A Closer Look at ADHD in Children

Introduction

Many parents start to wonder about ADHD when a child struggles with attention, restlessness, impulsiveness, strong emotions, or getting organised for school. Sometimes the question comes from repeated feedback about distractibility or unfinished work; sometimes it is that everyday routines — getting ready in the morning, homework, settling to sleep — feel far harder than they seem to be for other children. For some families a teacher or another parent raises it; for others it grows from reading about ADHD and recognising something familiar.

Thinking about ADHD can bring mixed feelings. For many parents it offers an explanation for behaviour that has been confusing or stressful. It also raises questions: is this normal for a child this age, or something more; would a diagnosis help or label them unnecessarily; what actually helps; should medication be considered? I've written this to try to help you think those through, along with practical things you can do now, whether or not your child has a diagnosis. It does not replace advice from a clinician who knows your child. It is not intended to be exhaustive or a definitive guide. It is based on my own experience as a clinician alongside my reading of the evidence, and is what I would share if I had unlimited consultation time. Other clinicians, parents and children see some of these questions differently, and that there is more than one reasonable position – I offer this as my own view I have come to over time based on clinical experience. I always maintain that each person is the expert in the details of their own lives and how they relate to and understand their own experience.

When an adult considers ADHD, they can weigh it up and decide for themselves. With a child, the adults around them — parents, teachers and clinicians — are making decisions on behalf of someone who is still developing and cannot yet weigh these things for themselves. That is a good reason to think carefully about a child's development, environment and circumstances alongside any diagnosis.

Key Points

- ADHD is a description of a pattern of traits, not a disease with a known biological fault. The difficulties are real, and they can have a real impact on a child and family.
- Children develop at different rates. Age within the school year matters, especially for summer-born children.
- A diagnosis can help, but support at home and school does not have to wait for one. You can ask the school's SENCO what can be put in place now.
- Medication helps many children in the short term. It is a tool to try, review and stop if it is not helping, and the decision deserves unhurried discussion.
- In England the routes to assessment are the NHS, Right to Choose and private. If you are considering going private, ask your GP practice about shared care first.

> - If you are worried about your child's safety or mood, seek help sooner (see the end of this guide).

What Is ADHD?

ADHD is a widely recognised diagnosis used around the world, and the difficulties it describes are real and can have a real impact — on learning, friendships, family life, confidence and safety.

It is helpful to look at what kind of thing ADHD is. It is not a disease with a defined physical fault behind it. There is no blood test, brain scan or genetic test that correlates reliably with the diagnosis. It is best understood as a description of a pattern — a group of traits that tend to go together and cause difficulty in some settings. Some other well-recognised conditions, such as migraine, work the same way and are diagnosed from the pattern rather than a test. And whatever the answer turns out to be, every child is far more than a diagnosis: the aim is always to help them build on their strengths and grow into a confident, capable person.

What clinicians mean by ADHD in children

In children, ADHD describes ongoing patterns of difficulty with attention, activity levels, impulsiveness or managing emotions that significantly get in the way of everyday life — and that show up across different settings, not just one. The difficulties are usually most obvious where a lot is being asked of attention and self-control, especially at school: sitting still, following instructions, finishing work, moving between activities, and managing impulses and feelings.

Because there is no single test, a diagnosis comes from careful assessment over time — detailed conversations with parents, information from school, and a look at how the child manages in different places.

A spectrum, and ordinary variation in childhood

The traits involved — high energy, distractibility, novelty-seeking, emotional intensity, difficulty sticking with repetitive tasks — are not something a child either has or does not have. They are spread right across all children, and every child sits somewhere on each of them. Most children show some of these at times, particularly when they are tired, bored, stressed or settling into something new.

Attention and self-control also develop gradually through childhood, and children of the same age can be at quite different stages — some organise themselves and settle to tasks earlier, others take longer, all within the normal range. What we call ADHD is towards the end of that range where the traits are strong and persistent enough, and cause difficulty with everyday demands. The point where behaviour crosses into a diagnosis is set by agreed criteria and clinical judgement — not a clear line separating two types of child or two types of brain.

Relative age — the “August-born effect”

One well-established finding is worth knowing, especially for parents of a child who is young for their year. In school systems where children are grouped by year, the youngest children in the year are more likely to be diagnosed with ADHD than the oldest. In the UK that means August-born children — usually the youngest in their class — are diagnosed more often than those born in September. The same pattern turns up across many countries.

The likely explanation is simply maturity. Within one school year there can be almost a full year’s difference in age, which at this stage of life is a big gap. A younger child can look more restless or distractible next to slightly older classmates while still developing perfectly normally for their age. This does not mean those diagnoses are necessarily “wrong” — many of these children do struggle — but it is a reminder to weigh a child’s age within their year, and their wider development, rather than judging by classroom behaviour alone, and is another illustration of the subjective nature of the diagnosis and the importance of context.

What is known — and not known — about the biology

ADHD is often called a neurodevelopmental condition, and there is something to that — but it is worth being clear about what it means. Large studies find small average differences in the brains of groups of children with and without ADHD, and the traits are partly inherited. But the differences are small, overlap heavily with other children, and are not present in every child diagnosed. If you scanned all children you would find variation anyway, because no two brains are the same, and it follows that if you scan children with certain traits there are likely to be some small overlapping similarities. The genetics work similarly: many genes, each with a tiny effect, common across the whole population, with no single “ADHD gene.” So biology adds context — it does not draw a clear line around ADHD, or fully explain why difficulties come and go with sleep, stress, school and home life, and it does not support the idea of a “different type of brain.”

A description, not a separate force

It is natural to talk about “my child’s ADHD,” and it can be a useful shorthand. The difficulties are real. One thing is worth thinking through though. ADHD is the name for a pattern of traits — it is a description, not a separate thing inside a child that makes them behave in certain ways. It is the name we as a culture currently give to a cluster of natural human traits that tend to occur together. The name dates from the later part of the 20th century; it first appeared in the psychiatric diagnosis manual, the DSM, in 1980, as attention deficit disorder. It is a description of those patterns — not a separate entity.

This matters because of how a label can affect a growing child. If ADHD comes to feel like the explanation for everything, it can lower what the adults around a child expect of them, and shape how the child comes to see themselves — as someone who can’t do certain things or will inevitably act in a certain way, rather than someone still learning and changing. Children grow and develop a great deal, and behaviour that is hard at one stage often shifts as they

mature. Seeing ADHD as a helpful description, useful at that particular time, rather than a fixed identity, keeps the focus on a child's strengths, on what they are learning to do, and on the support that helps them do it. I know that other clinicians and parents see this differently. I have found this framing useful, so I offer it for you to weigh.

Attention in a distracting world

It is also worth saying something about the world children are growing up in. A lot of modern childhood affects attention: less unstructured play and time outdoors, more time on screens that are designed to grab and hold focus with constant novelty, combined with classrooms that ask children to sit still and concentrate for long stretches. These demands make it harder for many children to settle and focus — not only those who might be considered for a diagnosis of ADHD.

It can help to see this as an interaction between how a particular child's attention works and what is being asked of it, rather than something simply wrong with the child. For some children their natural traits make the mismatch more pronounced. It means that adjusting the world around a child — protecting sleep, building in routine and outdoor time, classroom adjustments, reducing unnecessary distractions — often helps, whether or not a child has a diagnosis.

This also helps explain why far more children are being recognised and assessed than in the past, alongside greater awareness and a diagnostic line that has itself shifted over time. What matters in practice is whether understanding the pattern helps your child get the right support.

Getting an assessment

A diagnosis should follow a thorough assessment by a specialist trained in this — usually a paediatrician, child psychiatrist or a specialist team. A brief checklist or a questionnaire on its own is not enough; questionnaires can help as a first step but cannot make the diagnosis. A good assessment takes time, gathers information from both home and school (because children behave differently in different places), looks carefully at the child's development from early on, and weighs up other explanations — sleep problems, anxiety, stress at home or school, and learning difficulties can all affect attention and often sit alongside ADHD. Waits for assessment are often long, which is hard when a family is already struggling; there are things you can do in the meantime, set out further on.

In England there are three main routes. The standard NHS route is through your GP to a local service — usually community paediatrics or a child and adolescent mental health service (CAMHS) — which is free but often involves a long wait. The NHS Right to Choose scheme lets you ask your GP to refer your child to an NHS-approved provider elsewhere rather than only the local one; it is still free and is often quicker, though not all providers assess children. A private assessment is usually fastest but you pay for it. (Right to Choose applies in England; elsewhere in the UK the options are the local NHS service or going privately.)

Services, waiting times and local policies change and vary by area, so check the current position with your GP practice or the NHS before you decide.

If your child is diagnosed and starts medication, the dose is usually adjusted over a few weeks before it settles, after which prescriptions can often transfer to your GP under a shared-care agreement. It is worth knowing that not all GP practices accept shared care, especially from private providers — if yours does not, you may need to keep getting prescriptions through whoever assessed your child. So if you are considering going private, it is sensible to check with your own GP practice first.

The quality of assessments varies between providers. Your GP or local NHS service will check that an assessment meets recognised standards before taking over prescribing, so a thorough assessment in line with national (NICE) standards — drawing on information from both home and school — is less likely to cause difficulties later. If you are choosing a provider, it is worth checking they carry out a full assessment.

Diagnosis, support and treatment

An ADHD diagnosis can be helpful for some children and families. It can give a shared way of talking about difficulties, support access to school adjustments, and guide discussions about treatment. But many effective forms of support do not need a diagnosis. In everyday life, what often helps most is how well a child is understood, how expectations are shaped, and how their surroundings are adapted to support their development.

In much of medicine, a diagnosis is the discovery of an underlying cause, and naming that cause points to a treatment that corrects it. Type 1 diabetes is a clear example: the symptoms — thirst, tiredness, weight loss — turn out to be caused by a lack of insulin, and replacing the insulin corrects the problem. It is tempting to assume ADHD works the same way, and long waits can make it feel as though the diagnosis will be the moment everything is finally put right for your child. But ADHD is not like that. We are not uncovering a hidden condition beneath the traits; we are choosing to apply a diagnostic label to a pattern of traits that is already there, and is interacting with the current environment. That label can be genuinely useful — it can make sense of things, ease self-blame, open doors and guide support — but it is a description, not the discovery of something correctable underneath. Holding that in mind, and keeping expectations realistic, protects against pinning everything on a cure, since the “cure” framing doesn’t fit what is going on.

The aim of support is to reduce the difficulties associated with the diagnosis of ADHD and help your child manage and thrive. For most children the foundation is practical: clear routines, support at school, breaking tasks down, attention to sleep and activity, and helping the people around the child understand how best to help. The specific strategies are set out in the sections that follow.

Medication

Medication is offered for some children, usually when difficulties are significant and other support has not been enough. Because the decision is being made for a child rather than by them, it deserves extra care and unhurried discussion. Stimulant medicines (such as methylphenidate or lisdexamfetamine) are usually tried first, with non-stimulant options where those do not suit.

In the short term they can clearly reduce symptoms for many children — particularly restlessness, impulsivity and some attention difficulties — though they help some children much more than others. The effect is larger than for many psychiatric medicines: somewhere between half and three-quarters of children improve clearly on a stimulant, against around one in five on placebo, and most who do not respond to one stimulant respond to the other. Most research looks at short-term symptom change over months rather than years; there is much less good evidence of clear long-term benefit in broader outcomes such as attainment, wellbeing, relationships or quality of life. That does not mean long-term benefit doesn't occur, but it cannot be assumed, and should be reviewed over time. Medication works best, when it helps, as part of wider support.

Side effects are common and vary between children: reduced appetite or weight loss, trouble getting to sleep, headaches, stomach upset, and changes in heart rate or blood pressure — so a child's growth, sleep, heart rate and blood pressure are monitored while they take them. Some children become more irritable or emotionally up-and-down, less spontaneous or playful, or have mood dips as a dose wears off. Before starting, the prescriber should ask about any heart problems in your child or family, including sudden unexplained death at a young age. If your child has chest pain, fainting or a racing or irregular heartbeat on treatment, contact the prescriber or your GP promptly.

It also helps to know what to expect day to day. The usual stimulants are short-acting, so they mostly work on the day they are taken — a missed dose generally just means the difficulties return that day rather than causing withdrawal, and they can usually be stopped without trouble. A couple of the non-stimulant options work differently and should not be stopped suddenly, so any changes are best made together with whoever prescribes them rather than on your own.

The medicines work while they are in the body rather than curing anything, so they are best thought of as a tool that can help a child function — something to try, review, and stop if it is not helping (on the advice of a health professional). There is no pressure to choose medication, and choosing it, or not, are both reasonable decisions when made with clear information.

Support at school

Many helpful school adjustments are simple and benefit a wide range of children, not only those with a diagnosis. Children tend to cope best when expectations are realistic, explicit and consistent. Some that tend to make a difference:

1. **Keep routines predictable.** Visual schedules, written task lists, clear start and end points, and advance warning of changes all reduce uncertainty.
2. **Break work into steps.** Shorter, achievable chunks make a task feel manageable.
3. **Allow movement.** Regular movement breaks often help a child settle and focus rather than disrupting the class — especially with younger children.
4. **Give one instruction at a time.** Clear, simple instructions with a quick check that they have been understood.
5. **Encouragement, not punishment.** Noticing what is going well seems to help improve behaviour more reliably.

Talking to your child's school

You do not need a diagnosis to ask the school for support — help can begin through what schools call SEN support (special educational needs support), which is based on a child's needs rather than requiring a diagnosis. A good first step is to ask for a short meeting with the class teacher and, if needed, the school's SENCO (the special educational needs coordinator). It helps to be specific about what makes a difference, and to keep the tone collaborative. A few phrases that can open that conversation:

- "Could we meet to talk about how [child] is getting on, and what might help them focus and stay organised?"
- "[Child] does better with one instruction at a time and a quick check-back — would that work in class?"
- "Would a short movement break during longer tasks be okay? It seems to help them settle rather than disrupt."
- "Could homework be written down or emailed, so we can see it at home and help them keep on top of it?"
- "Could tasks be broken into smaller steps, with clear start and finish points?"

Because SEN support is based on need, it does not have to wait for an assessment — it is worth asking the SENCO what can be put in place now.

Support at home

A few tentative suggestions here, with the full understanding that parents are the experts in their family and children. These are the type of things that tend to help, as you see fit. At home, children usually manage best when things feel predictable and emotionally safe. Challenging behaviour after school often reflects overload or exhaustion. There are often local sources of support that can offer help and advice in these areas, such as the child and family wellbeing service. A few things that some people find can help:

1. **Keep routines consistent.** Predictable rhythms around mornings, homework and bedtime reduce the number of daily battles.
2. **Give short, concrete instructions.** One clear step at a time is easier to follow than a string of them.
3. **Notice effort, not just results.** Recognising the trying — not only the finished outcome — builds a child's sense of their own possibilities.
4. **Build in recovery time.** A calm gap after school, before homework or demands, lets an overloaded child calm down.
5. **Ease off when overwhelmed.** When a child is already overloaded, reducing what is being asked is usually more effective than insisting.

Understanding and managing emotions

Many children with ADHD-type difficulties feel emotions quickly and strongly, struggle to pause before reacting, and find it hard to put what they are feeling into words in the moment. This reflects regulation that is still developing under pressure, not poor behaviour or deliberate defiance. Emotional regulation grows gradually, and is strongly affected by the support and safety adults provide. A few things can help:

1. **Catch it early.** Notice and name the first signs of overwhelm, before things boil over.
2. **Put words to feelings.** Simple language — "you're frustrated because that was hard" — helps a child make sense of what they feel.
3. **Reduce demands in the moment.** When a child is already overloaded, that is not the time to push; steady them first.
4. **Practise in the calm.** Rehearse coping strategies when things are settled, not in the middle of a crisis.

While waiting for assessment or treatment

Waiting can be stressful, and it can start to feel as though life is on hold. But support can still be put in place, school adjustments can still be made, and progress is still possible. Putting everything on hold until a diagnosis or medication arrives can add to the pressure. Being realistic about the difference a diagnosis or medication will make, and acting on what helps now, is usually the most useful approach.

A name for the pattern can bring real relief and make sense of years of difficulty. It is worth remembering, though, that the label by itself does not change anything — what helps your child are the practical changes at home and school, and in some cases medication can be tried. That is also why support does not have to wait for an assessment, which can be particularly frustrating with the pressures on the system meaning such long waiting times. Whether or not

medication is used, it is the combination of practical adjustment with emotional understanding that usually helps significantly, and children change as they grow, so support can change over time as their needs change.

When to seek help sooner

- Persistent low mood, anxiety, big changes in sleep or behaviour, or refusing to go to school can occur alongside ADHD-type difficulties or be mistaken for them. Do not wait for an assessment. Speak to your GP.
- If your child talks about hurting themselves or not wanting to be alive, or you are worried about their safety, get help the same day. Contact your GP or call NHS 111 and choose the mental health option. If there is immediate danger, call 999.
- If your child is on medication and has chest pain, fainting or a racing or irregular heartbeat, contact the prescriber or your GP promptly.