The Winston Churchill Memorial Trust

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Travelling Fellowship Award

By Mrs Helen Peters

{W.C.F.98}

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INTRODUCTION

As a chairman of a support group for children with Attention Deficit Disorder, (ADD), or Attention Deficit Hyperactive Disorder, (ADHD) or AD/HD for short, which is one of the most misunderstood, often overlooked hereditary genetic disorders, one of the aims of my Fellowship was to visit The World Health Organisation in Geneva, to ask for their help and to discuss their policies and Guidelines on Methylphenidate (Ritalin) treatment. So that any child with, or suspected of having, AD/HD will not be denied the medical help which is so needed if we are to give them an equal chance in life, and to help them become participating members of their community. Also to visit a school in Geneva where a Psychologist works alongside teachers in helping children with AD/HD.

Medical research has shown AD/HD to be caused by a lack of a chemical called Dopamine in the front lobal part of the brain, which normally controls Mood, Emotion and Behaviour. Therefore, children who have AD/HD ***CAN NOT*** and ***DO NOT*** have control over their behaviour NOR do they realise the consequences of their actions. (please refer to Annex for further details of the condition). Children in the UK with AD/HD are still mostly regarded as uncontrollable and unteachable and are usually believed to be the result of bad parenting and the environment they live in. When a child's behaviour is giving his /her teachers cause for concern, school will contact the child's parents. They will then refer the child to an educational Psychologist, who after an assessment will advise school on a plan of action to help the child. The educational Psychologist might ask Social services to support the family because they feel it is a parenting problem.

Social services will make a visit to meet and observe the family. Social services will see what is to them a very dysfunctional family, so they too feel it is a parenting problem. Social services will not see that the AD/HD child's behavioural problems are the reason for the family being dysfunctional. (please refer to Annex for further details of how children are treated in the UK)

My further aim was to study in the USA, how children with AD/HD are having their educational and health care needs met. To study how teachers and professionals who work with AD/HD children and adolescents have accomplished positive results. Results that have allowed children and adolescents with AD/HD to achieve their full potential and go on to succeed in life. This could also include visits to UNICEF at the Headquarters of the UN in New York.

The Winston Churchill Trust Fellowship award has allowed me to achieve many of my aims.
By having this Fellowship I have gained more confidence in myself and I have a status when I tell others about my fellowship. This Fellowship award I feel opened doors which may not otherwise have been so freely accessible. Specialists such as, Dr Russell Barkley, Dr Thomas Brown and Dr Sam Goldstein who are respected around the world for their work in the field of AD/HD were very interested to hear of the award and helped me make the right contacts to plan my 8 week visit,

The grant I received from The Winston Churchill Trust Fellowship award was indeed very adequate since my major costs were my travel costs, as I was mainly staying with families, so I was able to cover everything I wanted to do including some sight seeing and pay my way. I knew some families would not accept money, so prior to my leaving the UK I had bought gifts, which again was helped by having the grant.

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I would now like to share my experiences and knowledge that I have gained through the Fellowship with the Rt Hon David Blunkett and officials of the D*f*EE (department for employment and education). To help give a better insight and understanding about educational and learning environment for children and adolescents with the condition of AD/HD, and how best those needs can be meet to release their full learning potential in a more positive and constructive way.

My studies will also be a great asset to me when meeting and working with the many other

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Part 1………Geneva and The World Health Organisation WHO]

Guidelines on Methylphenidate – (Ritalin)

Here I was to have meetings with the Mental Health Promotion/ Program team.

- Dr Billington, who is the chief of the mental health promotion/ program
- Dr Bertoltte, who is the head of mental disorders control unit
- Dr Yoshida, who is the head of the Division of Drug Management & Policies for Psychotropic & Narcotic drugs
- Dr Ruth Fox, paediatric adviser to the WHO

My meeting with Dr Rex Billington was to discuss the WHO guidelines on methylphenidate – (Ritalin) which can be used [but is often denied] in helping children and adolescents who suffer from Attention Deficit Disorder [ADD] - Attention Deficit Hyperactivity Disorder [ADHD].

I asked Dr Billington when deciding what these guidelines for Ritalin will be, before any decision will they meet or talk to parents about the positive benefits that Ritalin has given their children. As parents are the one who are on the front line with having to cope with AD/HD children and will have to live and breathe with the outcome of those guidelines.

Dr Billington has now invited me to submit my report, and if I can find a better way on how we approach the stigma of AD/HD being a disease and children are seen as having a mental health problem. This leaves them vulnerable and open to abuse from other children and professionals, something no child should be subjected to. Children who at the moment are in a world which either ignores or has very little understanding of how their AD/HD affects them and so are treated with animosity.

When I met with Dr Bertoltte we discussed how although there were many professional books and advice on AD/HD there is very little for parents by other parents. This could give the basic things to look for and what can be done to help change things and to give the answers on how to solve everyday problems. Dr Bertoltte said if I could put together such a booklet that I could submit it to him and if it did fill this gap it could be translated in to other languages and used by the WHO.

My meeting with Dr Ruth Fox was very interesting and we talked about the differences worldwide of the percentages of AD/HD children. Dr Fox also gave me names of professional people who were worth contacting about AD/HD research. I have since received a letter from Dr Fox part of which is below:-

“Following up on our conversation concerning ADHD in the summer of 1998, I have had some more thoughts. There appear to be no real statistics on incidence of the condition in developing countries and in different cultures around the world. This information might provide us with further clues as to potential causes and even management therapies. The consensus conference November 1998 in Washington at the U.S. National Institutes of Health included some presentations, which, for me at least, help to explain the differences in incidence and case definition between the U.S. and Britain. Specifically the findings that treatment with medication appeared to result in a lower incidence of subsequent conduct disorder and of subsequent substance abuse. I would surely like to see a cross-cultural, developing/developed nations study of incidence for starters. The WHO has no funds currently available for this, once funds can be found we can think about proceeding”.

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I also met with Dr Yoshida from the Division of Drug Management & Policies for Psychotropic & Narcotic drugs to see why Ritalin is still classed as a Class 2 addictive drug and to see what could be done to change its classification so doctors would be less reluctant in prescribing it for children. Dr Yoshida said that there have not been any studies to prove that it is non-addictive when used correctly.

Since this meeting I have contacted two professionals, Dr Russell Barkley and Dr Sam Goldstein to ask if any such research and the potential for addiction to Ritalin had ever been undertaken and I was given the following information:-

Regarding Studies into Substance Abuse and ADHD:

It seems that possibly the WHO fear is the "potential" for addiction (from intravenous and nasal ingestion) and diversion to street use. This occurred 20-30 years ago in the Scandinavian countries and Holland and led them to tightly regulate stimulants.

In studies comparing adolescents treated for ADHD with stimulant medications and adolescents without ADHD, treatment for ADHD was seen to decrease the risk for future adult drug and alcohol use (Beck, Langford, MacKay, & Sum, 1975; Loney, Kramer, & Milich, 1981; Henker, Whalen, Bugental, & Barker, 1981). Adolescents appropriately treated for ADHD showed similar, and in some cases, less incidences of substance abuse than controls. Fewer studies comparing treated vs untreated individuals with ADHD have been conducted. In one such study however, Kramer, Loney, & Whaley-Klahn (1981) found untreated hyperactive boys tended towards greater drug use than those properly treated for ADHD.

Studies, including Beck, Langford, et. al. (1975). These authors compared 30 teens previously medicated with 30 similar non-medicated controls. No difference in drug abuse was found. Further it has been suggested that stigma associated with having to take medication on a regular basis, actually decreases the likelihood of taking or abusing other drugs (Collins, Whelan and Henker, 1980). There is also no clear data suggesting that having ADHD in and of itself increases risk for drug abuse in the absence of developing delinquency. Taking stimulant medication for medical reasons has not been found to increase the likelihood of drug abuse or addiction (Gittleman, et. al. 1985; Weiss and Hechtman, 1986).

The most up to date review of medication is available in the 2nd edition of our ADHD text (Managing Attention Deficit Hyperactivity Disorder in Children - 2nd Edition, Wiley, 1998). The chapter is quite lengthy and covers all of the current research.

Long term studies of Ritalin, whether for weeks, months, or even naturalistic follow-up studies lasting years have never demonstrated any addiction to oral Ritalin to Dr Russell Barkley's knowledge. Yes, there are a few anecdotal cases around of teens or adults snorting the Ritalin to get high, but they are few in number and, given the difference in the delivery of the medication intra-nasally, do not speak to addiction from oral administration. The Swedes (Chris Gillberg) published what is the longest lasting placebo controlled trial of a stimulant for ADHD (Archives of General Psychiatry) and found no evidence of addiction after 15-18 months of daily treatment with amphetamine.

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There was an MIR study using primates two years ago that studied the brain uptake of methylphenidate (MPH) compared to cocaine and found that while the binding site was the same for both drugs (caudate/striatal region), cocaine had a much faster re-uptake and wash out than MPH. The authors concluded that this most likely accounts for the addictiveness of one drug and not the other.

From these studies and the hundreds of other studies of stimulants on ADHD, none of which ever noted addiction as a side effect, the evidence seems clear that oral administration is not addictive. You can see Russell Barkley's second edition of the ADHD Handbook (1998) just published for an up to-date review of stimulants and ADHD (Guilford Press, New York)

Part 2………8 weeks in the United States of America

To study how teachers and professionals who work with AD/HD children and adolescents have accomplished positive results. Results that have allowed children and adolescents with AD/HD to achieve their full potential and go on to succeed in life.

Which was to take me to the following States
Arizona Chino Valley & Phoenix
Wisconsin Kenosha
California Irvine [UCI]
Philadelphia Bethlehem, Lehigh Valley
Massachusetts Northampton, Prides Crossing & Putney Vermont
New York City
Rhode Island Providence

The only stipulation I made for my visit was that I only wanted to see positive programs within schools. I found that the vast majority the schools that I was to be taken to visit would be the alternative schools. Schools started by people who felt they could no longer teach in the State system or by parents who have decided to offer what they feel is better alternative schooling.

I was very fortunate in the help and advice I got from my friends, who were very efficient in making sure that I did not spend my time looking at the same schools everyday, but made sure that I saw a good cross-section, to understand the areas where help and support is most required. The one thing that was constant was, it is how you teach and the attitudes you use towards the children that will make all the difference. They can and do "make it" in a regular classroom if the adaptations are right and you also supply the support and accommodation in the areas where they have weaknesses.

I found that although I went with the intention of finding out what schools within the USA were doing in specifically helping and supporting children with AD/HD, what I found time and again was that the schools who were having the greatest success were the schools who had adapted their SEN (special educational needs) teaching practices to ensure that it suited not only AD/HD children, but also other children who needed to be supported for their SEN problems.

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Understanding there that are different learning styles.

The first lesson I had to understand that was all children have different learning styles and this especially applies to children with AD/HD. Too often here in the UK children are all taught in the same way and there is no room for compromise. Howard Garden's theory on the 7 different ways and skills of learning (below) which is known as the "Multi-intelligences" is a good example of those different ways of learning. Many of the schools I visited said that they find this is a great asset when determining children's learning skills and how best to help children.

1. THE LINGUISTIC LEARNER "The Word Player" Likes to read write and tell stories. **2. LOGICAL/MATHEMATICAL LEARNER** " The Questioner" Experiments, figure things out, work's with numbers and explore patterns and relationships. **3. THE INTERPERSONAL LEARNER** " The Individual" Works alone, pursues own interests **4. SPATIAL LEARNER** " The Visualiser" Draws, builds, daydreams and looks and watches	**5. MUSICAL LEARNER** " The Music Lover" Sings, hums listen and responds to music and plays an instrument. **6. BODILY/ KINESTHETIC LEARNER** " The Mover" Moves around, touches, talks and use body language **7. THE INTERPERSONAL LEARNER** " The Socialiser" Lots of friends, talks to people and joins groups

Classrooms, Structure and Continuity

I found that one major thing AD/HD children need is structure. Structure means organisation and consistency, not strict discipline or rigidity Without this structure it will have dire consequences which will result in emotional /behavioural disruption. So the schoolwork and classrooms need to be very structured. Teachers must ensure that everyday the lessons are such that the children do the same thing at the same time on the same day.

Do not have multiple things happening at the same time within the classroom e.g.

Reading
Writing
Play activities

As AD/HD children have great difficulty in staying focused, they will see all the other activities to hold their attention around the classroom and so these will be of far more interest to them. This results in the teacher blaming the AD/HD child for not paying attention and getting on with their work in a classroom.

One of the reasons that the schools I visited were having a greater success rate with AD/HD children is that they understand that ADHD children will have great difficulty in unstructured situations, and consequently the AD/HD child will become anxious which will result in emotional /behavioural disruption. Schools must form continuity throughout with the teachers and the AD/HD child understanding the ground rules. This will help in reducing the pressure on both teachers and children, which can lead to a lot of frustration and unhappiness on both sides.

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Bringing order back into the classroom

AD/HD children in the classroom can become distracting and noisy and this then starts a chain reaction whereby other non-AD/HD children will join in. A teacher when trying to bring order back into the classroom will often have to constantly shout, which will be no use as it will be lost as just one other loud voice and once a teacher has to raise their voice they have lost the battle.

So a good example of a different approach that I came across was very effective; this was a teacher who said, “if you can hear me clap hands once”. The teacher then repeated this and by the time the teacher has said, “if you can hear me clap hands three times”, the whole class had then been refocused on what was happening. The teacher then followed this by saying “did I tell you to put your pencils away” and some of the children would say, “yes you did". The teacher can then reply "that’s right I did". In this way a child does not need to be pointed out as not doing as they were told, instead the message was being put to them again as a reminder about what they should now be doing, this is less stressful for both teacher and child.
The Mingus Springs Charter School

AD/HD children and change

One of the other biggest problems and one that I was told is a very neglected area for the AD/HD children is that they are not comfortable with any change without advance notice even if it's for one hour, for one day or permanently. If schools do not understand that the disruptive behaviour of AD/HD children is because of their anxiety if things do change without notice, and will change their behaviour dramatically if they become very distressed and confused. So their reaction might well be in the form of bullying, overreaction to criticism or unable to take the blame. Taking the time to prepare the AD/HD child for the outing / event, finding a special friend who can stay with them and help them. You will need to talk to them about possible situations or problems that might occur, and talk about different ways the trouble could be avoided. This helps the AD/HD child identify possible trouble areas, as well as what to do if the trouble does occur.

Hidden Social and Curriculum Cues

AD/HD children do not pick up on the hidden social and curriculum cues, and have very little tolerance when frustrated. They may have short fuses and blow off steam for no apparent reason, or in ways that are out of proportion. Any confrontation will put the AD/HD child on the defensive and punishing them to gain control will result in increased anger. Some of the schools I found overcame this problem by making sure that the AD/HD child or children with SEN problems came into school the day before the school was due to restart where and with the help of a map they would be shown around the school. They would also be given a booklet explaining about the hidden rules that will eventually help them understand and learn and know the right things to do and when to do them. AD/HD children do need the help of a support worker or a child who will be a good role model and can work along side them in the classroom, who will guide and encourage them when they are working well and when they are not.

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Writing and homework

With so many ADHD children only knowing about handing in schoolwork/homework that has not been satisfactory, ADHD children often do not develop an awareness of the positive feelings associated with work completion, so the feelings associated with work completion is despondency, frustration and of being stupid. Many of the schools were sensitive to the extreme physical effort it takes these children to put down in writing what appears simple to you. What would take an average child 20 minutes to do, will often take the AD/HD child / student several hours to accomplish. So when looking at homework they should never reply with "is that all you have done" they should think of the effort that went into achieving that amount and would always compliment on what has been achieved.

AD/HD children (often very intelligent children) frequently know the information, but can't get it down, particularly on tests. So the school/colleges should allocate extra time for taking tests, and/or allow them to be assessed verbally.

To stand or to sit when working

One thing I found of interest was by chance an AD/HD adult told me that one-day he had to stand to complete some work on his laptop computer. By doing so he found that he produced more work then normal and when he sat down again the amount of work he completed became less. This adult said it was as if when standing up his brain was active and alert but when he sat down half his brain went asleep.

Walkman or CD players

Time after time I found schools who told me that they found the AD/HD children worked and concentrated better when they were allowed to listen to a Walkman or CD player as this becomes a white noise that blocks out all other external stimulation. Younger children, if they preferred, could lie on the floor while reading in a corner or under a table, and because they were comfortable they were able then to move their body around without disturbing other children. The teachers found that their concentration improved, as did the reading skills.

Rewards

Schools did these individually or as a class. Individually they gave them jobs to help in class or being able to decide what book to read for story time. Cleaning the blackboard, or if there is a special lesson i.e. Art, they might start the preparation for everyone. As a class they worked on a points scheme. E.g. you could have a brightly coloured horizontal chart; it can be a daily or weekly chart and the higher the list goes the greater the rewards will be. Include the children to contribute to what these might be e.g.-

☺ Playing a game, for the last lesson
☺ Getting to read comics for the last lesson
☺ Play with Lego or some other desired toy for the last lesson
☺ Doing a special art activity
☺ Getting to play with a special toy from home
☺ Getting to watch a video for the last lesson
☺ Earning extra computer time

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Punishments

Many schools and specialists did not recommend using break-time for the punishment to be carried out. This is because the hyperactive child needs this time to burn off excess energy and by insisting they stay in to write or read will only increase their frustration and cause their behaviour to deteriorate. Remember if the AD/HD child does not want to go out guess what they will do? The losing of a privilege is better or having a set time in the day preferably at the end where those who have behaved get to choose something they would like to do. Those who have not, will then do the writing or reading instead.

Social Skills/ Coaching

The AD/HD child can not and does not have control over their behaviour nor do they realise the consequences of their actions and will not understand about the punishment that will follow this form of behaviour. As ADHD children become older their lack of social skills and their inability to make satisfying friendships may result in them being constantly unsuccessful in school. They will begin to avoid interacting with other kids by watching too much television or may turn to behaviours that make them feel better or may begin to seek out fringe groups that make him/her feel accepted.

Schools in Kenosha were encouraged to help provide these Social Skills by the following way **Problems -Alternatives- Consequences- Role Play -Evaluation (PACRE)**. By using PACRE and presenting these situations to a group the AD/HD child is not singled out, and by talking about problems in a group will help the ADHD child to begin to respond with more of a "stop and think" approach.

Another school found that by encouraging children to help and talk to each other they learnt to understand each other's difficulties. AD/HD children also need to know if they have a problem in school that there is somewhere they can go and one person who will be there for them to talk through the problem with. Social skills for the AD/HD children are a great asset for them to have and should be given as young as possible.

The Lutheran school Lehigh Valley had what they called a "unto others box". This box was where if a child said or did something nice to another child, that child could put the child's name into the box explaining what they had done that was nice. Then in the assembly the teacher would read out the names in the box and what they had done. This the school found was something that the children wanted to happen by having their name read out, so there were always children trying very hard to help and be nice to others.

If their diagnoses for AD/HD did not come until they were in their teens, one of the first things they needed to learn is how to respect people. This can be very hard, as they would have spent many years blaming others for their problems, or relying on those around them to do things for them. Colleges would provide a coach / counsellor to work with them. So they learn the necessary skills to earn respect, but they also need no matter how small to receive respect from other people.

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Other questions I came across to ask when thinking of how to support the learning needs of the AD/HD child

- What is this child's learning style? Visual, Auditory, and/or Kinaesthetic Is the child helped or confused by Multi-sensory presentations?
- Brief lessons result in greater learning. Divide learning tasks into small, well-defined steps
- Offer frequent feedback. Remember that verbal clues are not the most noticeable means of reinforcing children with attention problems.
- Provide information in a brief, positive manner. Reinforce what will be accomplished.
- Present information by facing the AD/HD children directly and get them to repeat it back.
- Encourage children to take turns giving information to each other.
- Provide activities that offer the AD/HD child success.
- Colour code relevant features to capture the children's interest.
- Which subjects are the most difficult and which are the easiest for the child?
- What is length of lesson can this child tolerate?
- Should the length of homework in selected subjects be modified?
- Could this child respond better to computer-assisted instruction?

Would worksheets need to be modified because of the number of problems per page?

- Could highlighted instructions be of benefit?
- What could further assist in helping this child keep work and materials organised?
- Would rewards or incentives be beneficial with this child? If yes, how often, every 30 minutes, hourly, daily, or weekly?
- What natural consequences or punishments are most effective?
- Recognise when an emotional /behavioural disruption is coming? Should you provide the AD/HD child a place to go calm down after, or, preferably, before an emotional/behavioural disruption occurs?
- Does the AD/HD child recognise appropriate versus inappropriate social behaviour?
- Think about how the children are placed within a classroom how is the classroom arranged and how best to communicate with and not at the AD/HD child.
- Does the child have some existing positive social skills that can be reinforced and would serve as building blocks for developing their other skills?
- Think about how the children are placed within a classroom; how is the classroom arranged.

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As the number of recognised students here in the UK with AD/HD in a classroom increase, they will also require more individual teacher assistance. Consequently, schools need to make every effort to place no more than two students with AD/HD in a classroom of 25 students. If the class size is over 25, a classroom assistant should be considered for all age groups.

Things to think about to ensure a good mixture at the table, e.g.

- Is Johnny better by being as far away as possible from Robert?
- Does Claire who likes to talk a lot need to be placed where most children get on with their work?
- Is there a group of children needing more support from you than others, so they need to be seated near you?
- Is the classroom too open planned? If it is, try using bookcases, notice boards to make divided areas i.e. work-area/play-area, this will reduce the amount of external stimuli

- Always consider if the children can see you, the teacher, and can you the teacher, be seen by the children. If not, children will stop what they are doing and especially the AD/HD child who will start to mis-behave to get your attention and to ensure they can see you again.

Displaying the lesson

Many of the schools displayed the lesson on the wall on the blackboard or with an overhead where everyone can see it. Some even provided a written copy of the lesson. Although these suggestions seem time consuming, think about how many times you have to stop teaching because a child says

- "What did you say was next"?
- "Could you repeat what I was to do after page 5"?
- "Did you say I had to do AMCID 1say was 1004eiW0 12 57id 71002oETieD1 Tc (s1)o91i24ss3 Tm[("D0 0

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Examples on How you might talk to AD/HD Students/children

We respond differently to directives given us based on "how" the person has given us the directive. Learn how to change your commands to increase the chances of getting students' compliance. How we talk to students can be a preventative behaviour management technique.

CHANGE THIS…...	TO THIS...…
Please sit down. I'm going to start now.	I'll begin as soon as you are seated
Please be quiet. It's time to begin.	I'll be glad to start as soon as you show me that you are ready.
I'm not going to line you up until everyone is quiet.	I'll be lining people up as soon as it is quiet.
Don't talk out. Raise your	I'll listen to people
Turn your Homework in on time or you'll get a lower grade.	I'll give full credit for papers turned in on time.

Protecting AD/HD children Self-esteem

AD/HD Children's Self-esteem is very fragile. This low self-esteem will often result in them

- Always perceive themselves as failures
- Destroying work, for one mistake or wrong word about it
- Insulting themselves, because of their low self worth
- Depression/ some will even contemplate suicide
- Peer interactions will be Poor or non-existent
  Because they will play too roughly, do not follow the rules of the game and act without thinking.

Promoting AD/HD children self-esteem

To promote self-esteem, teachers and the support classroom assistant [if they had one] always gave lots of praise and encouragement, such as "Jenny I am glad you sat still while I was talking" or "Andy thank you for not interrupting me while I was helping Anne". This then helped the children to be refocused and are not only being spoken to negatively when they have misbehaved. Just as in academic areas it was noticed if all details of a social interaction were not taken into account. The ADHD child will often continue to operate with the feelings that he/she has been unfairly treated by the other people, which can make the child become defensive.

- Do not place the AD/HD child in situations where failure or embarrassment is guaranteed
- If the AD/HD child avoids peer interaction, deliberately pairing the student with someone who will be supportive.
- Stress and praise the amount of effort and the degree of enjoyment in the activity rather than the achievement of perfection.
- Give the AD/HD child opportunities to do things he does well and provide class recognition for his strengths.
- Display the work of all children, not just those who do the best work.

- Patience is the goal. Most of the AD/HD child's misbehaviour is involuntary and is not spitefully intended.

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Schools found that preservation of the AD/HD child's self-esteem is the primary factor in truly helping these children succeed in life, they valued the differences and their strengths and provided opportunities for these children to demonstrate what they do well. This often requires the teachers going back to the drawing board frequently, but the schools and the teachers felt that these children are worth the extra time and effort.

I found at schools that children who were being offered these kinds of approach and flexibility were enjoying their school life. Learning in an environment where they could go at their own pace and were not pressurised for being too slow, where charts showed progress not just achievement.

Providing discipline with self esteem Enhancement
By Kathy Hubbard & ADD Teachers resource guide Kenosha Unified School District No 1

- Remain calm, state infraction of rule, and don't debate or argue with the student.
- Have established consequences for misbehaviour.
- Administer consequences immediately, and look for good behaviour to reinforce.
- Enforce classroom rules consistently.
- Punishment should "fit the crime," without harshness.
- Avoid ridicule and criticism.
- Remember, AD/HD children have difficulty staying in control.
- Reward more than you punish, to build self-esteem.

Manage Your Own Stress/Frustration
By Kathy Hubbard & ADD Teachers resource guide Kenosha Unified School District No 1

- When the ADHD child is emotionally over aroused, remind yourself to take a deep breath and relax.
- Keep your sense of humour.
- Don't overreact to misbehaviour.
- Take a few seconds before deciding on a consequence.
- Think AD/HD! This means you should decide ahead of time how you would deal with the AD/HD behaviour, so when it occurs, you can deal with it effectively, with less stress.
- Periodically, remind yourself that the child has a disability.
- Ask for back-up help from special education staff, school psychologist, school social worker, and school counsellor as needed.
- Be flexible! Children respond negatively to overly rigid, ADHD controlling adults.

Understanding AD/HD and School Failure
Based on an USA study but is still relevant here in the UK

For children with ADHD, "school too often starts with failure . . . and goes downhill from there."

1. With failure rates double to triple those of other children, about 50 percent repeat a grade by adolescence.
2. Thirty-five percent eventually drop out of school and only 5 percent complete college.
3. One study found that, by age eleven, 80 percent were at least two years behind in reading, writing, spelling, and maths.
4. Even children with normal to superior intelligence show "chronic and severe underachievement."

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5. Unusually high suspension and expulsion rates further compromise school achievement and completion.
6. A long-term study found that 46 percent of children with ADHD had been suspended and 11 percent had been expelled.
7. Taken together, expulsion and dropout rates approach 50 percent--an alarming statistic, since children with ADHD compose up to seven percent of the population
8. Consider both the learner and the learning environment when planning intervention strategies.

A Schools' Response to Academic Failure

Well-meaning support to help the failing AD/HD child must not result in trying to change the child to fit the school environment. Too often it is assumed that the child is the problem. This one-sided view only isolates the child from the classroom and the learning environment, until such time that we stop blaming the child with AD/HD, the only conclusion will be a negative outcome. Where possible do not remove the child out of the classroom, to offer remedial assistance, this will only add to their feeling of being inadequate. Schools need to retain the AD/HD child in the classroom or you could find that any attempt to re-establish them successfully into the original classroom situation and setting will result in more problems because they have been made to feel different.

Solutions and Suggestions for a way Forward to Successfully Educating Children with AD/HD

Respect. Respect. Respect.

Throughout my travels and studies the word respect was the one word that the AD/HD children said made all the difference in their life. If just one teacher would take the time to understand their problems and help them those problems so they could get things right it gave them back their respect. When I asked one AD/HD child who had failed in the traditional school setting but was now making it in an alternative school setting what made the difference he told me "the teachers here help me and are not always on my case every time I make a mistake". Too often people can not see that they have a hidden handicap and because of their behaviour they are seen as trouble makers, out to disobey any rules, and that society would be better off without them. So when we look at AD/HD children we have to remember that they have hidden a handicap which makes their behaviour beyond their control; they have a hurt because they are punished for things they do not remember doing or have forgotten to do. So we as the adults and the professionals should go beyond what we see and find the ways to support these children to enable them to make it in society and to gain the respect that they are so often denied.

On a wall of a school I was visiting I noticed a poster that said

I LEARN MORE THAN …….. I CAN REMEMBER

Which summed up what a lot of people could relate to?
But for these AD/HD students they were never given the time to remember.

The need for ongoing review and IEP meetings

Hold regular ongoing review meetings to evaluate how the child is progressing and to discuss any problems and if they have an IEP (individual educational plan) whether it needs to be amended and advise on why the conflicts are happening and how to readdress them before they become major problems. Those who should be present are the teachers, the parents and the mentor/tutor, who will be the child's representative who would have met with the child prior to the meeting to discuss any problems they may be experiencing,

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By doing it this way you will gain far more support from the parents if they see that they are respected as a necessary person to be there. Also the fact that the child was represented by someone so their views were taken into account will make them far more co-operative towards any decisions made. So it becomes a partnership with the school and parents to ensure the child is provide with a 24hour structure.

The need for educational training / workshops are essential in supporting the AD/HD child/student

As schools attempt to help all students meet new goals for learning set by government for national standards, education policymakers, school head's and the teachers must determine how to create learning environments that meet the needs of students who fail to learn in traditional school settings. In the past the mismatch of ADHD and the traditional classroom practice's made school a distressing ordeal for many children with ADHD from nursery on. They would be expected to stay in their seats, to raise their hands before talking, to pay attention when the teacher speaks, to follow instructions, to complete repetitive work within time limits, and to become increasingly independent and organised.

That's why the LEA's (local education authority) need to provide for the SENCO (special education needs co-ordinater) and SEN (special education needs) teachers ongoing Educational Training / Workshops for AD/HD this is essential for both the schools and the SENCO and SEN teachers. SEN teachers should receive continuous on going training / workshops organised by specialists in the field of AD/HD-SEN. Any teachers who have not specialised in AD/HD-SEN training should not be allowed to teach without supervision until such time that they have gained necessary qualifications in AD/HD-SEN. This is because without the right understanding, the relationship between themselves and those children with AD/HD they are trying to reach and teach will deteriorate rapidly resulting in the untrained teacher doing even more damage to the already fragile AD/HD child.

The school will need organise INSET days (in school training days) for the SENCO to pass on their AD/HD-SEN training to other members of staff to make sure that there is complete continuity through out the school if any other members of the staff should encounter any problems.

Sufficient knowledge of a referral for an AD/HD assessment

The Headteacher, the school SENCO and the AD/HD child's classroom teacher must ensure they have had or have been given sufficient knowledge of the procedures that will follow the referral for an AD/HD assessment. It is crucial especially as the parents will naturally turn to the school and the staff for support about the possibility of AD/HD. So the first point of contact for the parents will always be through the school over any worries or concerns they may have regarding the AD/HD referral procedures.

Remember not to look at them as bad parents, bad parents do not worry about their children.

Why Medication

Methylphenidate – (Ritalin)

Although AD/HD is a Genetic problem, I do not believe that medication should be the first option in treating AD/HD children but when all other avenues of help and support have been tried without success. You then have to look at the outcome of AD/HD children without offering medical help their can be no other option left. Schools should not make parents feel guilty for allowing their child to take Methylphenidate – (Ritalin). Parents would have already weighed up the pros and cons themselves. Schools should not insist that the parent must come into school to administer the medication, which many schools in the UK will do.

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This only makes life very difficult for the parent but even more for the AD/HD child who has to suffer the embarrassment of having to leave the classroom. Medication can be timed so that it can cause no alteration to the school timetable by allowing it to be taken at the natural breaks in the school day. Keep a record of when it was taken this will show if there has been a problem if it coincided with a tablet was missed. This also helps to show that if tablets have been taken but any improvement has now started to deteriorate that the dose may need to be increased.

Remember the golden rule

NEVER publicly remind AD/HD child/students on medication to "take your medication."

Parent-Training Programs are a MUST

Parents **must** also take part in a parent-training program. To often this is an area over looked. Parents will have to learn new skills that will help their child to succeed and to unlearn the coping skills they have used in the past. This will help them understand the reasons behind their AD/HD child behaviours and how to correct them. They also need to understand that with what they do and what the school does and that by working together as a team they can and will help the child undo behaviours they have used in the past to get attention.

UNICEF Headquarters at the UN New York

As part of my studies I was very fortunate to be given an appointment with Elaine R Furniss the Senior Adviser of UNICIEF for Education Program Division responsible for Curriculum and Learning. UNICEF told me that “it is committed to working on educational and health issues related to children. Therefore, are interested in all forms of childhood disabilities and learning difficulties. UNICEF support to education includes special emphasis on girls' education, education of hard-to-reach and disadvantaged children, children in emergencies, and capacity building in such areas as teacher training and curriculum development, management information systems and educational technology.” “However, they do not consider themselves to be experts in the field of Attention Deficiency Disorders.” At this meeting I informed Elaine Furniss that some children with AD/HD in the UK were having their human rights denied. AD/HD children of being refused access in obtaining a referral for a possible diagnosis of AD/HD. Very often AD/HD children were denied the medication by their psychologist or GP, and that some schools will also refuse to administer the medication. Also that children and adolescents who had been excluded from school were only receiving up to 5 hours of education per week.

Elaine Furniss told me that at this moment in time UNICEF work had been aimed at the human rights of children mainly in the third world countries as they felt this was where they needed to concentrate their work. After our meeting it is hoped that they would start to look at AD/HD children from the year 2000. I have offered to be of any assistance and give them all the support I can as a professional and as a parent of AD/HD children. (Refer to Annex for further details of UNICEF policies and programmes, which are guided by the Convention on the Rights of the Child 1989).

Conclusion

Early Identification

The key to success for the AD/HD child is early identification. Health visitors should always pass on any concerns the parents have about how their young child is behaving to the family Doctor. This allows it to be placed on record, and this can also be passed on to the nursery class as the child starts school, where they can be monitored closely. This will provide the educational psychologist a way to provide the necessary early intervention and to also make the clinical psychologist aware of the child’s problem if the educational psychologists interventions are not sufficient and so will need to refer the parents and the AD/HD child on to them.

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This could be the key to ensure a positive outcome for these children. Everyone must work together and not to dismiss or perceive the AD/HD child as just a naughty child that is the outcome of bad parenting or that AD/HD is something that they do not believe in. If identified early and treated AD/HD children can go on to live a successful, productive, and happy life.

Without Early Identification

Without early identification, as AD/HD children become older they feel badly about their social skills and their inability to make satisfying friendships through their poor social interaction, and the lack of success in school which will all result in the AD/HD child developing attention-seeking behaviours that make them feel better. The AD/HD child may begin to seek out the wrong kind of friends and with their encouragement start to commit crimes or take drugs **or both** and so this makes him/her finally feel accepted. This only adds to their impulsivity. The AD/HD child will react to his/her feelings, rather than thinking through whether committing a crime is wrong. The AD/HD child because of lack of understanding will not think about any punishment that might result from their actions. This is why sending them to prison is never the answer to supporting them. To them this will become a way of the downward spiral of their future life of which without support there is no escape i.e. wrong kind of friends, commit worse crimes, take stronger drugs and go back to prison

The following was written by, Jenny Lyon Cert.Ed. BA (Hon's). M.Sc., C.Psychol.

As a teacher and psychologist, with 25 years of experience, I have a firm commitment towards a "bottom-up" approach, with teachers playing a key role in the assessment and management of AD/HD. I am also aware that early assessment of AD/HD is critical. Children who are not treated are at risk of becoming disaffected, oppositional / defiant depressed and anti-social. They are significantly more likely than their peers to experience substance abuse, unwanted pregnancies and to be in trouble with the police are. Conversely, AD/HD children who receive Multi-modal treatment can achieve as well as their peers in all aspects of their lives.

Success means Co-ordinated Team Approach

I, like the experts, would recommend the only way to move forward is through teamwork and collaboration between parents, doctors/clinical psychologists and the school educational psychologist. To co-ordinate essential family and school services, design effective intervention plans that address individual weaknesses and build on strengths to help children succeed at home and school. Many of the schools in the USA often have an Educational Psychologist on the staff role, which is very practical and beneficial.
This allows for early interventions by the educational psychologist who would have direct access to the child's teacher and in the classroom. So that if any problems do arise parents did not have to wait weeks or months before the child or the school received the right support which would be a challenge for the doctor/clinical psychologist to manage alone. This to us may seem a large expense but if schools share the expense and if you put that against the cost of what would be spent when the problem has got to the stage of having to bring in the Educational Psychologist which could take up to a month? The school then will have find to extra funds to pay for this extra resource and support, which can then drain those resources and remove support from others whose needs are just as great.

A recent survey indicated that 86 percent of the USA school psychologists
were based and worked in school settings.

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I would like to finish my report with this statement by my very dear friend
(Marcia Brehmer, ADD Coach & parent of two ADD children, 1998)

AD/HD Children are like a garden

"Children are like a garden" in that "just as plants and flowers need to be treated different to mature and grow just right" Her philosophy about the garden is roughly this: "When we look around us we see such variety in nature. Just look at all the different colours of flowers, different fragrances, etc, but besides the difference on the outside, there are differences in the environment in which they thrive and are nurtured. Some plants do well in a hot dry climate, some in a wet cool climate, and so on. Just take that a step further and apply the same theory to children and humanity. We have differences in colour of hair, eyes, cultures, etc. Is it too far a stretch to think that there may be differences in our ways of nurturing our children, learning, our brain "wiring", etc? So our educational systems need to be more diversified in their approach and work to include all needs of different learning styles.

"One size education does NOT FIT ALL!"

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- **Psychoologist Carla Tidmarsh** who works endlessly in helping others to understand AD/HD
- **Dr Rex Billington**- *and his colleagues from the WHO Mental health Team*
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- **International school** Chataignerie Theresa Nunn

- **The USA**

A special thank you goes to

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Kathy Daya -*AD/HD Adult Support Group*
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Laura Bristow-*Yapipi College*
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- ***WISCONSIN***

Kathy Hubbard/Weeks
ADD Program Consultant/ 504 Co-Ordanator
Unified School District No 1
Lakeview Technology Academy
The Bridges Centre
Indian Trails School
Kenosha*

- **CALIFORNIA**

Dr Jim Swanson
Ron Kotkin
Michael Muris
Dr Marc Learner
UCI Child development Centre/School
Orange County Irvine **

- ***PENNSYLVANIA***

Dr George Dupaul
Bethleham
Michelle Beck-*Whitehall School District*
Lea Kline *Hopewell Elementary School*
Janet Greenleaf *Lutheran School*
The AD/HD support group

NEW YORK

Elaine R Furniss -*Senior Adviser of UNICIEF*
Conference- AD/HD

- ***RHODE ISLAND***

Mark & Mary Motte
Providence- *Henry Barnard School*

- ***MASSACHUSETTS***

Sandy Maynard AD/HD coach
Northampton,
Connecticut - *Mitchell College*
Prides Crossing- *Landmark School*
Putney Vermont -*Landmark College*
Amenia-*The Kildonan School*
Sandy Maynard now lives in Washington DC

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*
This school district has ensured that all AD/HD children had their condition understood. All known children with AD/HD are placed on a database so when they changed schools the new school was also made aware of their condition and the different problems it brings them. I would recommend anyone who wanted to set up this kind of system would well advise to study The Kenosha Unified School District No 1 AD/HD support project.

**
A good example of how medical and educational teamwork can work with each other. Anyone who wanted to study to set up this kind of combination of teamwork I would recommend they go and study the UCI Child development Centre/School

This report is just a small part of what I have learnt through my studies into AD/HD. I shall now be using all the other educational information I have acquired about how to teach and support AD/HD children and adolescents to produce a comprehensive educational package. Here again I shall be acknowledging all those people who without their help, advice, and all the information they supplied me with none of this would have been made possible.

Annex

My recommendations and advice for future Winston Churchill Fellows.

I would most definitely advise future Fellows to do their homework extensively wherever possible by using the Internet and libraries. Learning about other customs and any word differences will save a lot of embarrassment, one example I always said was “American Indian”, this is an insult, as they are known as “Native American”. Making good use of maps so you can plan your journey effectively, learn about the climate, is also essential, as clothes will need to be kept to the minimum.

If you are travelling to several places within the country you are visiting you must definitely book all internal travel ASAP or you could find if left to the last moment that prices would have escalated. Let people know well in advance what exactly it is that you want to study, never be vague, this only would mean you may have wasted time of people who may not now be able to offer the things you wanted to study. You will find also that with your studies people will inevitably give you numerous books, papers etc to help with your studies which will soon become too heavy to transport. So I sent all mine home by post (overland) this is the cheapest way and it will take between 4 to 6 weeks to arrive so it will arrive just before or just after you.

Should you be staying with people you have never met before, have a good photo taken and have a photocopy enlargement to A4 size made and wherever possible fax it ahead so they have some idea of what you look like. If you have any dietary problems be sure they know in advance, there is nothing more embarrassing to both if you can not eat any food they have prepared especially for you, and a small gift as a thank you is always welcome. You must always leave enough time between where you are staying/studying next and for sight seeing. I would suggest you have long weekends for this, as you will not impose yourself on families etc at the weekends, as they will feel they need to entertain you, remember you need a break as much as they do.

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Always ensure that you leave all details (phone/ addresses,) of where you will be with someone in case of emergencies. Should you be staying with one family for your studies the same rule applies have long weekend breaks. If you should be spending the duration of your studies in a hotel do not stay in night after night but go out (if it's safe to do so?). Mix with the local people, you can gain a great deal about people and their way of life just by people watching.

I also found having the use of a laptop computer, which allowed me to record any information while it was still very fresh and having access to the Internet was indispensable. I could E-mail my family when I was feeling lonely and to know all was well at home. Also being able to keep up with the gossip with friends. The E-mail also allowed me to contact the family where I would be staying next to ensure that all was well for my visit still or they could contact me if they needed to know anything.

Understanding the condition of AD/HD

AD/HD has been around for a long time. As early as the mid 1800's, there was a paper written about a boy called "Fidgety Phil." The name has changed over time to reflect new understandings about the disorder.

- **Previous Diagnostic Terms**

1. Brain-Injured Child Syndrome (1940's)
2. Minimal Brain Damage (1950's)
3. Minimal Brain Dysfunction (1960's-1970's)
4. Hyperactive Child Syndrome (1960's)
5. Hyperkinetic Reaction of Childhood (1960's)
6. Attention Deficit Disorder With or Without Hyperactivity (1980)
7. Attention Deficit Hyperactivity Disorder (1987)
8. Undifferentiated Attention Deficit Disorder (1987)

AD/HD is Genetic and is a treatable (*Not Curable*) complex disorder which affects approximately 3 to 6 percent of the population (70% of children are from ADHD/ADD parents. Inattention, impulsivity and hyperactivity are common characteristics of the disorder. AD/HD often goes unnoticed, or gets described as the "Terrible Twos". Then AD/HD behaviours will be more noticeable from 3 years of age, becoming more apparent around Nursery and Primary School age onwards. The disorder was said to be more common in boys than in girls by 3 to 1. It is now believed that in females the numbers are much higher. This is because until recently research was concentrated on boys only, and because girls are more inclined to be inattentive than hyperactive and, therefore, are not seen as having any major behavioural problems.

At present it is thought to be a physiologically-based problem with the neurotransmitters in the brain caused by a lack of a chemical called Dopamine in the front lobal part of the brain. At present there are no blood test to show this lack of Dopamine. So the medical diagnosis has to be done on the child's past history, school reports and any family history to see if any other members of the family experienced similar problems and behaviours. This kind of diagnosis is flawed with many problems, which often result's in AD/HD being undiagnosed.

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- **ADHD** is usually characterised by a series of persistent difficulties resulting in, for example, poor attention span, weak impulse control, and hyperactivity, anti-social behaviours, low self-esteem and a lack of confidence
- **ADD** Sufferers can be harder to recognise as they do not necessarily display the hyperactive behavioural problems, they are more inattentive like **A** **D**olly **D**aydream, but will still have low self-esteem and a lack of confidence and poor organisational skills

AD/HD and Educational Attainment

Statistics by Dr Russell Barkley

95% of ADHD children are underachieving in school.
25% of ADHD children also have another learning disability.
35% of ADHD students drop out of school (vs. 9% of general population).
50% have been retained at least one grade (vs. 10% of general population).
20% will start college (vs. 45% of general population).
5% will graduate from college (vs. 25% of general population).
25% will be suspended from school for conduct problems.

ADHD with Conduct Problems

25% have problems with antisocial personality or criminality as adults.
25% of ADHD adolescents and 10% of ADHD adults will have problems with cigarette smoking and alcohol use. ADHD adolescents are no more likely than normal adolescents to become involved with cocaine or more serious drugs. More auto accidents/traffic offences occur than with normal population (30% vs. 15%). 50% of ADHD teens will have minor police contacts. (Criminal offences: skipping school, running away from home, fighting in school.) 20% of ADHD will have to go to court for delinquent activity. 20% will have problems, as adults, with physical aggression.

Although ADHD/ADD can continue into adolescence and adulthood, previously many adults would not have received a diagnosis as children although their symptoms would have been present. Instead adults would have been treated for depression, have poor job track records, poor relationships, also some may have turned to drink and drugs as a stimulant to help them focus.

How are children with suspected AD/HD treated here in the UK

When a child's behaviour, is giving his /her teachers cause for concern School will contact the child's parents. These will then refer the child to an educational Psychologist, who after an assessment will advise school on a plan of action to help the child. The educational Psychologist might ask Social services to support the family because they feel it is a parenting problem.

Social services will make a visit to meet and observe the family. Social services will see what is to them a very dysfunctional family, so they too feel it is a parenting problem. Social services will not see that the AD/HD child's behavioural problems are the reason for the family being dysfunctional.

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Social services may even decide that it is the parents poor parenting skills and possible mental abuse which have caused the child's behavioural problems. Parents can and do find the children are put on the "at risk" register because of Social services observations.

The educational Psychologist might advise the parents to contact their GP for a referral to see a clinical Psychologist about the possibility of AD/HD? This may be the first time parents have ever heard of AD/HD and 9 times out of 10 the GP also has never heard of AD/HD. So the GP will refuse to send the child to the clinical Psychologist and might also contact Social services to support the family as they feel it is a parenting problem.

Should the GP be prepared to refer the child on to a clinical Psychologist parents will often find that the clinical Psychologist will also have no knowledge of AD/HD. So they to may refer the family to Social services to support the family because they too feel it is a parenting problem. If the parents are fortunate in finding a clinical Psychologist who is happy to assess for AD/HD and treat if it was felt this would be the most appropriate way in dealing with the problem.

The parents then find themselves in the next uphill stage of the process. Upon returning to their GP many parents find the GP will refuse to prescribe the medication Methylphenidate [Ritalin]. The 3 main reasons will be;

- That AD/HD does not exist
- They have no understanding of AD/HD
- Ritalin is a class 2 drug so they decide it must be addictive

If the GP will prescribe the medication the parents will have to ask the school to administer the child medication during school time. Again parents will often be met with the same reaction as the GP's and the school will refuse to have the medication on school premises. Any parents who try and insist are regarded as pushy and trouble makers and the only compromise schools will make is that a parent must come into school and administer the medication which can be two or three times a day.

The child's teachers will be spilt in their opinion of the child and the diagnosis of AD/HD. Some will be supportive and try to learn more about AD/HD to help the child, other's will just see parents who have just found another excuse for bad parenting which has caused the child to become uncontrollable.

The Educational Psychologist will very often have no or very little knowledge of AD/HD children so is not able to offer schools the support they need in helping and working with the AD/HD child.

Parents suddenly confronted by the many professionals that have become involved in their child’s behavioural problems will find it overwhelming for them, but instead of seeing a light at the end of a long tunnel they will now find themselves inside a circle with the professionals (who through their own ignorance will refuse to accept AD/HD exists) will be on the on the outside.

Professionals should be working together in co-operation to support the family and the child with AD/HD, but because of their indifference and lack of knowledge do not see it as their problem, so will refuse to help the child or support the family.

Which will now have the school, the child and his/her family back at square one.

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Quotes from the Convention on the Rights of the Child 1989

"Article 23

States Parties recognise that a mentally or physically disabled child should enjoy a full and decent life, in conditions, which ensure dignity, promote self-reliance, and facilitate the child's active participation in the community. Education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities in a manner conducive to the child's achieving the fullest possible social integration and individual development,

Disabled children

A disabled child has the right to special care, education and training to help him or her enjoy a full and decent life in dignity and achieve the greatest degree of self-reliance and social integration possible.

Article 28

States Parties recognise the right of the child to education, and with a view to achieving this right progressively and on the basis of equal opportunity; they shall, in particular: Encourage the development of different forms of secondary education, including general and vocational education. Make them available and accessible to every child.

States Parties shall take all appropriate measures to ensure that school discipline is administered in a manner consistent with the child's human dignity and in conformity with the present Convention.

Education

The child has a right to education, and the State's duty is to ensure that primary education is free and compulsory, to encourage different forms of secondary education accessible to every child and to make higher education available to all on the basis of capacity. School discipline shall be consistent with the child's rights and dignity. The State shall engage in international co- operation to implement this right."

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