

ATTENTION DEFICIT HYPERACTIVITY DISORDER IN THE PRIMARY SCHOOL SETTING

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Introduction:

While methamphetamine captures headlines and political attention, other psychostimulants, dexamphetamine and methylphenidate, have long been common treatments for attention deficit hyperactivity disorder (ADHD). ADHD is a disorder principally identified in primary school children, with symptoms including difficulties in staying focused and hyperactivity, leading to significant functional impairment.

ADHD comes in 3 subtypes: includes predominately inattentive, predominantly hyperactive and both combined (National Health and Medical Research Council 2012). Behavioural issues must be seen in at least two or more settings for diagnosis. With changes in Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), symptom identification in multiple settings has been further highlighted (Prosser & Reid 2013).

Subsequently, the need for interactions between clinicians and educators, more specifically primary school teachers, has been amplified.

ADHD psychostimulants (principally dexamphetamine and methylphenidate) are a dominant therapy and are subsidised by the Government of Australia under the Pharmaceutical Benefits Scheme (PBS 2014).



Aim :

- (1) To identify the role (if any) of primary school teachers in ADHD diagnosis and the impact of ADHD-diagnosed children in the school setting.
- (2) To determine if school teachers had evidence of playground diversion of ADHD medications.

Method:

Following ethics approval, postcodes reflective of the highest rates of ADHD psychostimulant prescriptions in South Australia were obtained from Drug and Alcohol Services South Australia (DASSA) for the period 1st January 2014 through 31st May 2014 inclusive and relating to patients aged 6 to 12.

Data were analysed and primary schools in areas of interest were identified. Teachers from targeted areas were approached and recruited for focus group sessions. All sessions were recorded and transcribed by a third party. Focus groups were discontinued after the 5th session due to data saturation.

Thematic analysis of focus group data was performed.

Key Findings and Discussion:

1. Areas of high ADHD psychostimulant prescription rates reflected resident populations of lower socioeconomic status, a pattern congruent with previous studies (Reid, Hakendorf & Prosser 2002)
2. Participants reported that their training did not provide sufficient content on ADHD and related behavioural disorders. However working experience was deemed advantageous in ADHD symptom identification, similarly observed by (Bekle 2004)
3. Earlier research with parents and carers established that teachers and parents as well as clinicians play an important role in ADHD diagnosis (Leggett & Hotham 2011). In this study, teachers did not admit to a diagnostic role and emphasised their lack of medical training.
4. Participants reported observations of difficulty in learning, relationship problems with peers and parenting issues, which contributed to poor academic and social outcomes in children diagnosed with ADHD.
5. Behaviours of hyperactivity were noted as causing interruptions in the learning environment, reducing the productivity of the whole classroom.
6. There were no reports of psychostimulant diversion in the playground.

Conclusion:

Teachers identified indications of hyperactivity, inattention or both, which may be congruent with behavioural symptoms of ADHD. However, while reporting these to both parents and to medical practitioners, teachers did not offer a diagnosis. Management of these children was reported as highly challenging. Despite literature reports of psychostimulant diversion in school playgrounds (Boyd et al. 2007), no evidence of such activity emerged in this study.

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