



A Response to Fintan O'Regan's *Exclusion from School and Attention Deficit Hyperactivity Disorder* (2)

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This article puts together very relevant evidence on the troubling situation regarding fixed and permanent exclusions from schools in the UK. It raises the question about the effectiveness of this wide practice by highlighting the fact that around half of the students concerned receive multiple fixed exclusions, and that a third of schools are failing to provide excluded students with alternative full time education with the dire consequences for themselves and society.

At the same time, the article focuses on ADHD which is the one type of social, emotional and behavioural difficulties for which a neurological condition has been identified and specific medication prescribed. This assumption leads to a basic medical model approach in the article. Thus, the section on 'Early intervention and diagnosis' focuses on identifying 'an underlying behavioural condition'. The intervention discussed is based on the medical model whereby the problems are seen to lie completely within the child: 'In children with severe ADHD, drug treatment is routinely given as a first-line option, often in conjunction with educational training programmes for the parent.' The author also underlines as 'of crucial importance' evidence from the US that intervention can 'help *normalise* disruptive behaviour patterns' (my italics) through a combination of medication and intensive behavioural intervention.

In a whole section on relevant teacher education, the article's emphasis thus lies on 'educating school staff in the *identification* of behaviour difficulties' (my italics). Reference to the other Steer Report recommendation for the provision of 'behaviour management training for school leaders at all levels to ensure they were adequately equipped and able to support their colleagues' is only given as an addendum and not elaborated in the same way as the role of identification. There is empathy with the stress suffered by teachers and a reference to the hindrance of large class sizes, but there is no reference to a whole school approach to the development of constructive behaviour or to how interdisciplinary support services can back up teacher actions for individual students. This is in contrast to the mentioned findings of a survey among educators that also addressed 'school training needs' and which focused its main conclusion instead on management issues:

These findings underline the need for effective behaviour management techniques, as well as changes

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and greater flexibility in the delivery of the curriculum, in mainstream schools. Teaching staff need to be equipped with classroom strategies and suitable interventions for use with pupils who display ADHD-type characteristics. “There should be increased awareness of curricular contexts and approaches which have been found to produce fewer ADHD symptoms and to increase on-task behaviour” (Wheeler et al. 2008, p. 173).

While recognising the widely held view that there is a neurological basis for ADHD that can be addressed through medication, one has to also consider seriously the importance of the impact of environmental factors, at least in the expression of ADHD features, and particularly in relation to disruptive behaviours (Cooper and Olsen 2001; Barkley 2006; Brock Jimerson, and Hansen 2009). For instance, manipulating motivation was found to lead to an equally accurate performance by boys with ADHD as by typically developing boys (Geurts, Luman, and van Meel, 2008). Ofsted reported that a common feature noted in twenty schools that had almost completely avoided exclusions and enabled their students to succeed against the odds was ‘stimulating and enthusiastic teaching which interests, excites and motivates pupils and accelerates their learning’ (Ofsted 2009, p.15). Medication may enable a student to complete a task that he would otherwise have been unable to do, leading that student to acquire relevant knowledge and skills. It must be borne in mind however, that ‘pills don’t give skills’. Schools have the responsibility to offer all children, including those with ADHD, the opportunity to develop relevant competences. This can only be achieved if the schools are committed and able to understand students’ strengths and needs and accommodate educational provision to meet such student characteristics. For the development of individual students’ potential, it is very meaningful to point out that ‘one important ingredient in the alleviation of this suffering [arising from specific conditions] is an emphasis on the *positive* dimensions of people who have traditionally been stigmatised as *less than normal*’ (Armstrong 2010, p.6). Indeed when one listens to the disengaged students’ own voices, one hears a lot about them not feeling valued and respected (e.g. Spiteri 2007).

Psycho-social action does not consist only in individualised intervention. Psychologists, who have traditionally worked with individuals, are now realising that the welfare of individuals is greatly influenced also by the context. Intervention has therefore to be also at the systems level, in our case at a whole school and community level (Bartolo 2010). Social, emotional and behaviour difficulties have been strongly linked to home, school and community variables (Cefai, Cooper and Camilleri 2008). Given the complexity and comorbidities often found in ADHD, as well as the challenges for engagement with school learning for the great diversity of students, a whole-school approach to the prevention of disruptive behaviour and the development of constructive participation in learning, is a necessary ingredient in the reduction of disruptive behaviour and successful inclusion of students with ADHD and other forms of SEBD (Ofsted 2006; Hughes and Cooper 2007).

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