ADHD in Our Schools: How can Teachers and Doctors Pay Attention?

Dr. Paul Soper MD FRCPC
Patricia Schwandt BSc BEd MA

Overview

- Identification of children (K to 12) with ADHD (hyperactive/impulsive, inattentive and combined subtypes) within the classroom.
- Evidence based school and classroom strategies and mental health supports that improve student function.
- Teacher/child/parents/doctor working together – creating a team that collaborates to solve problems.

Student 1

- Ricky is an 8 year old boy in your grade 3 classroom.
- He is having a hard time in school:
  - He teases the girls and shoves the boys in the boot room.
  - He takes other kids pencils without asking.
  - He loses his agenda every day (at least it seems that way!).
  - He forgets to eat lunch because he is too busy visiting with classmates.
  - He keeps getting into fights with the grade 6 lunch helper.
  - He never gets his work done in class – the teacher is continually prompting him to get on task.
  - He does not listen to instructions.
  - His writing is really messy…..

Student 1

- The teacher reviewed his CUM file and past report cards have usually said something like… "Ricky is a friendly boy who is trying really hard but sometimes has a difficult time getting along with others and following classroom routines."
- Another common description in his report cards is that "He has the potential to do better if only he followed instructions and completed assignments."
- When discussed at beginning of year transition meetings past teachers said "He probably has ADHD."
- Yearly literacy and writing assessments indicate he is a little behind grade level.

Student 1

- Teacher has tried to lots of different strategies to help Ricky including:
  - Seating at the front of the class.
  - A reward chart that gives stickers for having a good day.
  - She repeats instructions and often uses the TA intended for the autistic student to keep Ricky on track.
  - She has an extra desk in the hallway and the back of the room for when he is having a hard time completing work.
  - She has given him a hand squeeze ball.
  - She has kept him in at recess to help him complete his work and talked to him about how he is a great kid who she knows can do better.

Student 1

- Teacher goes to the Special Education Person in the school and outlines her concerns.
- They review strategies to help “active” kids and decide to try:
  - Increased movement breaks during the day.
  - Breaking his work into smaller chunks.
  - They give him a “Move n’ Sit Cushion”.
  - Schedule a meeting with the parent and discuss a referral to OT/PT.

Student 1

- Teacher and Special Ed. Person meet with mom and give her a form to fill out for OT/PT.
- They reiterate the above comments that he is a great kid who has a lot of potential.
- 6 to 12 weeks later the OT sees the child and recommends using gum as well as other sensory diet strategies.
- Ricky continues to struggle in school and now is spending a lot of time in the principal's office and is missing recess because he has to earn it.
- Aggression is becoming an increasing issue.

Student 1

- There are frequent parent meetings to discuss Ricky's behavior. Mom often cries as she is struggling at home and she feels bad for her son.
- Her husband and mother-in-law think mom isn't being firm enough with him and that is why he is like this.
- However, dad says that mom worries too much as he laughs and jokes "I was this way when I was young."
- By February, everybody is exhausted and someone suggests the parents talk to their family doctor to see what he thinks. "Maybe Ricky has an imbalance or a food allergy that could be causing this."

Patient 1

- A family doctor has referred a 9 yo boy to my clinic at the Glenrose.
- The referral letter says
  - "Dear Dr. Soper, Please see Richard Randal. The school is having problems with behaviors and are suggesting ADHD with their language. However, this is unlikely as he was fine in my office today. Your assessment would be appreciated."

Patient 1

- Richard presents to the clinic with his mother.
- They describe difficulties starting this year in school but present for several years at home.
- Mother describes all the symptoms of ADHD combined type in the home but cannot confirm these symptoms in the school.
- "All they say is that my son cannot keep his hands to himself and he is always fighting. The principal thinks he has Opposition Defiancy Disorder."

Patient 1

- The doctor completes the rest of his assessment and concludes that it is likely the child has ADHD.
- However, the history of difficulties at school is not typical for ADHD and the diagnosis cannot be confirmed without information from the school.
- He gives the mother SNAPIV forms to take to the school to be completed by the teacher.
- Dr. Soper's next available appointment is in three months.

Student 1

- Ricky returns to class the day after the teacher knew he was going to see the specialist.
- Teacher notes that Ricky is the same as he was prior to the visit.
- The teacher had students see this physician before and they came back "completely different" because they had tried meds.
- She concludes that Ricky's mom must have decided not to let Rick try medications. Since this was the last option, the teacher continues to do her best to support Ricky in the classroom.
- She knows that she has tried everything and there is no point in highlighting the negative to mother as that is just hard on everyone. Teacher is going to focus on the positive.

Patient 1

- Richard and his mother return for the their appointment in three months.
- Mother forgot to get the SNAPIV forms completed but states that it doesn't matter anyways.
- "Richard has turned it around. The school is no longer calling every day to talk about his behaviors. Things must be good."
- They decide he must not have had ADHD after all and she will look into family therapy.

ADHD and the Classroom

What is ADHD? – A Problem of School

- DSM IV Criteria – Inattention
- Six or more of the following symptoms of **inattention** have persisted for at least six months to a degree that is maladaptive and inconsistent with the developmental level:
  - Often fails to give ***close attention to details*** or makes careless ***mistakes in schoolwork***, work, or other activities
  - Often has difficulty ***sustaining attention in tasks*** or play activities
  - Often does not seem to listen when spoken to directly
  - Often does not ***follow through on instructions*** and ***fails to finish schoolwork***, chores, or duties in the workplace (not due to oppositional behaviour or failure of comprehension)
  - Often has ***difficulty organizing tasks*** and activities
  - Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (***such as schoolwork or homework)***
  - Often ***loses things necessary for tasks*** or activities at school or at home (e.g. toys, ***pencils, books, assignments)***
  - Is often ***easily distracted*** by extraneous stimuli
  - Is often ***forgetful*** in daily activities

What is ADHD? – A Problem of School

- Six or more of the following symptoms of **hyperactivity-impulsivity** have persisted for at least 6 months to a degree that is maladaptive and inconsistent with the developmental level:
  - Often ***fidgets*** with hands or feet or squirms in seat
  - Often ***leaves seat in classroom*** or in other situations in which remaining seated is expected
  - Often ***runs about or climbs excessively*** in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
  - Often has difficulty playing or engaging in leisure activities quietly
  - Often ***talks excessively***
  - Is often ***'on the go'*** or often acts as if 'driven by a motor’
  - Often has ***difficulty awaiting turn*** in games or group situations
  - Often ***blurts out answers to questions*** before they have been completed
  - Often ***interrupts or intrudes*** on others, e.g. butts into other children's games

ADHD Clinical Presentation: Preschool Years

- Motor restlessness (always on the go)
- Aggressive (hits others)
- Spills things
- Insatiable curiosity
- “Fearless–may endanger self or others
- Low levels of compliance

- Vigorous and often destructive play
- Demanding, argumentative, noisy
- Interrupts others
- Excessive temper tantrums

Dupaul GJ, et al. *J Am Acad Child Adolesc Psychiatry* 2001;40:508-15.

ADHD Clinical Presentation: School Children

- Easily distracted
- Homework poorly organized, careless errors, often incomplete or lost
- Low academic scores
- Frequent trips to the principal’s office
- Blurts out answers before question completed (often disruptive in class)
- Often interrupts and intrudes on others
- Low self-esteem

- Displays aggression
- Difficult peer relationships
- Does not wait turns in games
- Often out seat
- Perception of “immaturity”
- Unwilling or unable to do chores at home
- Accident prone

Greenhill LL. *J Clin Psychiatry* 1998;59 Suppl 7:31-41.

ADHD Clinical Presentation: Adolescents

- May have sense of inner restlessness rather than hyperactivity
- Procrastinates and displays disorganized school work with poor follow-through
- Fails to work independently
- Poor self-esteem
- Poor peer relationships
- Inability to delay gratification
- Specific learning disabilities
- Behavior not usually modified by reward or punishment
- Engages in "risky" behavior (speeding, unprotected sex, substance abuse)
- Apparent disregard for own safety (injuries and accidents)
- Difficulties or clashes with authority

Greenhill LL. *J Clin Psychiatry* 1998;59 (Suppl 7):31-41.

ADHD and the Classroom

- Children with ADHD fall behind their peers academically.
- It has been shown that this trend extends to children who are severely inattentive, hyperactive and impulsive in the classroom, even if they do not have a formal diagnosis of ADHD.

(Barbaresi et al., 2007; Barkley et al., 1990; Frazier et al., 2007; Lahey et al., 1994; Marshall et al., 1999; Nussbaum et al., 1990; Willcutt et al., 2000; Zentall, 1993).
(Barry et al., 2002; Gaub & Carlson, 1997; McGee et al., 2002; Merrell & Tymms, 2001; Merrell & Tymms, 2005a)

ADHD and the Classroom

- Galloway and colleagues (1995) proposed that ‘differences between teachers are substantially greater than differences between schools’, suggesting that the teacher was the dominant influence on behaviour in the classroom.
- Although the ordinary experience of teachers and anecdotal evidence suggests that the behaviour of children with ADHD is influenced by school and teachers, there is no formal evidence to support this.

NICE Guidelines (2009)

ADHD and the Classroom
Teaching Teachers

- The evidence suggests that there is little to no effect in providing advice to teachers in relation to children’s ADHD symptoms or academic achievement unless it is combined with a parent training component.
- The quality of the evidence overall is moderate.

NICE Guidelines (2009)

ADHD and the Classroom Teaching Teachers

- Techniques that are usually suggested to teacher:
  - Seating the child in a place that is relatively free from distraction (for example, doors and windows) in a position where the teacher can easily intervene if the child is not attending
  - Having a designated quiet area for a child to work in
  - Providing stimulating activities
  - Giving concise, clear instructions
  - Following a defined, regular timetable
  - Avoiding repetitive tasks
  - Breaking down tasks into a series of small steps
  - Giving frequent positive feedback
  - Working in a pair rather than a group
  - Isolating the child from the class for a short time when they are misbehaving
  - Giving points or tokens as rewards to be exchanged at a later time for a favourite activity or treat
  - Taking away points or tokens if the child misbehaves.

Cooper and Ideus (1996)

Other Suggestions - web

- www.caddac.ca
- www.calgarylearningcentre.com
- www.teachADHD.ca
- www.caddra.ca
- http://www.ldalberta.ca/barkley-session/nov-7-session-hand-outs
- http://education.alberta.ca/admin/special/resources/adhd.aspx

Other Suggestions - books

- Focusing on Success: Teaching Students with Attention Deficit/ Hyperactivity Disorder (2006), Alberta Education
- Taking Charge of ADHD (2000), Russell Barkley
- Executive Skills in Children and Adolescents (2010), Peg Dawson & Richard Guare
- Smart but Scattered (2009), Dawson & Guare
- Kids in the Syndrome Mix of ADHD, LD, Asperger's, Tourette's, Bi-Polar and More (2005), Martin Kutscher
- Lost at School, Why Our Kids with Behavioural Challenges are Falling Through the Cracks and How We Can Help (2008), Ross Greene
- The Explosive Child (1998), Ross Greene
- Making the System Work for your Child with ADHD (2004) Peter S. Jensen

ADHD and the Classroom Training Teachers

- There is evidence from KAPALKA (2005) indicating a large effect (SMD 1.47) of teacher-led behaviour interventions compared with a control group in reducing conduct problems as rated by teachers. NICE Guidelines (2009)
- Pelham et Fabiano (2008) conclude at behavior contingency management in the classroom (BCM) clearly met criteria for well-established treatment with 23 studies supporting its effectiveness, based on a large number of single subject design studies.

NICE Guidelines (2009)

ADHD and the Classroom
Training Teachers

- The provision of in-service training, peer observation and coaching by professionals can be effective[1] but the process takes time, and Adey and colleagues (2004) suggested that 30 hours of in-service provision are required for sustained changes to teachers' classroom practice.

1. Adey et al., 2004; Dreyfus & Dreyfus, 1986; Dall'Alba & Sandberg, 2006; Joyce & Showers, 1980; Sparks, 1986), NICE Guidelines (2009)

ADHD and the Classroom
Training Teachers

- The NICE Guidelines recommend:
  – The Department for Children, Schools and Families should consider providing more education to trainee teachers about ADHD by working with the Training and Development Agency for Schools (TDA) and relevant health service organizations to produce training programs and guidance for supporting children with ADHD.

NICE Guidelines (2009)

ADHD and the Classroom
Training Teachers

- The NICE Guidelines recommend:
  - When a child or young person with disordered conduct and suspected ADHD is referred to a school's special educational needs coordinator (SENCO), the SENCO, in addition to helping the child with their behaviour, should inform the parents about local parent-training/education programmes.

NICE Guidelines (2009)

ADHD and the Classroom
Training Teachers

- The NICE Guidelines recommend:
  - Following a diagnosis of ADHD in a school-age child or young person, healthcare professionals should, with the parents' or caregivers' consent, contact the child or young person's teacher to explain:
    - The diagnosis and severity of symptoms and impairment
    - The care plan
    - Any special educational needs.

NICE Guidelines (2009)

ADHD and the Classroom
Training Teachers

- The NICE Guidelines recommend:
  - Teachers who have received training about ADHD and its management should provide behavioural interventions in the classroom to help children and young people with ADHD.

NICE Guidelines (2009)

Clinical Evidence for Medical Treatment of ADHD

MTA Study: Objective and Design

579 Children
ADHD, Combined type
Age Range: 7-9.9 years

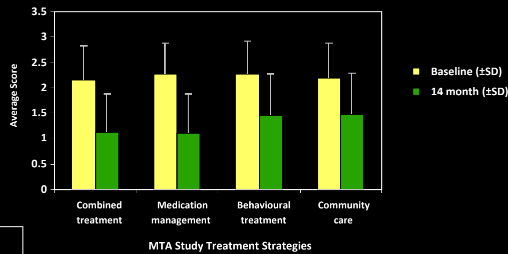
Randomly assigned
14-month study

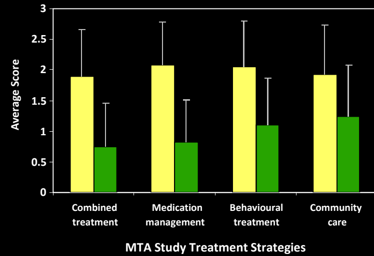
- Medication management (primarily methylphenidate)
- Behavioral treatment
- Combination treatment: medication and behavioral therapy
- Routine Community Care

MTA Cooperative Group. Arch Gen Psych. 1999;56:1073-1086.

MTA Study: ADHD Core Symptoms Baseline vs. 14-month Measures

Parent-reported Inattention symptoms



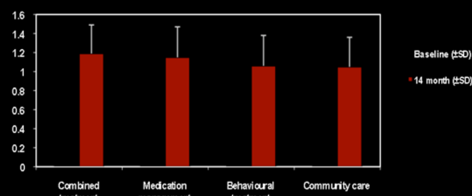


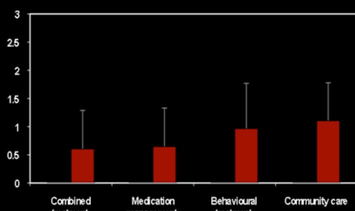
Teacher reported Hyperactive-Impulsive symptoms

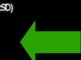
MTA Cooperative Group. Arch Gen Psych. 1999;56:1073-86.

MTA Study: Additional ADHD Symptoms Baseline vs. 14-month Measures

Teacher-reported social skills behavior







Teacher-reported Aggression-ODD (oppositional defiant disorder) behavior

MTA Cooperative Group. Arch Gen Psych. 1999;56:1073-1086.

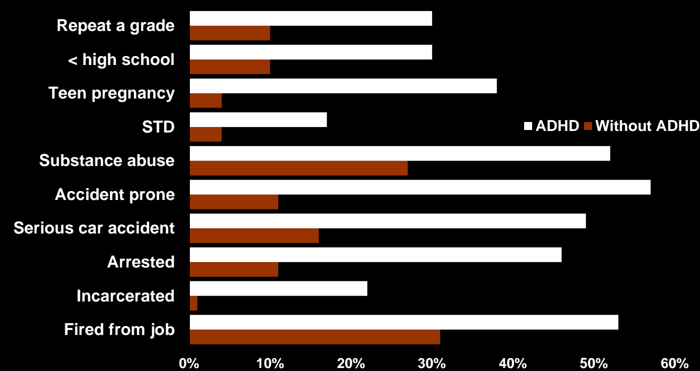
MTA Study: Conclusions

- Combined treatment and medication management were more effective than behavioral treatment and community care in reducing ADHD core symptoms:
  - Inattention
  - Hyperactive-impulsive behavior
- Patients in the combined treatment group experienced:
  1. No significant difference in core ADHD symptoms vs. those in the medication management group
  2. Improvements in core ADHD symptoms at a lower dose than patients in the medication management group
  3. Modest advantages in non-ADHD symptoms and positive functioning outcomes vs. patients in the medication management group

Possible Complications Due to Non-Treatment

In Childhood	In Adolescence
Disruptive behavior	School suspension and/or expulsion
Oppositional defiant disorder	Further academic difficulties
Poor academic performance and learning delay	Substance dependence or abuse
Low self-esteem	Social exclusion
Poor social skills	Mood disorders
Parent-child relationship difficulties	Conduct disorder
Physical injury	Poor motivation
	Teen pregnancy
	Driving accidents

Looking Beyond the Classroom: Functional Impairment in ADHD Patients



Barkley RA. Attention-deficit hyperactivity disorder. A handbook for diagnosis and treatment. 1998. Barkley RA et al. J Am Acad Child Adolesc Psychiatry. 1990;29(4):546-57. Biederman J et al. Arch Gen Psychiatry. 1996;53(5):437-46. Weiss M et al. J Am Acad Child Adolesc Psychiatry. 2005;44(7):647-55. Satterfield JH, Schell A. J Am Acad Child Adolesc Psychiatry. 1997;36(12):1726-35. Biederman J et al. Am J Psychiatry. 1995;152(3):431-5.

Stimulants improve Outcomes

- At 10 years' follow-up, stimulant treatment was associated with a highly significant…
  - 78% reduction in the relative risk of developing major depression
  - 79% decrease in conduct disorder
  - 85% reduction in the risk of having two or more anxiety disorders
  - 79% reduction in oppositional defiant disorder
  - 75% less likely to have repeated a grade

Biederman 2009

How to make it better?

Collaborate

Collaboration

- Medical and education systems can collaborate with parents to help a child.
- Collaboration enables those involved in the child's diagnosis, medical treatment, classroom pedagogy and family support to work together.
- Collaboration results in the production of a holistic picture of the child – who she or he is now and how to best assist.

Collaboration – Advantages Everyone

- Much better communication for everyone, parent, teacher, doctor.
  - More immediate
  - More accurate
- Collaborative vision for child's comprehensive treatment plan.
- Child knows that everyone helping knows everything so he/she can talk to anyone about problems and worries.

Collaboration – Advantages Medical

- Physician has contact with two key areas of child's life, home and school, and can compare and contrast this information.
- Helps physicians who lack information from a majority of a kid's day.
- School time is key because:
  - This is the predominant social time for kids.
  - This is the greatest demand for a kid's attention.

Collaboration – Advantages Medical

- Medications most effective during child's day at school, teacher feedback describes symptoms present during school hours.
- Teacher is able to provide immediate observations and / or concerns in response to medication changes.
- Physician has positive perception of school supporting the child.

Collaboration – Advantages Education

- Teacher / School has accurate, timely information regarding diagnosis.
- Teacher learns that child's 'behaviour' is based in neurobiology versus a character flaw - lazy, unmotivated, lack of will.
- Teacher learns that child's lack of output is a result of inherited neurobiology versus learning disability or cognitive delay – 'just slow'.
- Teacher can seek and learn educational interventions best suited to support children with ADHD.

Collaboration – Advantages Education

- Teacher and parent have more positive, goal oriented interactions in their joint effort to support the child.
- There are no secrets, the teacher is aware of diagnosis and medical treatment plan. Allows for faster, more accurate communication between school and parent; everyone can get to the point quickly without triggering defensive feelings.
- Collaboration saves time in the long term.

Collaboration – Advantages Parent

- Parent has someone to talk to about child who understands – the child's teacher.
- Parent has access to immediate feedback from teacher about impact of medical treatment plan.
- Parent feels better supported. Teacher cares about their child and worries and plans with them.
- Teacher can direct parent to good sources of information about ADHD.

ADHD and the Classroom Inherent Teacher Qualifications

- Teachers are incredibly valuable in the identification of a child's difficulties, for multiple reasons.
  - They spend a great deal of time with the child, second only to the parents.
  - They have had contact with many other children over time, helping them to establish a basis of "typical."
  - They have ongoing typical "control" children in the class. They can see which child is different from all of the other kids in the same classroom.

Kutscher , M.L. 2005

ADHD and the Classroom
Inherent Teacher Qualifications

– If a teacher is experiencing a problem with a child, then, by definition, there is a problem.
– When report card comments are read in sequence, there is usually significant conformity over the years. This pattern attests that the difficulty is with a particular child, rather than a particular teacher / student match."

Kutscher , M.L. 2005

Education and Medical Collaboration

The Unsolved Problems

Unsolved Problems – Education

- Teachers are often unaware of medical diagnoses that affect education.
- Teachers do not know that their opinion is wanted by the healthcare system.
- Teachers do not know that they are able and capable of discussing “medical issues” with students (families) and their healthcare team.
- Talking about a child’s mental health causes anxiety for teacher, principal, district personal.

Unsolved Problems - Education

- ADHD diagnosis may not meet criteria for ‘coding’ for Special Education designation in Alberta.
- ADHD is not considered to be a serious disability.
- Too many kids have symptoms of ADHD and there is severely limited access to mental health support in schools.
- There are delays in feedback from the medical community about the child’s difficulties.

Unsolved Problems - Education

- Teacher training is not geared towards collaborating with medical professionals.
  - Teacher not trained to talk to parent about educational problems that may have a medical base, especially not a mental health condition.
  - Teacher not trained to recognize mental health conditions that have a negative impact on learning.
  - Teacher cannot make direct contact with child's medical team.

Unsolved Problems - Education

- Education system not geared towards collaborating with medical system.
  - Systems of communication between education and medical care are slow or non existent. There is lack of continuity of service; the child moves on to the next grade with the next teacher.
  - Belief that a teachers must try everything (pyramid of interventions) before suggesting that the may child require more then differentiated instruction designed to "support the learning of *all* students through strategic assessment, thoughtful planning and targeted, flexible instruction".

    (Making a Difference: Meeting diverse learning needs with differentiated instruction, Alberta Ed 2010)

Unsolved Problems - Medical

- Physician training is not geared towards collaborating with schools.
  - Most physicians are not trained to work with schools.
  - Physicians are not trained to handle mental health difficulties in “regular schools”.
  - Physicians trained in Child Psychiatry/ Developmental Pediatrics usually work with schools/teachers that already have the expertize.

Unsolved Problems - Medical

- Physician training is not geared towards collaborating with schools.
  - Physicians are usually not trained to write letters for school.
  - Physicians are usually not trained on how to give recommendations to teachers.

Unsolved Problems - Medical

- Physician practice is not geared towards collaborating with schools.
  - Physician offices are not usually located in schools.
  - Physicians usually see patients during class time.
  - Parents are responsible for bringing the child and the concerns of the school to the appointment.

Unsolved Problems - Medical

- The healthcare system is not geared towards collaborating with schools.
  - The referral system is designed to treat medical issues in an increasing level of expertise (primary – secondary – tertiary) without necessarily communicating directly with the environment in which the problem exists.
  - "The system" is chronically underfunded with long wait lists for services. (Sound Familiar?)
  - There are few people who specialize in the field and it is often "slim pickings."
  - "The system" does not advertise what is available.

Unsolved Problems - Medical

- Physician regulations are not geared towards collaborating with schools.
  - The preservation of confidentiality is something physicians hold dear.
  - The Alberta government has stringent rules on releasing information (HIAA).
  - Release information forms need to be filled out at an AHS facility and are specific for the type of information and duration in which the information can be released.

Unsolved Problems - Medical

- Physician reimbursement is not geared towards collaborating with schools.
  - The physician is usually paid the most for seeing patients directly and not meeting with schools.
  - That pay is usually not time based: i.e. the faster the appointment, the better the compensation (payment same for 8min up to 22min).
  - Schools usually struggle to send teachers/school representatives to appointments.
  - Physicians are not paid to talk on phone/email/read letters/review forms/write letters. (Physicians can't even get paid to telehealth into non-AHS facilities).

Developing the Collaborative Connection…

Possible Solutions

Potential Solutions – School Teacher Prepares for Collaboration

- Teacher observes that child is a struggling learner and reviews known information:
  - Teacher reviews CUM file: there may be diagnosis of ADHD on file and/or a pattern of report card comments noting attention concerns and/or a non-coded IPP describing necessary adaptations and supports.
  - Teacher talks to previous teacher.
- Teacher responds to student's learning difficulties / poor executive function skills as soon as they are apparent in the classroom, prior to diagnosis, by implementing recommendations for children with ADHD.
- Teacher initiates a meeting with parent and Special Education Person.

Potential Solutions – School
Teacher Collaborates with Parent

- Goal is to create collaborative relationship with parent, more listening and less telling. Ask questions that allow the parent to inform the teacher versus the teacher informing the parent. (Paul would call this Motivational Enhancement Therapy!)
- Teacher says: child appears to be struggling in class; I would like to have a conversation about learning, would that be OK? Teacher asks permission to have conversation.

Potential Solutions – School
Teacher Collaborates with Parent

- Teacher says: it may be that the child is struggling with their attention in school, give specific examples “Child not able to follow 2 step instruction, struggles with organization” and wonders if the parent notices this at home.
- Teacher wonders what has happened in the past in school and home setting. Asks what the parent has heard from previous teachers and if the parent can share their successful home strategies.
- After some discussion and sharing of observations parents often say ‘I think child has ADHD…’

Potential Solutions – School
Teacher Collaborates with Parent

- Teacher says: I wonder… and gives parents a copy of the DSM-IV criteria and invites parents check off symptoms that apply and often many do.
- Teacher says: Well, ADHD is a medical diagnosis but something is in the way of this child's learning, perhaps you should make an appointment with your family to talk about your concerns.
- Teacher says: I know in the past that doctors have appreciated information from the school and if you would like I can write a note describing what we see at school and complete a checklist – SNAPIV that you can take to the doctor.
- Teacher says: Alberta Education has good information on ADHD and if you like I can send you some good websites and a pdf of 'Focusing on Success'.
- Teacher emails parent and email contact is initiated.

Potential Solutions – School
Teacher Collaborates with Parent

- Parents and teachers need to initiate the collaborative process with the medical doctor, physicians do not consider this possibility.
- Teachers need to gather information from the family – can't get information from the family doctor or office about appointments.
- Teachers need to train parents and parents need to train teachers. Parents may also have ADHD.
- Teachers and parents need to learn how the medical system works, who do you call, what do you ask.

Potential Solutions – School Teacher Collaborates with Parent

- Teacher should talk to the family about child's privacy. "The results of a medical appointment are private, but if you think it will be helpful for your child, we would welcome knowing what the doctor recommends and if there is anything more we should be doing in the classroom or if additional information is needed. "
- Inform parent that it is parent decision to release medical letters to the school and CUM file.
- Invite parents to follow up with the teacher as to what happened at the appointment.

Potential Solutions – School Teacher/Parent collaborates with Doctor

- Once parent and teacher have created a collaborative partnership then the parent can choose to have teacher and doctor collaborate.
- Teacher says: if you think it would be helpful let the doctor know that they can contact me. Teacher must be sure to include clear contact information on notes and checklists.
- Get to know the doctor and their process – which checklist.
- Learn the follow up procedure and time for appointments, teacher gets checklists and notes completed.
- Send information and checklist directly to doctor office.

Potential Solutions – School
Teacher/Parent collaborates with Doctor

- Teacher records on IPP that there is parent consent for school to talk to physician and physician talk to school.
- Teacher tells parent that they are welling to attend doctors appointments if appropriate. (Give parent permission to kick teacher out of appointment at anytime.)

Potential Solutions - Medical

- Help parents to be organized:
  - Create a file for the child (This is a chronic condition – they will see a lot of us)
  - Bring the info I need to appointments (Everything! And don't forget it on kitchen table.)
  - Come to appointment with an agenda and state it upfront – don't wait until the end of the appointment.
  - Help families determine how much time they need and how to get it. (First appointment in the morning or last one on the evening).
  - Teach them when and how to take notes.

Potential Solutions - Medical

- Teach parents to be assertive not passive nor aggressive.
  - Do not upset the admin staff or the nurse.
    - You can't usually shop around.
  - Do not bad talk other doctors / professionals.
  - Educate parents about ADHD before they arrive. (Diagnosis, Treatments, Prognosis)
  - Do not be demanding of service.
  - Start sentences with "I wonder…" or "I'm hoping".
  - Have parents practice what they are going to say.
  - Try the "Broken Record Technique".
  - Use medical language if you can.

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Potential Solutions - Medical

- Other things schools can do:
  - Make space for mental health.
  - Ask why isn't this child achieving.
  - Read the information in the file and try it.
  - Learn. Ask. Learn more. Ask. (Seriously, ask questions, we usually like to teach).
  - Do try. Teachers make a difference. Try to remain positive.
  - LETTERS – make sure you need it.
  - Fill out the questionnaires and send them.

Potential Solutions - Medical

- Other things schools can do:
  - Come to appointments or be available on the phone for the time of the meeting.
  - Be prepared to give more information than you get.
  - Do focus on the relationship with the child and family.
  - Know that there are ways for doctors to be paid to collaborate with school (conference codes) but you have to show up to the office or be at a telehealth site.
  - Try to keep the child from seeing a psychiatrist.

Contact Information

Dr. Paul Soper MD FRCPC

Glenrose Rehabilitation Hospital
10230 111Ave Rm 329
Edmonton AB T5G 0B7

Patricia Schwandt BSc Bed MA

patriciaschwandt@gmail.com