ul>
	I cope better as I get older	<ul style="list-style-type: none"> <li>ADHD improved with age</li> </ul>
ADHD means medication		<ul style="list-style-type: none"> <li>ADHD = medication</li> <li>Medication necessary</li> <li>Medication- positive view</li> <li>Medication- neutral view</li> <li>Medication- negative view</li> <li>Medication side effects</li> </ul>
Blurred lines	Comorbidities	<ul style="list-style-type: none"> <li>Autism</li> <li>Comorbidities</li> </ul>
	Family context	<ul style="list-style-type: none"> <li>Environmental issues</li> <li>ADHD in family</li> </ul>

The label	Understanding myself	<ul style="list-style-type: none"> <li>ADHD- knowing about it</li> </ul>
	Stigma	<ul style="list-style-type: none"> <li>ADHD stigma</li> <li>Pupil emotions</li> </ul>
	I am not normal	<ul style="list-style-type: none"> <li>ADHD = different brain</li> <li>View of self- negative</li> <li>Own ability- negative view</li> <li>Future- worries</li> </ul>
	I am no different	<ul style="list-style-type: none"> <li>ADHD = positive</li> <li>ADHD = different brain</li> <li>View of self- positive</li> <li>Own ability- positive or neutral view</li> <li>Friends' views</li> <li>Aspirations</li> </ul>
	Future worries	<ul style="list-style-type: none"> <li>Future worries</li> </ul>
	Is misunderstood and unclear	<ul style="list-style-type: none"> <li>ADHD- don't know what it is</li> </ul>

## 9.16 Pen portraits of pupil participants

	Autumn term of Year 7 when interviewed. White British, English is first language.
Family life	Has lived in LA X all his life, same for mother. Mother talked about pupil going through a difficult time when at primary school.
Primary school	Pupil said he was 'violent' in primary school because the teachers could not control him.
Secondary school	Pupil said he does not like other people in school. Described himself as a 'teacher's worst nightmare' when not on medication but he has calmed down a lot since primary school. Said he does not have many friends but has a girlfriend. Parent said school could do more to support him and communicate with parents.
Achievement	Reaches age-expected levels. Wants to be a mechanic.
SES	Has free school meals.
ADHD and comorbidities	Parent reported ADHD diagnosis was when he was aged 6-7. Received diagnosis of ASD recently (November 2017). Has been taking medication for 2-3 years. Has counselling for anger management. Pupil spoke very quietly and had low eye contact throughout interview. Conners 3 indicates criteria reached for inattention and hyperactivity-impulsivity. Criteria also reached for conduct disorder and oppositional defiance disorder and score was significantly high for defiance-aggression
EHCP	No, but SENCo said it was being considered.
	In summer term of Year 8 when interviewed. White British, English is first language.
Family life	Dad committed suicide when he was in primary school. Mum has remarried. Mum was a drug addict and has been clean for 5 years. One of five children. Oldest sister is 18, youngest brother is in nursery. Stepdad is being assessed for ADHD.
Primary school	Parent felt he did not receive necessary support at primary school. Meant he would often refuse to work.
Secondary school	School is new and only went up to Year 9 when interviewed. Lots of interventions for reading, writing, maths. Has TA in about half of lessons. Has laptop and C-Pen but refuses to use C-Pen. Parents are happy with support he receives. Got into trouble for taking a

	knife into school. Had broken hand of time of interview because punched a door at home.
Achievement	Below expected levels for his age. Good progress towards his targets. Wants to be a farrier or gamer.
SES	Has free school meals.
ADHD and comorbidities	Comorbidities: ASD (diagnosed around one year before interview) and dyslexia. Parent reported ADHD diagnosis was when 9 years old. Parent reported combined subtype. Takes medication, parent said it works well. Conners 3 indicates criteria reached for inattention but not hyperactivity-impulsivity. Also indicates significant learning difficulties.
EHCP	Yes, recently received.
	In summer term of Year 10 when interviewed. British/ other mixed, English is first language.
Family life	Lives with mother. Had family worker from CAMHS for a while, mum feels this should have been for longer.
Primary school	Attended special school. Both pupil and mum did not like the behaviour of the other pupils. Used to run out of the class or hide under the desk.
Secondary school	Moved to mainstream. In small groups for social development. Found it hard going from small class of 6 to 30. Has good friends. Pupil feels he found it harder at secondary because of missed learning because of his and others' behaviour at primary.
Achievement	Works below expected levels, low literacy levels. Wants to do an apprenticeship in 'something practical' and travel the world.
SES	Is pupil premium.
ADHD and comorbidities	Mum reported diagnosis was at 4-5 years old. Learning difficulties: no official diagnosis but school suggested MLD. Does not take medication and so was discharged from CAMHS. Sensory difficulties: sensitive to temperature and feel of clothing. Conners 3 indicates criteria reached for inattention but not hyperactivity-impulsivity. Also indicates significant learning difficulties.
EHCP	Had EHCP from 6 years old.



	<p>In summer term of Year 9 when interviewed.</p> <p>White British, English is first language.</p>
Family life	<p>Parents divorced when Pupil was in Year 2. This meant he and his mum moved into his Grandma's house and he moved school before he started Year 3. Mum had new partner since Pupil was about 7 years old. Mum reported they had family therapy. Still sees his dad.</p>
Primary school	<p>When he moved school, felt he had to make an impression on others and this was difficult because he was shy. Came out of his shell more in Year 4 and this continued to get better and he enjoyed school more and more.</p>
Secondary school	<p>Found Year 7 difficult at first but made friends and got into less arguments. Was bullied when in Year 8. Broke his hand in an incident and his mum took him out of school for a month. Was moved to a different 'side' of the school and this improved things. Had ups and downs in Year 9: has been hit a couple of times but was dealt with by school. Feeling the pressure of exams/ GCSEs. Pupil said he likes his school. Finds lessons interesting. Chose all positive words to describe self/ how others see him.</p>
Achievement	<p>Making good progress in line with peers across all subjects and exceeding his own targets in several areas. Came across as conscientious, did not want to miss revision session. Wants to be a history teacher and go to college.</p>
SES	<p>Not on free school meals or pupil premium</p>
ADHD and comorbidities	<p>Comorbidities: ASD, DCD, hypermobility. Takes medication. Diagnosed with ADHD at 5 years old. Pupil recalls being told about ADHD when he was in Year 1-2. Parent reported as combined subtype. Takes medication and said it improved his grades. Conners not completed because pupil moved school/ outside of LA X.</p>
EHCP	<p>Does not have EHCP. Awaiting assessment for one.</p>
Family life	<p>In summer term of Year 8 when interviewed.</p> <p>White British, English is first language.</p> <p>Currently living with mum and stepdad. Spent some time living with Grandparents after mum hit him. Social care involvement. Parents looking to send him to a residential school: in discussions with social care to fund it. Stepdad unable to work because of pupil's reduced timetable. Parents feel unable to cope with pupil's behaviour.</p>

Primary school	Changed primary school around Year 2.
Secondary school	Currently on a reduced timetable: half a day. Joins peers for technology and PE lessons. Rest of time in SEN support with 1:1. Sees EP weekly for motivational interviewing. After interview: school said they could not meet pupil's needs at the end of the summer term and he was asked not to come back. Trial at a specialist provision in nearby town agreed, seen as the only option.
Achievement	EHCP report said pupil's "learning skills have been assessed and are not a concern. He can do the work if he wants to." Fell behind in progress and achievement due to school factors (behaviour, reduced timetable).
SES	On free school meals.
ADHD and comorbidities	Parent reported diagnosis was when 9 years old. Pupil remembers being diagnosed in Year 4-5. Comorbid ASD, possible PDA. Takes medication but parent said it no longer works as it did before, they must wait for pupil to turn 14 before dosage can be increased. Conners indicated criteria reached for inattention and hyperactivity-impulsivity. Also indicates significant difficulties with family relations and criteria reached for conduct disorder and oppositional defiance disorder.
EHCP	In process, agreed after interviews took place. Difficulties agreeing placement: parents want expensive residential school.
	In summer term of Year 9 when interviewed. White British, English is first language.
Family life	Mum is concerned the pupil has an obsession with food and he is overweight. Mum involved in 'SEN circles'. Accessed LA SEN charity and member of Facebook groups. Has one brother with Soto syndrome. Parents receive respite from social services.
Primary school	Remembers teachers and school trips. Mum feels primary school were not supportive at all.
Secondary school	Had difficult time in Year 7, felt everyone was bullied. Bullying reduced in Year 8 and 9. Mum says he never lies but peers can get him into trouble. Fixated on a rock band. Responds well to having TA support. Mum feels the current SENCo is great, but one before was terrible.

Achievement	Reaches expected levels. Expected to get 5+ A-C grade GCSEs. Wants to do something in ICT.
SES	Not on free school meals or pupil premium.
ADHD and comorbidities	Comorbidities: ASD and DCD. Takes medication for ADHD and to aid sleep. Remembers being diagnosed with ADHD in Year 5, parent reported he was 10 years old. Parent reported they were not told which subtype of ADHD but would say inattentive. Conners indicated criteria not reached for inattention or hyperactivity-impulsivity but both scores were above average. No other high scores or criteria reached.
EHCP	Yes, issued recently. Parent said it had made a big difference.
	Autumn term of Year 8 when interviewed. White British, English is first language.
Family life	Biological father never involved in life. Pupil and mum lived with her parents when he was young. Mother remarried when he was in Year 3. Family involved with local ADHD charity and participated in intervention through them. Mum is a teacher.
Primary school	Parent was not told about his difficulties with hyperactivity until he was in Year 3. Social difficulties and anxiety throughout primary school. Parent said he was not supported nor understood.
Secondary school	Attends grammar school. Doing well academically and has friends. Has calmed down behaviourally. Parent feels school could be providing more support e.g. emotion coaching.
Achievement	Attends grammar school and doing well. Achieving expected levels. Wants to build cars.
SES	Not pupil premium.
ADHD and comorbidities	Diagnosed at 7 years old. Never taken medication. Has been doing NDT which pupil and mum feel has reduced ADHD symptoms to extent he may no longer reach ADHD criteria. Parent reported ASD traits but said did not want to go down diagnosis pathway. Parent said ADHD diagnosis had negative impact on pupil's self-esteem. Conners indicated no ADHD or other criteria were reached, though hyperactivity-impulsivity and oppositional defiance disorder scores were above average.
EHCP	No. Managing well in school so not required.

	Autumn term of Year 7 when interviewed. White British, English is first language.
Family life	Mum works at pupil's primary school and is involved with local SEN charity.
Primary school	Parent felt primary school had good understanding of ADHD and supported pupil well. Pupil said he liked primary school.
Secondary school	Parent said support had dropped off despite EHCP e.g. reluctant to use one-to-one TAs. School turned pupil down at first, saying they could not meet his needs. Parent feels pupil does not like secondary school and school could be doing more to support him e.g. TA, emotional support. Pupil reported having difficulties building friendships and said secondary school was not as good as primary.
Achievement	Below age-related expectations. Wants to be a footballer.
SES	Not on free school meals.
ADHD and comorbidities	Parent said was age 7-8 when diagnosed with ADHD. Has ASD, diagnosed aged 4. Speech and language difficulties. Takes medication, started as soon as diagnosed, parent said it works well and can tell when it wears off. Starting Lego Therapy (social skills intervention). Conners indicated criteria reached for inattention and hyperactivity-impulsivity. Also, significant difficulties with learning problems and family relations.
EHCP	Yes, from when age 5-6. Parent said this was mainly for difficulties associated with ASD.
	In summer term of Year 7 when interviewed. Mixed white and black Caribbean, English is first language.
Family life	Mum and dad are separated. Currently living with Grandmother away from mum and siblings. Pupil said this was difficult for him. Family history of Bipolar Affective Disorder. Mum reported she has 3 brothers with ADHD.
Primary school	Just remembered school trips.
Secondary school	Attends nurture group and this works well for him. Parent felt school should give him one-to-one support. Pupil said he has good friendships.
Achievement	Reaching age-related expectations. Wants to be a YouTuber.

SES	Is pupil premium.
ADHD and comorbidities	Parent questionnaire and CAMHS letter reported inattentive subtype, 'moderate ADHD'. ADHD diagnosis aged 7. Had speech and language difficulties when younger but no comorbid diagnosis. Does not take medication, because of this was discharged from CAMHS. Conners indicates criteria reached for hyperactivity-impulsivity but not inattention. Also, significant difficulties with defiance-aggression and family relations and reached criteria for oppositional defiance disorder.
EHCP	No EHCP.

## 9.17 Rating of tool effectiveness

The tools used in pupil participant interviews were rated on a scale of 1-5 by the researcher as to their perceived ease of use for the interviewer and quality of response from the participant (see table below). A mean was calculated for each tool/step for the quality of response.

Tool	Question/step	No. of participants tool was used with	Ease of use*	Quality of response ** (mean)	Approx. length of time needed
Grid rating activity	N/A	9	4	3.3	5-10 minutes
Vignette	Advice	7	3	2.3	3-5 minutes
	How feeling?	5	3	3.0	
	What thinking?	7	3	3.1	
	What might happen to him?	3	3	2.0	
Post-it activity	Things like about school	9	4	2.6	5-10 minutes
	Things don't like about school	9	4	3.2	
	Things wish teachers knew about ADHD	9	4	3.4	
Three comments	Teacher	8	3	1.8	3-5 minutes
	Parent	8	3	2.1	
	Friend	8	3	2.0	
	Yourself	8	3	2.0	
Ideal	Teacher	Drawn: 3 Verbal: 6	3	Drawn: 3.3 Verbal: 3.2	Drawn: 10-20 minutes Verbal: 5-10 minutes
	Classroom	Drawn: 2 Verbal: 7	3	Drawn: 4.0 Verbal: 2.9	
	School	Drawn: 1 Verbal: 7	3	Drawn: 2.0 Verbal: 2.4	
Opposite of ideal/ worst	Teacher	Drawn: 1 Verbal: 1	3	Drawn: 4.0 Verbal: 3.0	
	Classroom	Drawn: 1 Verbal: 1	3	Drawn: 4.0 Verbal: 1.0	

	School	1 (verbal)	3	Verbal: 1.0	
Timeline	N/A	9	4	3.6	5-10 minutes

**\*Ease of use:**

1. Difficult: specialist knowledge and/ or resources needed
2. Somewhat difficult: specialist resources and some specialist knowledge needed
3. Intermediate: resources easy to create and little specialist knowledge needed
4. Easy: resources easy to create and no specialist knowledge needed
5. Very easy: no specialist knowledge or resources needed

**\*\*Quality of response:**

1. Very little or no information given
2. Little information given, surface-level
3. Some information given, surface-level
4. Some information given, deeper level
5. Lots of information given, deeper level

### Summary

All activities were rated as intermediate level (resources easy to create and little specialist knowledge needed) or easy to use (resources easy to create and no specialist knowledge needed), so school staff would be able to use them with little or no reading or EP input.

The highest means for quality of response were for the drawn 'ideal/worst teacher and classroom' activity. However, this activity takes the longest, needing approximately 10-20 minutes, and the ideal school task was seen as less effective.

The 'timeline' activity received the next highest mean for quality of response and was perceived to be useful for discussing key events in the participants' lives. However, some pupils found it difficult to remember what had happened in their past and some did not discuss difficult times in their lives.

Next, the grid rating activity was viewed as being effective for seeing which strategies participants found most helpful and in which lessons. Participants tended to elaborate on their responses and the use of a numbered rating system with prepared stickers meant they all gave an answer every time.

In the Post-it activity, asking what pupils did not like about school and what they wished teachers knew about ADHD received higher mean scores for quality of response than asking what they liked about school. However, it was felt starting with the positively framed question helped to put participants at ease, so it is not recommended this step is removed from this activity.

The vignette activity questions received mixed scores for the quality of response. Asking what the boy in the photograph was thinking or feeling upon being told he had

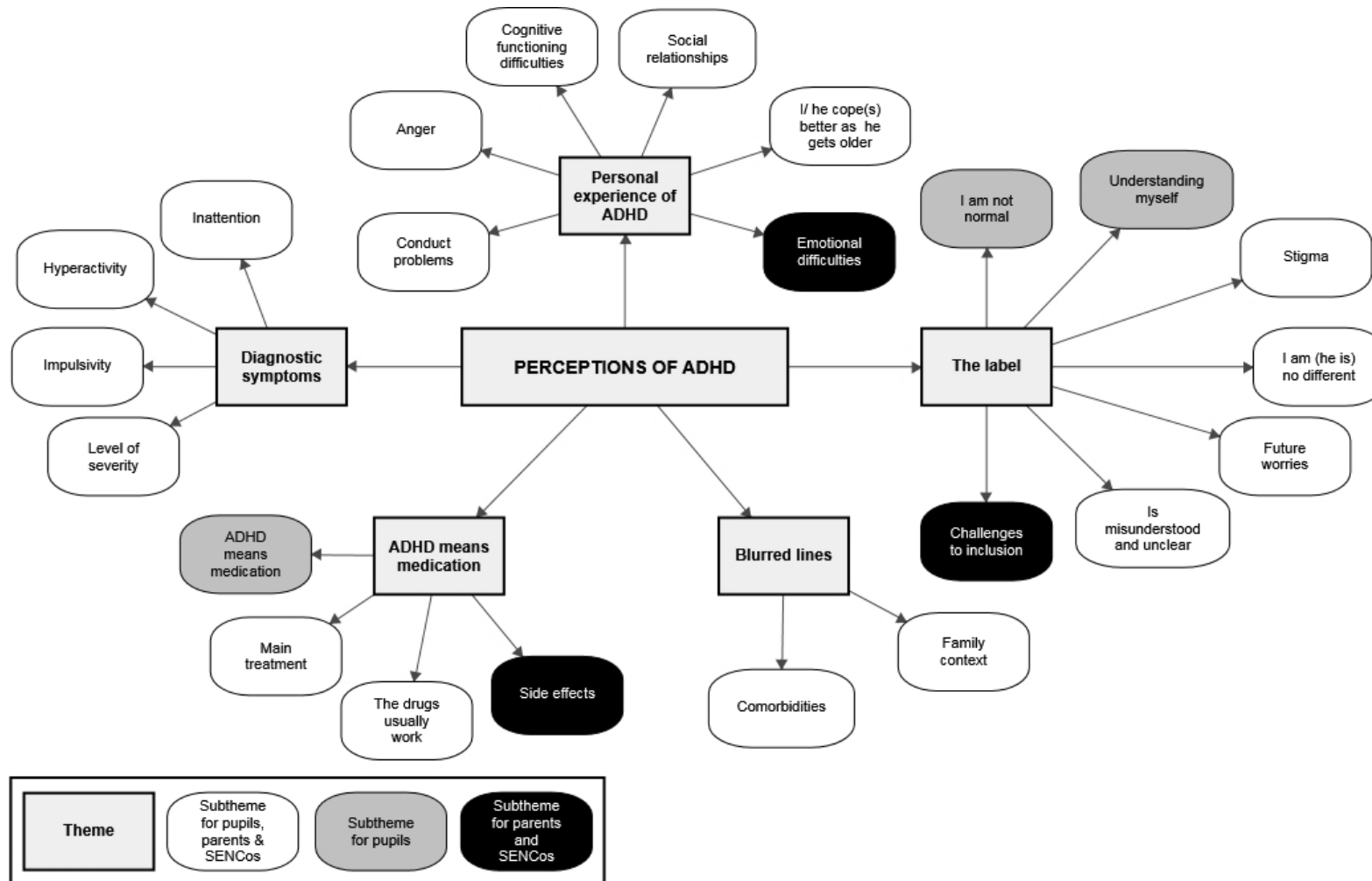
ADHD prompted responses that gave more insight than asking what advice they might give, or what might happen to the boy. This task only required 3-5 minutes to complete.

The tool that received the lowest mean for quality of response was 'three comments'. Participants did not tend to elaborate on their responses, unlike in other tasks.

It should be noted the quality of responses varied by participant, for example, some with ASD found the ideal teacher/classroom/school tasks more difficult, possibly due to the ASD trait of difficulty with imagination.

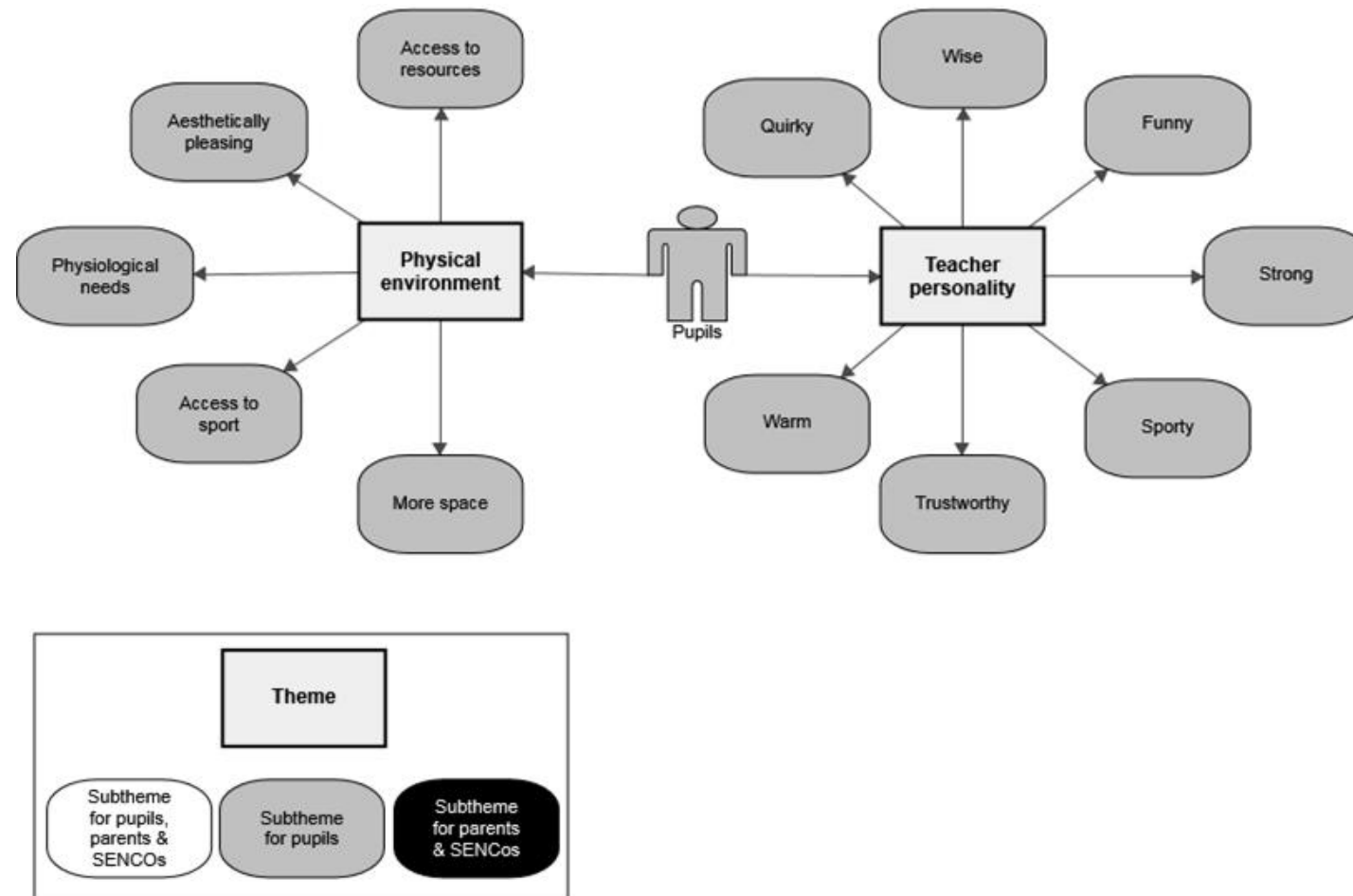


## 9.18 Thematic map showing themes and subthemes for perceptions of ADHD

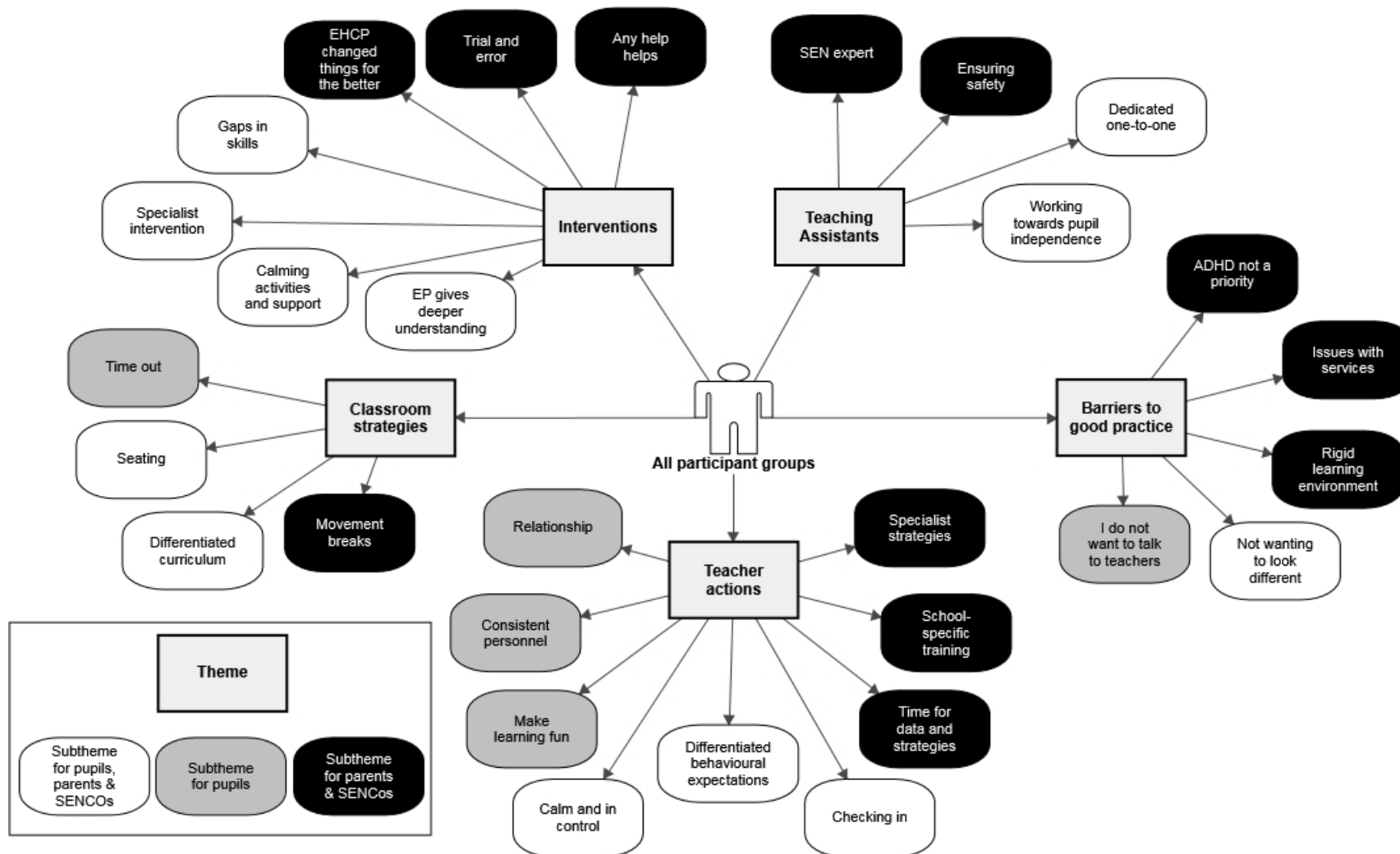


## 9.19 Thematic maps showing themes and subthemes for views on good practice when support young people with ADHD

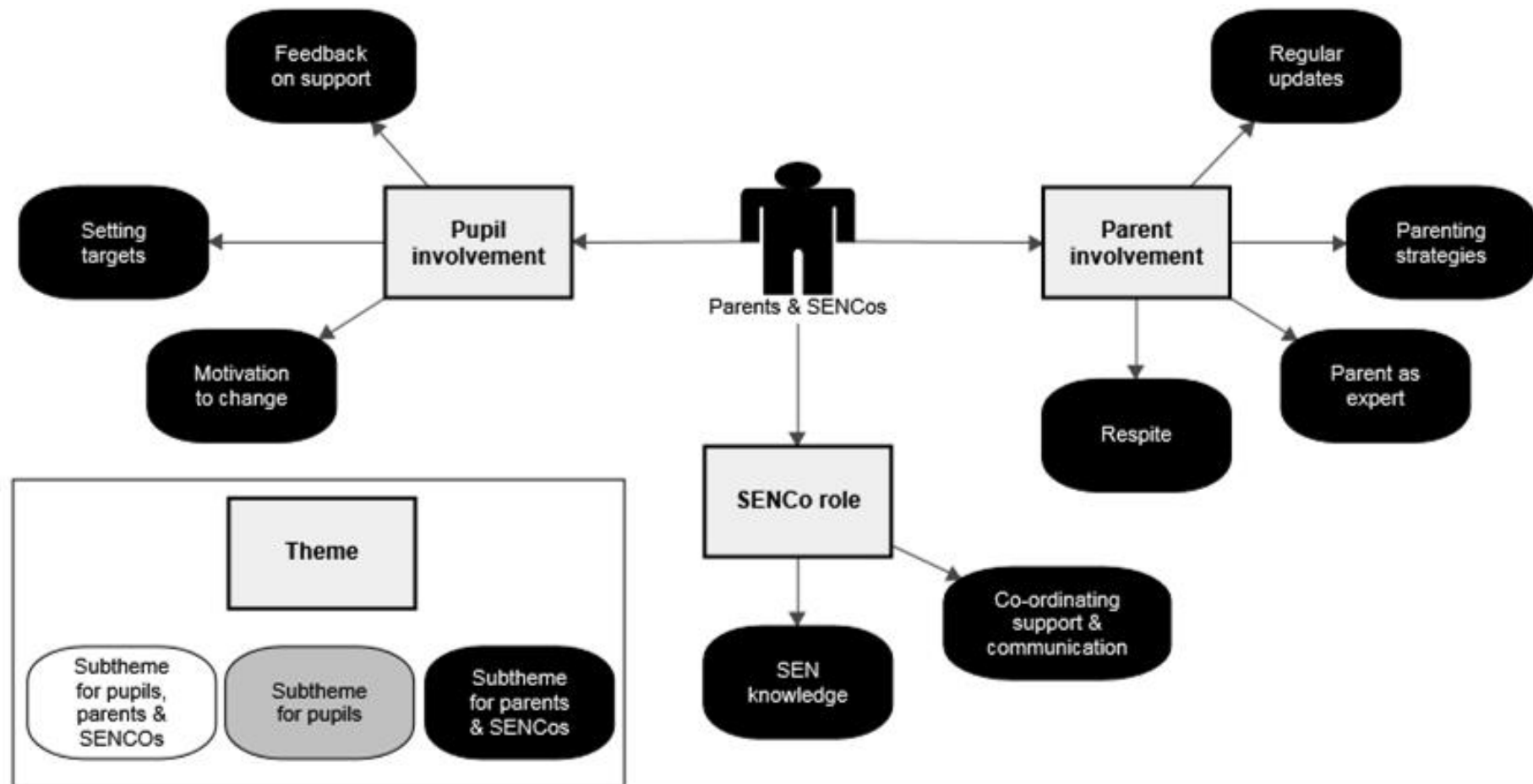
### a) Pupil participants



b) All participant groups



c) Parent and SENCo participants



## 9.20 Links between interventions and strategies in the findings and previous research

Intervention/ strategy identified in findings	No. of participants that endorsed the intervention/ strategy	Evidence in previous research
Focus on gaps in social, literacy or numeracy skills.	Five SENCoS, two pupils.	Moore et al. (2017): UK school staff reported supporting pupils with ADHD to develop their social skills.
Having a good relationship with the teacher.	Three pupils.	Singh's (2012): a supportive school environment is instrumental in helping children with ADHD. Sherman et al. (2008): teacher-pupil relationship impacts on a young person's behaviour.
Making learning fun.	Four pupils.	Gibbs et al. (2016) and Wiener and Daniels (2016): pupils with ADHD valued strategies that captured and sustained their attention, had a quick pace and an engaging learning environment.
Consistent personnel.	Three pupils (all with comorbid ASD).	Moore et al. (2017): A key factor to success was a positive teacher-pupil relationship but it was acknowledged they can be hard to build.
Teacher checking-in with pupils to keep them on track.	Four pupils, three parents and one SENCo.	Kendall (2016) and Gibbs et al. (2016): pupils said it was helpful for the teacher to check-in and explain things to them.
Differentiated curriculum e.g. breaking tasks down into small steps.	Six pupils, two SENCoS, one parent.	Gibbs et al. (2016) and Wiener and Daniels (2016): pupils value strategies that sustain their attention and teachers should give clear instructions. Walker-Noack et al. (2013): young people with ADHD wanted fewer assignments and less homework.
Use of rewards.	Three pupils, one SENCo.	Gaastra et al.'s (2016): behavioural interventions, including the use of rewards, produce the strongest effects for positive behaviour changes in pupils with ADHD. Walker-Noack et al. (2013): pupils felt rewards became less effective as they got older.
Choice of seating.	All pupils and four SENCoS, mixed views on where is best.	Wiener and Daniels (2016): pupils most valued strategies in their ideal classroom that minimised distractions, which seating could be a key factor in, especially as pupils also reported being distracted by peers.

Time out card.	Three pupils, one parent.	Singh (2012) and Kendall (2016): pupils with ADHD said a time out card was useful.
Teacher being calm and in control.	Control of class: four pupils. Calm: five pupils. Both: two SENCos.	Sherman, Rasmussen, and Baydala (2008): teachers' attitude and reactions to ADHD behaviours can influence children's self-efficacy, perception of themselves and social and academic outcomes. Kendall (2016): pupils want a calm teacher. If a teacher reacts negatively to a pupil's behaviour, it can lead to low self-esteem, aggression, withdrawal, embarrassment or social isolation for the pupil. Finding also shown by Gibbs et al., (2016) and Ljusberg (2011).
Comfortable, nice environment.	More space: four pupils. School looks nice: six pupils. More comfortable seating: four pupils. Air conditioning: one pupil.	Gaastra et al. (2016): antecedent-based interventions, where adjustments were made to the environment, yielded small-to-medium effect sizes. Maslow's hierarchy of needs theory (1943): basic physiological needs must be met as a first step for one to meet their full potential. Vilcekova et al., (2017): classroom environmental conditions play a crucial role in the health, performance, and behaviour of pupils. This is more important for students with SEN.
Access to good food.	Three pupils.	NICE guidelines (2018): stress the value of a balanced diet. Maslow's hierarchy of needs theory (1943): basic physiological needs must be met as a first step for one to meet their full potential. Some studies have shown altering diet can impact on ADHD symptoms for some children e.g. children and adolescents with inattention responded to treatment with omega 3/6 fatty acid capsules (Johnson, Östlund, Fransson, Kadesjö, & Gillberg, 2009) and children with low serum ferritin levels improved after taking iron supplements to a level comparable to stimulants (Konofal et al., 2008).
Access to resources e.g. technology.	Seven pupils.	Gibbs et al. (2016) and Wiener and Daniels (2016): pupils with ADHD valued strategies that captured and sustained their attention, had a quick pace and an engaging learning environment.
TA support.	Five pupils, all parents, all SENCos.	Sikirica et al. (2015): parents felt one-to-one help was needed. Kendall (2016): having a learning mentor or TA (but not all the time) was a useful strategy identified by pupils.

Pupil involvement in planning for support and targets.	Four SENCOs.	Bussing, Koro-Ljungberg, Gagnon, et al. (2016) and Bussing, Koro-Ljungberg, Gurnani, et al. (2016): student views should be included when developing interventions to lower the risk of them being resisted by pupils. Wiener and Daniels (2016): although pupils with ADHD know what factors contribute to academic success, they struggle to put them into place which suggests they will need support with working towards targets as well as setting them.
Neuro-Developmental Therapy.	One pupil, one parent.	A small number of studies show a correlation between retained reflexes and ADHD symptoms (Bob, Konicarova, & Raboch, 2013; Konicarova & Bob, 2012), but no evidence base as to the therapy leading to improvements in symptoms. Also, pertains to apply to those with a wide range of difficulties (Hyland, 2011).
Nurture group.	One pupil.	The Nurture Group Network (2018): 42% of pupils that attend a Nurture Group in secondary school have a diagnosed psychiatric disorder, most commonly ADHD. Nurture groups are an EP-designed, teacher-led intervention for disengaged and troubled young people, that aims to remove barriers to engagement and attainment in schools.
ADHD psycho-education course.	One parent.	Moore et al. (2015): Synthesis of four systematic reviews emphasised the importance of psychoeducation for teachers, parents and pupils to help overcome lack of knowledge and stigma around ADHD.