

Children and ADHD: seeking control within the constraints of diagnosis

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The views of children diagnosed with ADHD have, until recently, largely been neglected in research, policy and practice. This article focuses on qualitative research which explored children's lived experience, drawing attention to the ways that they actively 'take' responsibility for managing their physical, psychological and emotional well-being within the constraints of a medical diagnosis. The neglect of a tradition which asks children about their own experiences of ADHD is crucially bound up with children's low social and political status in UK society and notions of competency and responsibility in relation to ADHD. © 2014 John Wiley & Sons Ltd and National Children's Bureau.

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Introduction

This article focuses on a group of children who are often subject to pharmacological intervention, namely, those that are diagnosed with the condition of ADHD. The contemporary and most dominant framework of understanding of behaviour associated with the condition is the Diagnostic and Statistical Manual of Mental Disorders (the most recent versions being DSM IV, 1994; DSM TR, 2000; DSM V, 2013; APA). DSM V details the areas of difficulty identified as significant — inattention, impulsivity and overactivity. While a range of professionals from health, education and social care can be involved in supporting children who are so diagnosed, multi-agency working and pervasive views of children's development have led to the increasing dominance of biomedical understandings across all other disciplines. The biomedical framework has become embraced by a wide range of professionals and practitioners, including psychiatrists, psychologists, teachers (Timimi and Radcliffe, 2005), social workers, early years' workers and, increasingly, many of those who have a remit for working with children.

It remains debatable whether ADHD diagnosis provides an adequate explanation for children's behaviour or simply a neat classification so that we think we know who and what we are talking about if a child is described as 'having' ADHD — in effect, the essentialising of 'the ADHD child'. It is perhaps just one claim to truth, alternative frames of reference may offer a less medicalised more social explanation and form of intervention as children diagnosed with ADHD in the UK are often prescribed psychostimulant medication (Methylphenidate) to control their 'symptoms'. The increasing normalisation of diagnosis and of pharmacological treatment has implications, particularly in a UK context where the government's approach is to emphasise early intervention to prevent future problems (Allen and Duncan Smith, 2008; Duncan Smith, 2011).

The behaviours or traits associated with ADHD arise from simultaneous biological and social processes; children's behaviour only becomes invested with meaning in relation to a particular cultural interpretation which pathologises such behaviour and constructs it as a condition or disorder, a medical 'within-child' rather than social issue. This is not to underplay any distress

or anxiety experienced by parents or children themselves who do not meet contemporary societal expectations of appropriate parenting or appropriate child development. It is also not to ignore the reality of living with such a diagnosis and its consequences. However, as there are alternative ways of interpreting behaviour, listening to the experience of children is a useful way of understanding the interplay of social, environmental and biological factors. ADHD is both a medical and social phenomenon (Brady, 2004a, 2004b).

One idea which can be used to conceptualise the active role that children play in responding to the designated label, and to treatment with medication within the context of managing their own lives is the health care division of labour. The approach, most notably developed by Stacey (1981, 1984, 1988) is distinctive, through the inclusion of the contributions of both lay and professional, paid and unpaid carers, each participant being regarded as a social actor and all part of a social process. The concept has since been developed further by Mayall (1990, 1996, 1998, 2002) in relation to the active role which children play in caring for their own health. The process is played out across professional/lay, and adult/child boundaries and the public/private domain. Focusing on the division of labour in child health care entails taking into account the contributions made by both professional and lay persons; the latter's contribution is informal and can often go unrecognised, but both parents and children play a part in managing overall health and well-being.

There has been an under-engagement with the lived realities of ADHD 'symptoms' and drug treatment (Bendelow and Brady, 2002; Brady, 2005; Singh, 2005). Children's accounts challenge dominant understandings and shed light on the ways that they use their agency to make decisions that are right for them, which may not necessarily be those that adults would make or agree with (Brady, 2005). LeFrançois (2008) draws on Sinclair (2004) and Coppock (1997) to argue that the agency and competency of children who have a mental health diagnosis are constructed in very particular ways. Although there is a growing acknowledgement of children's rights and right to participate in mental health services, practice in terms of children's decision-making needs to improve and move away from an authoritarian medical model of treatment.

The purpose of this article is to contribute to knowledge about children's understandings and experiences of ADHD, drawing on a study of children in England carried out during 2000–2001. Over the years since this study was carried out, clinical practice and treatment, the prevalence of cases as well as public discourses on ADHD and other neuro-psychiatric conditions may have changed, to some extent. However, it is reasonable to argue that fundamental aspects of children's understandings and experiences of living with ADHD have not changed so quickly. Increasingly, there are more children diagnosed with ADHD and prescribed medication, and yet there is still minimal attention paid to the child's perspective and the meanings which they give to living with such a diagnosis. Taken together, studies from different periods of time can contribute to our stock of knowledge about the meaning of ADHD. This can help in thinking about past, present and future generations of children and their experiences of psychiatrisation.

The significance of dominant biomedical understandings of children's behaviour

As the biomedical framework for understanding ADHD is neurobiological (DSM V, American Psychiatric Association, 2013) it comes to be thought of as a disorder which needs to be treated. The research literature is dominated by arguments which highlight the economic, emotional and social consequences associated with not dealing with the behaviours associated with ADHD. For example, the significant financial and emotional costs to the health care system, educational services, carers, families and society as a whole are highlighted in 'Diagnosis and management of ADHD in children, young people and adults' (BPS/RCP,

2009). It is argued that providing assessment, diagnosis and treatment, and access to other support is crucial in helping to avoid negative outcomes for children, their families and wider society; it also serves to protect individual rights and promote equality of opportunity. Barkley (1990) and Goldstein and Goldstein (1990) believe that ADHD must be treated to allow individuals to comply with the demands of society; untreated they are at risk of long-term social failure.

Following this line of thought, not to diagnose could leave children unintentionally suffering. This is a persuasive argument, why would we not intervene if diagnosis and treatment could ameliorate the risk of school failure, school exclusion, family breakdown and contact with the criminal justice system? Critics have argued that this viewpoint was largely accepted by the group/task force that developed the National Institute for Health and Clinical Excellence (NICE) guidance on use of medication.¹ Lloyd and others (2006:3) argue that there is a need to 'redress the balance between addressing the needs of the individual child (in school) and critically examining the systems which are supporting and perpetuating increasing diagnosis of ADHD and the resulting medicalisation of the behaviour of children'.

National Institute for Health and Clinical Excellence guidelines state that '[d]rug treatment for children and young people with ADHD should always form part of a comprehensive treatment plan that includes psychological, behavioural and educational advice and interventions' (NICE Clinical Guidance 72, 2008: 31). In practice, it is often not the case that medication is but a part of treatment, it may form the primary treatment or be what is known as the 'first line response' (Timimi and Radcliffe, 2005). A recent audit of the NICE guidelines carried out in one urban health authority highlighted a lack of psychosocial support offered to children with a diagnosis of ADHD and concerns with increasing numbers of diagnosed children in some of the more socioeconomically deprived communities (confidential correspondence; also see Ogundele and others, 2012). In the US context there is recognition of a different distribution of ADHD diagnosis across gender, racial, cultural and socioeconomic boundaries (Centers for Disease Control and Prevention, 2005). In some health care systems, children and young people of colour are disproportionately represented in mental health care, receiving a wide range of psychiatric diagnoses. Also in the USA, health care disparity between socioeconomic groups may influence the treatment of ADHD as children in ethnic minority populations are less likely to be medicated (Harrison and Falco, 2005). In addition, in the UK a further dimension links to ethnic minority populations' engagement with mental health services and the inference that Child and Adolescent Mental Health Services (CAMHS) can be institutionally racist (Children and Young People Now, 2006).

Competency, rights and responsibility

Until relatively recently limited attention has been given to children as beings in their own right, a notion which has been widely recognised within interdisciplinary childhood studies, as well as politically outlined in the United Nations Convention on the Rights of the Child (Liegghio and others, 2010). Theoretical and methodological contributions from a range of disciplines in the social studies of childhood field now take as their starting point children's competency (for a recent reflection on the UK sociology of childhood see Moran-Ellis, 2010). As understandings of childhood have shifted, sociological research has thrown light on children's own accounts, focusing on the meanings which children and young people attach to their lives, their knowledge of the social order, their experiences and their opinion on the childhoods they are asked to live (Bendelow and Brady, 2002). Participatory approaches to research recognise that children are quite capable of playing an active role in defining and responding to their life problems and in identifying their own solutions (Davis, 2006). Yet in the field of health, children's participation in decision-making about their own lives can be

limited. Some studies have focused on children's views of self-management of a chronic or long-term illness but these are also not common (Fleming, 2010). Consultation with children about aspects of service development or clinical environments does occur, but opportunity to really influence decision-making is variable.

As the focus is often on the development of future responsible citizens there can be limitations to the extent to which their contributions are taken seriously or regarded as legitimate if they do not correspond with adult or professional viewpoints (LeFrançois, 2007). Conceptions of children as human becomings (future focus) rather than human beings (present focus) (Halldén, 1991; Qvortrup, 1994) have meant that scant attention has been given to children's role as social actors within health practices and their capacity to negotiate and make sense of their diagnosis or label.

Mayall (2006) advocates that a serious recognition of children's rights requires tackling the low social and political status of childhood in the UK, it is not enough to listen to children or to recognise childhood as a social construction, 'children are not just objects of concern; they are citizens with rights who contribute through their daily activities to the maintenance and continuation of the social order' (Mayall, 2006:15). Processes of civilisation, regulation and surveillance are imposed upon children, yet children are active participants in the management of both their bodies and their minds (Mayall, 1996, 1998). Such processes are, however, influenced by class, race and gender so, for example, surveillance will manifest differently for different children. In the rest of this article the specific issues that will be discussed are drawn from the findings of the study carried out during 2000–2001 regarding children's accounts of their experiences of ADHD. By deploying the concept of the health care division of labour their understandings of what the condition, and the medication, 'does' to their abilities and performances will be highlighted. In the examples that follow, children's actions can be interpreted as acts of negotiation and attempts to retain a sense of control within the constraints of medical diagnosis and treatment. Such issues have relevance and significance for discussion of contemporary practice.

Research design and methods

The wider research study drawn upon here focused on the process of seeking and receiving child health care, and on the subjective experiences of children before and after receiving a diagnosis of ADHD. Qualitative methods were used to highlight the meanings which children gave to their actions, the meanings which parents gave to their health-seeking behaviour (Brady, 2013), which professionals gave to their practice and delivery of services and which children gave to being diagnosed with ADHD.

In the UK, the mental health needs of children fall under the remit of CAMHS; their aim is to engage in multidisciplinary early intervention, promotion of mental health and to assess, diagnose and manage conditions, minimising adverse impact. The research began with non-participant observation of children's assessment appointments at an English city CAMHS ADHD specialist service. This was followed by a questionnaire being sent to all parents of children diagnosed with or being assessed for ADHD (response rate 40%, $n = 46$). Seven families who expressed an interest in contributing further to the research took part in narrative interviews and I worked with seven children, ranging in age from 6 to 15 years, in their own homes through three in-depth data-gathering sessions over a period of 6–12 months. Four children had a formal clinical diagnosis of ADHD at the start of the study and three were diagnosed during the period of observation. The seven recruited included six boys and one girl, four were White British, one White North American and one was Black British. Within the wider survey of this city's CAMHS clients with an ADHD diagnosis (referred to above) 86.7 per cent of those who responded were parents of a boy and 93 per cent defined as

White British. In the smaller sample, parents had a range of occupations including nurse, care assistant, childminder, qualified social worker, security guard, light goods vehicle (LGV) driver, sales representative and civil engineer. In terms of housing tenure, three families were owner occupiers, three rented from the Local Authority and one rented privately. This demographic and social background is of relevance as the gendered, racialised and classed levels of diagnosis and children's experience of ADHD plays out differently across geographical, social, economic and historical contexts. Although recognising this as being important to better understand the additional dimensions which such factors can bring, at the time of this study as children's views were not being included in debates about ADHD, the main focus was to contribute to redressing this balance. However, it raises questions about the intersection of assumptions of appropriate childhood, classification of mental health and structural differentials. Recent international UK/USA larger scale research which explored the views of children with an ADHD diagnosis aimed to recruit a diverse sample of children (Singh, 2013), however, this proved to be challenging and most children included in the study were White lower middle-class boys.

The methodology used in my study included a mixture of oral, written and artistic contributions to encourage children to define, both verbally and visually, the meanings which they attached to their lives, and to their health and illness experiences. The study was granted University ethical approval and by a Medical Research Ethics Committee. Consent was gained from parents and health care professionals for observations of clinic consultations, and from parents and children who took part in interviews. Anonymity was protected through the use of pseudonyms for named individuals and the location of research.

Children, self-management and responsibility

Within the context of health care services, CAMHS were responsible for assessing, diagnosing and treating children, and performing regular check-ups. However, the study shows that in everyday life, health care work takes place in a domain that moves between the professional and the lay; children have their own perspectives on ADHD and actively take responsibility for their own well-being, including medication management. Most children in the intensive study group of seven had been prescribed 10 mg of methylphenidate to be taken around 8 am, and an additional 10 mg to be taken around midday.² Sean aged 12, said that there was no member of staff willing to take responsibility for his medication at his secondary school, but he was not overly worried about taking care of it himself:

My mum tapes the tablet to my can of coke, but sometimes I take it off and put it in my pocket. (Sean, 12)

Ross, educated at a different secondary school, also kept his medication with him, to be taken during lunch break:

When I take it during lunch maybe I'm taking it a couple of minutes too early, or a couple of minutes too late, so just for like 5 min I feel a bit weird, like zombie-ish, like I've taken too much medication. (Ross, 12)

At the time of the study, as a number of schools were unwilling to nominate a staff member to be responsible for medication it was a possibility that it could be obtained by children for whom it was not prescribed. No one was available to ensure that the medication was taken at the appropriate time or to offer support to the young person if they felt unwell. In an additional example Trevor had thought that he was the only person who had ADHD in his large comprehensive school, but discovered that a boy in his year group had the same diagnosis and was also prescribed Ritalin:

Before, I knew him, but I didn't get on very well with him. But now it's better (pause) we're soul mates, well, tablet mates!! (Trevor, 14)

It seems that these boys gravitated towards each other once they discovered their common identity; both were taking medication for ADHD, they shared an understanding. It transpired that on one occasion Trevor had forgotten to bring his afternoon dose of medication to school so the other boy gave him his tablet. Adults who were informed of this expressed surprise that the boy did not think of the consequences and that the young people were in a position where they could freely borrow medication from each other. As LeFrançois (2008) states, such actions are likely to elicit a protectionist response from adults who may deem these young people as both vulnerable and incompetent, by virtue of their dual status as a child with a mental health condition.

Furthermore, when young people do actively 'take' responsibility for maintaining their own health, and their medication, their idea of acting responsibly may differ from that of adults. Lay concepts of health and illness have their own logic, integrity and complexity; they have an important influence on how people evaluate medical care and practice, and have a huge relevance on compliance with medical treatment (Conrad, 1985; Wirsing and Sommerfeld, 1992). Striving towards diminishing adult/child power relationships means the recognition that children and young people may not always share adults' world view but they have an equally valid view (Alderson, 1993; Hill and Tisdall, 1997; James and Prout, 1990, 1997; Mayall, 1996, 2002, 2006).

Yet notions of responsibility, agency and autonomy intersect with ideas about mental health, illness and childhood. Children's understanding of ADHD and its treatment involves an element of learning how to be an active mental health consumer, by making choices, taking decisions and ultimately accepting responsibility. At the same time, the mental health label of ADHD emphasises deficit and difficulty, any demonstration of agency is likely to be viewed as faulty thinking. Such pathologised understandings of mental health and well-being lead to questioning how far children do have agency within a framework of understanding that regards them as having a neurological condition that renders their choices and decisions as impulsive or lacking attention and focus.

Embodied understandings of medical treatment

Concerns relating to children diagnosed with ADHD tend to focus on the safety of medication and its associated side effects. Side effects are of note, to the extent that the United States Food and Drug Administration insists that all approved medications for ADHD list warnings of risk for growth suppression, psychological conditions including psychosis and cardiovascular effects (FDA, 2007). The psychosocial aspects of ADHD have been largely overlooked.

Children make active choices and decisions around caring for their health which make sense to them, in the context of their lives. They take their embodied selves backward and forwards across the public and private divide, but decisions are made in a somewhat intermediate domain which links home and school, body and mind, self and society (Mayall, 1996, 2002; Stacey, 1984). The full and detailed explanations provided by Ross seem to capture this complexity:

When I do take the tablet I'm usually concentrating and doing something so I don't really have time to talk, but everything is in my mind when I don't take it, I just can't stop [...] I'm usually better at drawing and art when I'm not taking my tablet, because when I do take my tablet it's sort of hard to do, because when I don't take it my head's everywhere, and then you think about so many ideas and then it just comes. I drew the collage when the tablet was wearing off.

Ross explains how he would tackle his maths homework when first arriving home from school, as his medication would allow him to concentrate; as the medication began to wear off he would move on to subjects that allowed for more imaginative, creative thinking, such as art. This is an example of the way that children can look after their own well-being by recognising what medication can be useful for, and when it is better to capitalise on their inherent qualities. Ross used his own 'internal rationality' (Wirsing and Sommerfeld, 1992) to strategically plan when to do which homework.

It is known that psychostimulants increase focus, attention and reduce impulsivity, and not just for children who meet the diagnostic criteria for ADHD. The experience of taking medication is not well understood from the perspective of children and young people themselves (Brady, 2004a; Singh, 2008). The children in this study who were taking medication were asked how they felt when taking medication. Ross gave a rich verbal explanation of how medication affected his thought processes:

(When not taking medication) You can't control it, you say something and then ... just keep on trying to say something more about that thing, so I'm trying to stay on track and say that, but another thought is coming in. But the bad thing about taking the tablet is when I do take the tablet, it's really hard to start a conversation because when you start a conversation you start on one subject and you lead onto another, and another, but I can only concentrate on one subject, so it's hard to go to another.

Ross's example helped to illuminate this process further:

Like my mum earlier was telling you that she saw a dead person at work, then you start talking about 'Have you ever seen a dead person?' then someone else says, 'Oh yeah, I saw a dead person, my grandma died, we had a funeral'. So then you're talking about funerals when you were talking about how she [mum] worked at a hospital, but I'd still be talking about how she works at the hospital.

I wanted to clarify this so I asked whether this meant that the medication helped him to focus on one thing, but that he could not then make connections. He explained:

Erm, well you could, but you couldn't go really far, like you couldn't change the whole subject; you could bend to think about the subject, different things about the same subject, but you couldn't just go onto a completely different subject. It doesn't work for classes, I mean, in class like say I was doing maths and then I went to Latin, I could concentrate on the Latin, it's just like when one thing leads onto another. So you can actually bend it, but you can't just change onto a whole other subject.

The findings serve to illustrate the emotional complexity of children's lives. The real implications of medication are the affect on thoughts, actions, decisions and ultimately self-identity (Brady, 2005). In the way in which diagnosis plays out in an everyday context quality of life is important to children, and this is self-defined rather than defined by adults. Experience provides children with relevant knowledge, which leads to competent decision-making especially regarding issues important to them (Alderson, 1993, 2007; Bluebond-Langner, 1978). Children feel the pressure to conform and to comply with medical instruction yet they need it to be relevant to their lives. This insight into the affect of medication is important; ADHD is one of the most common conditions to be diagnosed in children, but once children are under the remit of the mental health care system further diagnoses may follow. A rising concern with psychotropic polypharmacy in outpatient practice and a shift in child psychiatry towards prescription of medication is evident (Southall, 2007). Where psychiatrised children are concerned, agency and competency are constructed in particular ways in relation to mental health diagnosis (LeFrançois, 2008), so if children have been socialised into taking responsibility they may conform and perhaps be less likely to develop or maintain a questioning approach towards other diagnoses.

Medication and decision-making: the importance of the lived context

Across the clinic population of children diagnosed with ADHD in some cases, particularly as children grew older, they began to question their need for medication and some made the decision to discontinue it. Referred to as 'non compliance', this was deemed to be problematic by both parents and the ADHD clinical team. Yet the concept of 'compliance' or 'adherence' is problematic, as it implies that patients should dutifully and unquestioningly follow doctor's orders (Sachs, 1992). Perspectives on compliance which take interaction between the clinician and the patient into account move closer to explaining decisions made by patients concerning their condition and any medication regime.

The reasons presumed to underlie decision-making around medication were different for each of the young people in the study and ranged from dislike of taking tablets, the inconvenience of a medication regime, and a need to be in control of their own life and body. At the outset of the fieldwork Chris's school took no responsibility for medication and did not accept that he had a medical condition (according to both Chris and his parents). Eventually the school agreed to store the medication and to nominate a staff member to dispense it at the end of break time. In common with other young people, the extraordinary amount of negotiation involved in this had caused inconvenience to Chris, and had been influential in his decision not to take medication any more.

I have to take it, and then I miss the lesson anyway. Cos I take it after break, and sometimes the teacher (dispensing the medication) don't turn up for about 10 min and I miss the lesson, then I have to sit at the front of the class which I don't like doing — sitting at the front of the class is not good (Chris, 15)

Asked whether he felt that taking medication had any positive impact, he says 'I fight more when I'm not on medication, and I don't fight when I am on medication'. Chris acknowledges that this can be a positive outcome yet provides insight into why the decision to take medication is less than straightforward within the context of his life. Other children confirmed that when schools did authorise a staff member to give out medication, making a special visit to find them drew unwanted attention. Mayall (1998) reminds us that children's status as health care actors is ambiguous; health agendas stress individual responsibility for health yet the social order of school inhibits children from enacting responsibly.

Young people are not simply acting irresponsibly when declining to take medication, they have their own very valid reasons, which do not often come to light during the average clinic consultation when parents are present. To understand why some children show resistance to taking medication their actions need to be seen in the context of their lives. Yet often in psychiatric or paediatric consultations about children their views are not sought and only parents are given the opportunity to talk to the health care professional, often in a highly structured manner (Aronsson and Rundstrom, 1994; Strong, 1979). Empirical research shows that an interesting interplay of scientific, medical and common-sense understandings mediate people's experience of medicalisation. According to Williams (2001:147), 'Lay people, in short, are not passive or active, dependent or autonomous, believers or sceptics. Rather they are a complex mixture of all these things'.

Concluding reflections

It is important to know that children are weighing up the strengths and limitations of diagnosis and of taking medication. They recognise both benefits and disadvantages to medical diagnosis and psychostimulant treatment; they neither fully accept nor fully reject the medical definition of their experience but actively work to redefine the experience to make it

meaningful to them. Their motivation in doing this appears to be related to a desire to maintain some sense of control over their lives. Children have agency but the way that this is interpreted rests on assumptions about lack of competence and understanding, relating to the intersection of being a child and having a mental health condition. Seeking the views of children sheds light on the complex and ambivalent meaning of ADHD diagnosis and the role which children play in negotiating the health care division of labour. The data presented here particularly call into question simplistic perspectives on the taking of medication to regulate the 'symptoms' associated with ADHD.

The adoption of a biomedical framework contributes to pathologising children's behaviour, as difficulties in learning and behaviour become characterised as a disorder/condition and children are regarded as incompetent, impulsive, irrational and incapable of being responsible. Such behaviours are regarded as in need of controlling or addressing, and the complexity of children's emotional, psychological and social experiences are overlooked as are children's own responses, choices, decisions and role in managing their behaviour and well-being. The findings serve to illustrate what Mayall (1996) might mean when she draws attention to the ways in which 'care' and 'control' are inextricably linked, across the public/private divide. Children with ADHD are rarely asked what they feel and when they are they are often not considered to be competent enough to make decisions about their own health and well-being. This raises an important issue regarding the rights of children to privacy, confidentiality and to withdraw their consent to treatment. Adult views are perceived to be 'rational' and sensible, and so if medication is associated with improved behaviour and academic success (which it often is — by parents and children themselves) parents may not comprehend why their child is unhappy about taking it. In the way in which diagnosis plays out in an everyday context quality of life is important to children, and this is self-defined rather than defined by adults. Adults, for example, may not be able to comprehend that 'risk' can be pleasurable (France and others, 2000), so the 'risks' perceived to be involved when children actively choose not to take medication may not be negatively defined by children or young people themselves (Bendelow and Brady, 2002; Brady, 2005). Decisions made are based on children's own moral competence, and competence varies, given that it is linked to experience, as well as chronological age. Experience provides children with relevant knowledge, which leads to competent decision-making especially regarding issues important to them (Alderson, 1993, 2007; Bluebond-Langner, 1978). Jutel (2009:281) argues that within doctor-patient interaction individuals 'dynamically modify the boundaries of what they consider respectively normal and problematic', however, there are limitations to the extent that children who have the diagnosis of ADHD are considered within such diagnostic encounters, standing as they do at the interface of discourses of threat (to the social order) and victim (of their biology).

Increasingly, it is becoming important to know who the children are who are more likely to come into contact with mental health services. This analysis does not particularly further understandings of class, race or gender, however, children with an ADHD label are also a social group that experience commonality in terms of being part of a diagnostic cohort. This often means that assumptions are made about them which essentialise 'the ADHD child', this construction then intersects with structural differentials which can reinforce a marginalised status. The capacity for agency within the dominant biomedical framework will be contingent upon a number of factors and further research which explores this intersection is needed. Related to this, Tisdall (2012) urges researchers to take seriously the social construction of childhood in our own research; the data here were drawn from a small qualitative study and this article has used the lens of the health care division of labour to analyse children's contributions, in isolation from the adults with whom they are interrelated and inter-

dependent. The accounts demonstrate that children care for their own health and well-being in ways which make sense to them. Their moral reasoning and agency should be recognised and respected as children and young people are clearly competent reporters of their own experience (Alderson, 1993; Alderson, 1995; Christensen and James, 2000; Mayall, 1996).

The following points need to be borne in mind when considering the relevance of these findings. The research on which this article is based explored children with an ADHD diagnosis' views of their lives whereby managing medication was part of that process. The data were collected over a decade ago, however, it is still not usual in clinical practice, in policy or in most research to talk directly and at length with children about their experiences of ADHD. More knowledge from a child perspective is needed and in particular the rights of children to truly participate in mental health services have not been strongly recognised (LeFrançois, 2007).

Diagnosed cases of ADHD in the UK continue to rise, as does treatment with psychostimulant medication (prescriptions in England increasing by 50% from 2007 to 2012, Care Quality Commission, 2013). There are unforeseen implications to defining aspects of children's behaviour as a neurological disorder, including the depoliticisation and individualisation of social problems (Conrad, 1976; Zola, 1972). An intensification of the problematisation of children and childhood is occurring, coupled with a declining tradition of critical inquiry regarding the validity and construction of ADHD. It is my contention that whether ADHD is a valid medical diagnosis or a label of social control is less debated currently than at the time of this empirical study. Indeed, the current policy drive in the UK towards early intervention in families where children appear not to be developing 'neurotypically' should be received cautiously. An emphasis on assessment with a view to early intervention has led to child health teams and childcare providers being increasingly concerned with children's skill development, competency linked to developmental milestones and behaviour viewed as inappropriate. Increasingly, medical vocabulary has begun to be used to describe children's behaviour and signs of developmental delay or disorder are looked for within pre-school children. Such normalisation of biomedical frameworks for understanding children should be questioned, as their prevalence influences many of the institutions of control in the lives of children.

[...] children experience the rupture of who they feel themselves to be in their everyday lives and who they are expected to be. This, indeed, is one of the principal dynamics behind what adults perceive as children's naughtiness and bad behaviour. Adult society asks children to conform. In so doing, it effectively defuses the revolutionary potential of children's ways of seeing (Oakley, 1994:29)

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Notes

1 NICE is responsible for producing evidence based guidance, advice and quality standards for National Health Service and other public health and social care services in the UK.

2 It is important to note that the fieldwork took place during 2000–2001, with the first cohort of children to be diagnosed in the UK and to proceed through CAMHS on to adult psychiatric services. At the time of this study only short-acting psychostimulant medication was available to children, a longer acting stimulant now being in popular use.

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