Introduction

ADHD. Attention Deficit Hyperactivity Disorder. One of the most baffling and misunderstood conditions affecting kids today - and one of the most hotly disputed when the issue of treatment is raised.

Is that what’s wrong with Corey?

Or might it be ODD? Oppositional Defiant Disorder: a condition which prevents kids from complying with and fighting against simple, everyday routine and instruction?

Is ODD or ADHD the problem with Seth, explaining why he is so destructive? Seth isn’t destructive – he is oppositional! Rather – has Seth inherited his father’s ADHD?

And is ODD rather than ADHD the reason that James throws such terrible tantrums?

Is ADHD why little Sam and his sister Emily have such poor learning skills?

WHAT other conditions might be causing these problems? And is medication the most appropriate solution for children with psycho-social disabilities?

Is stimulant medication like Ritalin the most appropriate treatment in all cases?

‘You get a million different diagnoses...it’s called the medico roundabout,’ says Kathryn, mother of Corey.

Parents are baffled, confused, stressed, frustrated and despairing. And myth and confusion abound. Children and families branded with the label are demonized by a society that, whilst unable to properly understand the condition, often seeks to control ADHD’s disruptive symptoms almost exclusively through medication. A diagnosis of ADHD attracts no additional government support; so affected families have nowhere to turn. They suffer the stigma regardless of whether they medicate their children, or try coping with the aberrant and taxing behavior.

‘Kids on Speed?’ (Note that QUESTION MARK) is the title of a compelling, thought-provoking three-part documentary, a hybrid of observational documentary, factual intervention and social experiment, from Essential Media and Entertainment, in association with the Australian Broadcasting Corporation and Screen NSW. Produced, directed and written by Marc Radomsky and narrated by...
Deborah Kennedy, the camera takes us on a nine-week journey with four families whose children have behavioral difficulties in a variety of areas - learning, socializing, self-actualization, self-esteem and family inter-relations. As we take this journey, we will also be adding to our store of knowledge about the many misconceptions regarding the diagnosis of ADHD, the facts and figures connected with this, the varieties of treatments and the success rates and other types of behavioral disorders which may account for some of the behaviors of our subjects. As Leila, mother of James tells us at the end, ‘a family with a really difficult child with not one identifiable, ‘easy fix diagnosis’ can undo a whole family, and loving parents can be divided and the whole family can fall apart.’

Clinical Psychologist Professor Mark Dadds, Paediatrician Professor Michael Kohn and Education Expert Dr. Samantha Hornery are embarking on a nine-week intervention program which will engage with parents and children in a number of ways – how the family dynamic can affect behavior, how behavioral problems impact upon learning, how a possible prescription of medication like Ritalin may bring about a change and an improvement in learning and social outcomes.

Approximately 7% of the population is affected with ADHD of which the cause remains a mystery. As Professor Kohn says, ‘We can see the smoke signals, but we don’t know where the fire is.’ ADHD it is said, is ‘a diagnosis without a cause.’ Treatment, we are told, is controversial; medications like Ritalin are described in sensationalized media as connected to ‘street drugs’ like ‘Speed’ and cocaine. Headlines will continually flash across the screen in our documentary:

» COLLEGES TACKLE ILLICIT USE OF ADHD PILLS.
» SUICIDE LINK TO ADHD DRUGS
» ZOMBIE KIDS: WHY MORE CHILDREN ARE ON ADHD DRUGS

The controversy over medicating children with behavioral issues is ongoing and always newsworthy. Professor Michael Kohn tells us that he has been involved in bitter public debates about medication. He believes the statistics have been ‘sensationalized’; here is what he has to say:

‘If ADHD is in 5% of the population, and we’re only treating less than 3%, another very important question is: Are we not treating enough people? So just on the basis of the number of people we’re talking about, there is not an over-prescription of medication.’

In fact, accurate information about the best treatment is seldom reported. And in the nine-week intervention program, medication, whilst a significant and valuable modifier of problem behavior, is regarded as a last resort.

Working together for the first time, our three experts combine psychology, pediatrics and learning strategies to take on a formidable task: treating five children in four families all pushed to the brink by different pieces of ‘the ADHD puzzle.’ And by the program’s conclusion, we will see how the children – and their parents - have combined a variety of strategies – and medication in some cases - to produce a new order and understanding in their relationships. ‘Kids on Speed?’ is a potent testament to the power of evidence based multi-faceted best practice treatment and family team-work and dedication to improve children’s lives so they can build a more harmonious future.

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The Aims of this Study Guide:

• To explain and access information about childhood behavioral problems and ADHD in particular;
• To develop awareness of the medico-psychological responses to and treatments of these problems;
• To examine case studies in these disorders and the familial and clinical approaches taken to rectify them;
• To access and evaluate media information/responses to the medico-scientific approaches to issues of ADHD, ODD and other behavioral disorders and the controversy surrounding stimulant medication;
• To assess this documentary as an example of documentary filming.
In Episode One of this three-part documentary, our three experts embark upon a nine-week trial ‘intervention program’ to diagnose and treat five children suspected of having ADHD. The controversial decision about whether or not to prescribe medication is always at the forefront as a possible strategy, but Professor Dadds’ focus is much more on working with the parents of these children - a ‘team approach’ to ensure positive outcomes in their relationships with their children, and their children’s relationships with the world at large. Some of these children have learning difficulties, others have issues communicating and socializing within family and school environments, some have problems curbing violent responses to those around them. ‘Re-training’ of parents is at the core of this daring experiment, with the experts tackling suspected ADHD where other clinicians have failed.

Our narrator informs us - as indeed do the news headlines constantly shown on-screen - that the option of prescribing drugs such as Ritalin for children with ADHD has become extremely controversial:

Headlines such as:

- A NATION OF KIDS ON SPEED
- PILL-POPPERS: 32,000 KIDS TAKING DRUGS
- MYTHS, MISCONCEPTIONS AND STIGMA TIED TO ADHD
- THE RITALIN GENERATION

- all indicate the media focus on ‘medicating’ children who present with certain behavioral symptoms and the concerns that perhaps drugs are being too freely prescribed for these conditions.

‘The dumping-ground diagnosis’

Our narrator observes that since the causes of ADHD are virtually impossible to detect, a ‘generic’ diagnosis of ADHD has often been the case for any child with behavioral difficulties – ‘a dumping-ground diagnosis’. To refer to Professor Dadds once more, ‘ADHD is a label we use for a very real disorder but it says nothing about the causes. All we know is this the child is hyperactive, suffering attention problems … and that it’s wrecking their life...’

And given the frequent ‘bad press’ that medications such as Ritalin receive, many parents are reluctant to take this option.

What are the facts about medication?

The controversial answer to ADHD has been stimulant medication like Ritalin, stigmatizing the condition and the kids prescribed it. Members of Parliament have mounted campaigns against the use of ADHD drugs, ignoring significantly the science, vilifying doctors and condemning parents who allow their children to take them. Critics argue that Ritalin works like an amphetamine, the chemical found in the highly addictive street drugs like ‘speed’ and ‘ice’. However, expert and specialist Professor Kohn points out that Ritalin is ‘pharmacologically controlled’, does not cause dependency, is safe to use in the prescribed doses and is effective. Furthermore, new guidelines in Australia require that social and familial factors need to be considered over and above the use of medication. And this will be the focus of the nine-week experiment.

How does Ritalin work?

The millions of nerves in our brain communicate by means of chemical ‘messengers’. One of the most important is dopamine. Produced in the base of the brain, dopamine works in the frontal lobes to organize planning and focus.

The brain of someone with ADHD has fewer nerve connections in this frontal area so dopamine is less effective. Ritalin and similar drugs flood the frontal lobes with dopamine, ‘speeding up’ thinking.

Are there side effects to such medications?

‘The last thing we want to do,’ says Professor Dadds, ‘is to be throwing drugs out there for our kids, willy-nilly.’ Side effects, he observes – growth stunting, anxiety, changes in alertness - are ‘less than optimal.’

On the other hand, studies show that
kids with ADHD who are not medicated do worse in their social and work outcomes.

The four families involved in this nine-week trial program are at their wits’ end in addressing their children’s problems. As Professor Dadds says, ‘We are the clinic people come to when they’ve been everywhere else.’ In this very brief period, every option will be considered and the ‘medication debate’ will be confronted head-on to decide whether or not it is appropriate to put these kids in the series on Stimulant medication.

**WEEK ONE:** Assessment begins.

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Introducing our families and answering more questions

In the initial introductory session, each family will sit in a room and engage with each other while, through a two-way mirror, the experts will observe behavior and family dynamics; this will result in some conclusions about the children’s and parents’ needs. Our camera will also place itself in the homes of our four families, the interconnections between members so these, too, may be assessed and recommendations made later.

Ryan and Emma, parents, and Seth, 6 years old

Seth has behavioral problems both at home and at school. He appears unable to control his impulses. Tantrums, shouting, throwing objects, abuse, an obvious inability to ‘keep still’ are clearly evident in the home and the classroom. Samantha Dimech, Seth’s classroom teacher, assesses Seth as ‘very loving and caring… likes to please his teacher… but can only maintain attention for short periods at a time.’ We see Seth in the classroom, losing focus on the task at hand, but certainly responding to his teacher’s extraordinarily gentle, patient commands. His learning levels are poorer than his peers and he is enrolled in the school’s ‘Reading Recovery’ program.

Both parents are adamant that they will not allow their son to take medication under any circumstances. Seth’s father, Ryan, was himself diagnosed with ADHD at the age of 7; he took Ritalin until he was 16 years old and was, in his estimation, ‘catatonic… a zombie’ as a result. However, he was finally able to control his erratic thoughts and behaviors himself. It is a concern for Ryan that Seth may have possibly inherited his ADHD – if that, in fact, is what Seth suffers from – the diagnosis is some distance away as yet.

Are parents really to blame for their child’s ADHD-type behavior?

Ryan and Emma have been subjected to criticism from other parents - they have been blamed for their son’s behavior and often feel responsible and inadequate as a result: ‘failed parents’. This has naturally lead to a great deal of anguish. Professor Dadds’ assessment of Ryan and Emma is, however, positive: ‘I’m seeing two parents who are really doing quite well; this is really difficult stuff’ - a great reassurance for
the young couple. And Professor Kohn concurs: ‘ADHD is not a consequence of bad parenting. It is the result of cognitive deficits which inform behavior’.

Professor Kohn is looking for other possible reasons apart from ADHD to explain Seth’s lack of attention and focus. It appears that a night without sufficient sleep may be a trigger for that uncontrolled, destructive action. Perhaps Seth has a sleep disorder?

**What are the statistics?**

- Statistics tell us that around 7% of children have some degree of ADHD, yet the cause remains a mystery.
- Boys are affected four times more than girls.
- Brain growth in children with ADHD is generally two years behind other children.
- Only 3% of the population are treated with stimulant medication.

**Why do children with ADHD ‘play up’?**

As we said before, the delay in brain growth in ADHD children means that the brain attempts a range of ways to try and compensate for this lack; children often become impulsive and in doing so, develop patterns of behavior that are the hallmarks of ADHD:

- Inattention
- Hyperactivity
- Impulsivity

Stuart and Leila, parents, and James, 10 years old.

James’ father classifies his son as ‘a caring person by nature, but he flips… to the point where he gets so angry that he’s not controlling his temper or rage…’ One doctor, after a very brief consultation, had diagnosed him with ADHD and offered medication, but his father is not prepared to take this path. His mother, Leila, is worried about the physical safety of the whole family; he has a daily ‘meltdown’ at home but ‘no issues’ at school, which reassures her that perhaps something can be done to affect a change in his behavior. Home video shows James in a fully-fledged tantrum, shrieking and striking his father. Why is he so violent? Could this be ADHD? Or ODD? or emotional immaturity? Or possibly even autism?

**ODD**

**ODD** _Oppositional Defiant Disorder_. A self-explanatory term in which children appear incapable of complying with rules and routines and set about to be regularly destructive.

ADHD has been described as a ‘murky’ disorder because the behaviors that trigger diagnosis can be due to other conditions like anxiety or ‘ODD’, often mistaken for ADHD.

**And what is autism?**

The definition of Autism and Autism Spectrum Disorder (ASD) is provided by the Diagnostic and Statistical manual of Mental Disorders (DSM-IV). Children with autism are less able to interact with the world as other children do. Typically they have deficits in three key areas:

- Verbal and non-verbal
Communication

- Social awareness and interactions
- Imaginative play (variable interests and behaviors).

To provide a comprehensive definition of Autism Spectrum Disorder, there are separate labels given to children with autism for different points on the Autism spectrum. At the least affected end, you may find labels such as “Asperger’s Syndrome”, “High Functioning Autism” and “Pervasive Developmental Disorder - Not Otherwise Specified” (PDD-NOS). At the other end of the spectrum you may find labels such as “Autism”, “Classic Autism” and “Kanner Autism”.

Autism sufferers generally don’t demonstrate emotion, however, in a consultation with Professor Michael Kohn, James talks about the difficult year that has just passed for him, with the death of his grandfather; this recollection brings tears. This, interestingly, is a positive sign for the Professor; autism, a difficult area to treat, may not be the key to James’ problems.

‘The love test’

Challenging kids can be difficult to love, declares our narrator, and, as part of the Assessment period, the clinicians ask each set of parents to take on an often revealing exercise: to show and tell their difficult child how much they love him/her. For Leila and Stuart, this is difficult. The conclusion, reflects Professor Dadds, may be that the parents will have difficulty functioning as a team because they are having problems with their own relationship.

Janine & Darrell, parents, Emily, 11 years old and Samuel, 6 years old

With four children, Janine and Darrell have a very full nest, and with two of the children presenting with behavioral problems, life is stressful. Darrell fills us in on Emily’s earlier history of medication: when medicated, she was ‘quiet, not rowdy, but not Emily, really.’ Compliant, obedient but very withdrawn, they took her off the medication because it seriously obscured the ‘real Emily.’ When non-medicated, the household battles returned with gusto. Janine asks: ‘Do we want the drugged-out, zoned-out child, or do we have a human being we can have a conversation with but struggles to keep still and drives us pretty crazy?’ And with young Samuel’s poor learning abilities and uncontrolled and disturbing violent outbursts, the parents are dreading a potential diagnosis that says they now have two children with ADHD.

WEEK TWO: Assessment continues

The concept of ‘self’

Education expert Dr. Samantha Hornery offers her findings on children with behavior corresponding to ADHD: they probably have all the learning disabilities, and have a more ‘battered self-concept’. Emily, for example, ‘has had a long period of failed learning experiences,’ and on the cusp of entering secondary school, where she will be required to address time-tables, routines, rules and the like, she will be facing many challenges.

The costs of not identifying the educational gaps are enormous: children with learning difficulties are

- more likely to end up with drinking problems,
- drug-taking,
- risk-taking

says Dr. Hornery, ‘because they don’t have a sense of a strong value of self, they don’t believe that they’re worth more, that they’re capable of more things…’
The five-minute speech

Here we see another task all parents are asked to perform during this experimental program: to make a five-minute speech in which they express their feelings for their child aloud, on their own; this is recorded. We see Janine undertake this emotional task, hear her speak of how Emily was her ‘perfect baby’ and how ‘blessed’ she felt when she had her daughter, although her behavior is distressing. Nevertheless, ‘she is something special’ and medication might ‘dampen that unique personality.’ Samuel, ‘the baby of the family’ worries Janine for ‘what comes out of his mouth… he talks about violence’ in frightening terms; she doesn’t know where this has come from.

These speeches show parents at their most vulnerable and require a degree of bravery for them to undertake this intervention program treatment.

Assessing a variety of data, Professor Dadds hopes to establish a strategy, whether it be medication or ‘parenting interventions’ to address oppositional behavior. Once this is in place he feels this will result in some improvement in Emily and Sam’s lives.

Kathryn & Jade, parents, and son, Corey, age 7 years old.

Corey, we will see as soon as we meet him, comes across as an expressive, confident boy; he has been previously diagnosed with ADHD, ODD and anxiety. Because Corey’s time in the school environment was a danger to other children, his parents have been forced to ‘home-school’ him. Kathryn has done a great deal of research into parenting techniques for this very difficult boy, but we see they often do not result in a pleasant, positive outcome; on one occasion, Corey threatens to stab his ever-patient, calmly positive mother in the eye with a pencil. He becomes angry when he produces an incorrect answer to his current schoolwork. His parents nevertheless classify Corey as ‘a very clever boy and very sensitive’, who, when on medication in the past, became so depressed he threatened suicide. All available strategies have been tried for five years, which is why they have come to this trial.

In the introductory session, we see how Corey’s parents cannot engage with him, and he wanders away to the conspicuously placed toy-box and proceeds to play on his own. This boy is going to be difficult to engage with.

The comprehensive two week diagnostic assessment is over and its time for treatment to begin. We now have only seven weeks left for Professor Dadds and his team to effect a change in the behaviors of all children in the program; first step is to uncover ‘the trigger’ that sets off children and families?

WEEK THREE: Diagnoses

Detailed assessments are complete; our three experts meet for a ‘think tank’ session to pool their findings and come up with a diagnosis of the children.

And here are their findings:

» **Seth**: he only has **features** of ADHD; he has sleep-deprivation disorder and ODD, which may be causing his ADHD-like symptoms. **Recommendations**: a sleep study and parent-training for the constant fighting -without medication. The parents are elated that medication is not an option.

» **Emily**: Of all the children assessed, she presents the most concerns from an educational perspective; reading skills are 12-24 months behind and Maths are worse. Professor Kohn believes ‘she is strongly in the clinical range for ADHD’ … (and) she has regressed since she came...
off medication, in terms of her behavior...’ Her learning has been hampered by her ADHD and that has contributed to her ODD. **Recommendation:** despite her earlier bad reaction to Ritalin, the team recommend ‘a low dose of stimulant along with parent-training.’

» **Samuel (Sam):** school behavior is bad; we are already beginning to see some ‘learned helplessness’, his first response to most questions being ‘I don’t know’... He is ‘text-book ADHD’ as well as ODD. These two siblings ‘set each other off in ways that bring the family into conflict.’

**Recommendation:** The team decides upon medication and parent-assisted therapy. These diagnoses come as a double shock for Janine and Darrell, and Janine reflects that the way she has parented over the past 18 years may mean it will be difficult to reassess her methods, but admits ‘something has to change.’

» **James:** generally immature for his age, has a range of aggressive and oppositional behaviors, and yet is a successful student; his standardized reading tests are two years above the average, as is his Maths. He was apparently not experiencing too much difficulty until the relationship issues at home began to break down. It has already been observed that his parents are not acting as a team. So James’ diagnosis, we are informed, remains a mystery, while a part diagnosis concludes that his emotional immaturity and full-blown ODD are ‘leading to ADHD behaviors.’ There is no evidence that he has ‘classic ADHD.’

**Recommendation:** Intensive parent training and no medication.

» **Corey:** described by Professor Dadds as ‘a tricky one.’ The team conclude that he is ‘functionally autistic’ and definitely a case for medication in conjunction with comprehensive programming and some ‘powerful management strategies’.

**Recommendation:** despite Corey’s past suicidal response to medication, this option is back on the table. This is dispiriting for Kathryn and Jade after their years of work with him, and formal diagnoses, according to the experts, are not going to do much to help Corey. The question is, says Professor Dadds, ‘how do we take this little boy and move him to a better place than where he is now?’

This, of course, is the same for every child in the program. As the parents will be required to apply discipline, total commitment will be needed from all families to implement management strategies.

Hitting the ‘sweet spot’

This is a term Professor Dadds uses on occasion to describe the exact balance of medication and training that each child needs to readjust his/her behavior. The American studies into the use of medication work on a carefully ‘titrated’ dosage, meaning the medication is adjusted and monitored constantly so that in time the dose is calibrated perfectly to the individual.

Given Corey’s dangerous reaction to past medication, Kathryn and Jade prefer to see what Professor Dadd’s intervention strategies can offer.

Here is the method advised by the Professor: it’s known as descriptive praise

**What can you do to ‘max up’ the amount of attention that Corey can get from you when he’s behaving in a good fashion?** This is about finding space to give love and engagement when nothing is going wrong, complimenting and praising **The method for the first week is go around the house, looking for good behavior and responding in a way that is unpredictable**
The camera in Corey’s home shows us a relatively peaceful period of time over the next few days, with Corey being complimented and praised for work achieved. This, concludes Professor Dadds, suggests the program has created a ‘positive wedge.’ Is this the beginning of success?

How are things progressing for James?

The answer: not so well. Stuck in a violent loop until filming began, one hypothesis is that the camera crew is affecting the family dynamic. Therefore, in cooperation with James’ parents, the camera crew is removed and replaced with a fixed camera. The fixed camera nevertheless reveals a new dimension: conflict with James is splitting Stuart and Leila apart; the violent, disobedient behavior continues and the experts are worried about the functionality of the parents as a team.

Stuart and Leila are interviewed once more with positive advice about ODD: the bad news is that, if un-treated, the outcomes are bad; the good news is that it can be treated. The main treatment involves parent-assisted therapy, a program in which the parents need to work together on effective discipline. While Stuart thinks they can be a team, Leila declares she is ‘not sure.’

Our next Episode will show us how the intervention is ‘ramping up’, the medication dilemma comes to a head and the experts discover just how tough this experiment is going to get....

* Episode two

WEEK FOUR:
‘Descriptive praise’, teamwork and putting the parents back in control

‘Drugs are easy. This is a lot harder’. (Janine, mother of Emily and Sam)

It’s three weeks into the nine-week program and as we have seen, the experts have diagnosed five challenging children. Over the next six weeks, Professor Dadds will push our four families to their limits, challenging them to change completely how they reward and punish their children.

James: diagnosed in the past with ADHD. The experts have formed the opinion that ODD is a more accurate assessment. He’s already a big boy, and there are recognizable concerns for the physical safety of the whole family. His daily tantrums have been ongoing for the past two years. ADHD and ODD often occur together, thus making a distinct diagnosis complicated. All of these disorders have lots of overlap, so even though ‘naughty and aggressive’ is not central to ADHD, it does lead to over-estimates of ODD. Is this the problem with James?

How Positive/Descriptive Praise works:

1. The strategy to adopt now is to reduce the attention paid to
misbehavior and increase the attention for when the child is behaving well.

2. Positive praise must be unpredictable or the child quickly gets bored; kids should know that good behaviour leads to praise but not what the reward will be. Unpredictable rewards have the best effect on behavior.

3. Most parenting programs get this part wrong because they make the rewards very predictable.

What the Professor tells Leila and Stuart is:

‘What James really wants is for his parents to spend time with him; this is the most power they will have with James but this must be done as a team.’

The result: We see Stuart and Leila sitting companionably together while Stuart plays his guitar, James is quietly absorbed on his computer. Next, the parents embark on their strategy to engage with James by reading to him. But this doesn’t work out; he is inattentive and erratic in behavior. Stuart gives up.

Upon observing this scenario, Professor Dadds reflects that he has always felt the least confident of being able to help this family because the ‘team effort’ is still not in evidence.

Nevertheless, after this shaky start, and earlier faltering attempts, Stuart steps up, complimenting James on his good manners. Leila contacts Professor Dadds talking about a change in behavior, and we can now observe James interacting affectionately with his mother, telling her he loves her, allowing physical contact (cuddling). This may be some evidence that things have changed.

Emily and Sam: These two siblings have demonstrated to the experts that when ADHD is not treated it can also cause ODD; life at home is a battlefield for the entire family, including Grandma, whose attempts at disciplining Emily to complete her homework are futile. Professor Dadds discusses how ADHD is driving much of Emily’s problems and she is starting to feel really bad about herself, emotional and anxious.

We know from the observations of our clinicians that the ‘first-line-treatment’ for ADHD is stimulant medication like Ritalin and we know from Janine that this drug made Emily ill. Emily, when captured alone talking to the camera, reveals that she often hid her tablets rather than take them, or threw them into the toilet. When the medication wore off, Janine recalls that Emily’s behavior became a nightmare. Sam, if left untreated, will also suffer with problems of a more aggressive nature.

The parents’ greatest fear with Emily going back on medication is that they ‘will get the zombie-child back’. Paediatrician Professor Michael Kohn understands this and counsels them to see that medication is a part of the solution; this will put the parent back in control of the family. Emily will start on a low dose and will be carefully monitored; this is, after all, a trial. After Emily’s next major tantrum, the parents agree, reluctantly. After all, Emily is about to start high school and she needs ‘the right balance’.

It is a difficult call explaining to this obviously unhappy little girl that she should start returning to medication; Janine and Darrell break the news gently and Emily complies tearfully.

With Emily and Samuel now on Ritalin, will Dr. Hornery see a difference in their learning capabilities? ‘Children with ADHD are entirely capable of learning,’ she insists, ‘they just need a different way of learning.’ Since Emily’s school-based learning has been of the writing kind, ‘Learning Links’ with Dr. Hornery adopts a
games-based learning approach; this is a successful strategy and we can see how delighted Emily is with her ongoing successes. Her school’s teacher has given her ‘fantastic results’ as well, regarding classroom conduct. Not so with Sam; however, his concentration and learning do show some obvious improvement.

**Seth:** Despite Seth’s initial diagnosis of ‘only mild ADHD’ the incessant daily battles continue. The parents are still over-reacting and life at home continues in a ‘vicious circle’. Professor Dadds still maintains that changing the parenting will bring about a change. He needs to ‘re-wire’ their reactions to Seth.

The plan: walk round the house and ‘catch’ Seth being good; pick an option as a response, keeping these rewards unpredictable

• spend some time with him;
• provide a treat;
• demonstrate affection.

This should present a promising start to addressing the problems.

However, at home that night, Seth behaves very badly, refusing to do homework, continuing with the same pattern of lacking concentration and destructiveness. Flaring tempers are beginning to replace descriptive praise. Professor Dadds is beginning to feel that Emma and Ryan are not being totally honest with him about their focus on this strategy. Poor sleep patterns have been marked as possible reasons for his erratic behavior and his Remedial Recovery teacher at school is very concerned.

**Corey:** When it comes to mastering schoolwork, his anxiety makes him becomes very agitated; his ADHD makes it almost impossible for him to sit still. The strategies provided by the experts are beginning to show some positive outcomes, but the question remains whether he will ever be able to return to school; he has never had a positive experience in the classroom situation. Dr. Hornery wonders if the home-schooling is meeting Corey’s social needs, since he is ‘missing out’ on the regular interactions that are a part of life in the average classroom.

Back at ‘Learning Links’, Dr. Hornery’s trial lessons with Corey show objectionable and disruptive responses, leading her to conclude that at this point, she cannot help him with an educational program but she also notes that he has ‘not demonstrated gaps in his learning – his core needs are in the social aspect and learning to follow instructions. Perhaps the ‘cotton-wool’ environment he has lived in with his home-schooling has meant he feels threatened by outside experiences?

There are a number of co-existing problems with Corey and ‘which one exactly is driving which one’ is a tricky puzzle to solve.

In consultation with professor Michael Kohn Corey’s parents have decided to try him once more on Ritalin and new anti-anxiety medication called Rispidal, but to avoid dangerous side-effects, the Rispidal is prescribed at a low dose. Rispidal needs a week to start working in the human system; Ritalin starts working almost immediately.

Reviewing the physical health of his young cohort, Professor Kohn notes how weight loss is a by-product of Ritalin; he prescribes an extra serving of ice-cream after dinner for Emily; naturally, this goes down well!

‘Praise Week’ nears its end

As the program reaches its half-way mark, Stuart’s persistence sees James thriving. Helping his father to ‘assistant manage’ a car-boot sale, the two
males relate calmly and positively. As a result, he is given a massive reward: a drum kit!

This may be a little misguided, reflects Professor Dadds. Leila nevertheless believes that ‘there’s a genuine relationship-repair happening; you can feel that in his gentle tone and I respond to that and vice-versa.’ Leila is now clearly able to articulate ‘I love you, James’ with James’ reply being ‘I like cuddling you, mum.’

**Cognitive Behavioral Therapy VS medication**

Cognitive Behavioral Therapy is the scientific term for the strategies laid down by our team, and is according to Professor Kohn, ‘a very powerful way that psychologists can change behavior, but can’t necessarily change function in ADHD. The evidence is such that medication is likely to be the best treatment for that.’

**The next steps**

From here on, to enforce change, Professor Dadds needs the parents to step up to a new level. ‘Some people will love the change, some will see the changes as very disturbing, but what I’m trying to do is say: Here’s the techniques, you guys take control. I’m going to be like a coach and help you through this until we get it right.’

**WEEK FIVE: Discipline**

‘Do this. Don’t do that.’ (Professor Dadds.)

Instructions are now to be the focus. If an instruction is disobeyed, it is to be repeated one more time, and if disobeyed, the child is to be placed in a ‘Time Out’ area. Parents are put through some role-playing activities to see how this part of the program is to be followed.

**Sam:** Janine and Darrell have cause to enforce this discipline the same night: Sam is sent to Time Out for refusing to eat his dinner when instructed. This provokes an emotionally stressful situation for Janine, because Sam’s sobbing and screaming are heart-rending for her. Nevertheless, the policy is adhered to and eventually Sam returns to the dinner table and quietly eats.

**James:** While the family seems to be coping well, the situation still remains fragile, with James in an interview with Professor Dadds being deliberately disobedient and obstructive. This sudden relapse has left Stuart and Leila confused. Is it the result of as yet undiagnosed ADHD? Professor Kohn is beginning to think so; James’s ODD may be hiding the fact that he does in fact have ADHD as well.

**Corey:** The anti-anxiety medication should now be working. He seems more settled. His next home-school session will test the combination of medications, Professor Dabb’s techniques and Kathryn’s parenting strategies.

A tantrum is the initial response to the instruction to start schoolwork, with Corey declaring he will not work until he has attended to a more interesting game he wants to play. Kathryn keeps to the plan; no compromise, no anger at the display of anger. Eventually, Corey settles down to work companionably and cheerfully. A success but it will be a hard journey for Corey; will he learn enough behavioral control to
go back into a class of twenty children and a teacher?

WEEK SIX: Experts Think Tank

‘If, at the end of this, I see no improvement, I’m going to be really disappointed in me and in the program’ (Emma, mother of Seth)

Professors Dadds and Kohn and Educational Expert Dr Hornery meet again as a group to review their diagnoses and treatment plans. Video-ed footage of the children is re-visited as they pool their responses to the strategies they’ve developed over the weeks.

Emily & Sam: The clinicians conclude that there’s been a good response to the trial thus far, with Emily reacting more positively to the Ritalin than Sam has. The decision made now is to ‘tweak’ his medication a little, just to see if some of his difficulties with mood can be over-ridden. Dr. Hornery is pleased with his ‘more sustained attention at a task’; he is, she believes ‘on the right path.’ The parents, however, still need some degree of ‘re-training.’

Corey: ‘What an incredible experience this has been!’ declares Professor Dadds. We see Corey engaging happily with his parents, while Professor Dadds refers to ‘the two-pronged approach’ (1) parent-assisted therapy (2) medication which appears to have indeed ‘hit the sweet spot’ - that much-desired balance. Dr. Hornery also believes that the next educational experience for Corey ‘needs to be successful.’

But the experts all agree that Corey isn’t ready for school yet; more of the same strategies need to be repeated, as well as exposing Corey to more challenging social experiences.

The effect of improvement on parents

For Kathryn, Corey’s rapid improvement comes as a shock. For someone who gave up her career to address Corey’s needs full-time and after having spent so much of her time and effort on him, if he improves enough to go back to school, what will her future be? She regards this as a ‘fear.’

Seth: Professor Dadds is not sure if parents Ryan and Emma are following the instructions fully; they tell him that everything is progressing well, but he is not so sure. We see film footage of Seth’s oppositional, aggressive behavior as an exhausted Emma, alone for the night (Ryan has to work late) has to do battle with the little boy’s refusal to follow instructions. She articulates to the camera that somehow she and Ryan have been more of the focus of the trial and not Seth. Professor Dadds wants to re-interview them and emphasize the need to take the parenting plan more seriously. Seth’s sleep problems can only be assessed in the next six months; there is a long waiting list for this study at the Children’s Hospital.

James: After six weeks in the program and with some very promising signs, James is still a mystery, with the possibility that untreated ADHD is an explanation for his disruptive conduct. The recommendation is a trial - for a few weeks - of Ritalin. But can Leila and Stuart ultimately succeed with James? We witness a night of terrible tantrums with confusion and anger from the parents who, by now, are at a loss as to what to do next.

* Episode three

‘We’re in the last phase of the structured program now…some people just go ‘Bang!’ and get it; others struggle and need fine tuning. We don’t really move forward until we can see the
little glint in the parent’s eyes that says ‘I get it…’ (Professor Dadds.)

As Professor Dadds tries to pick up the pieces where certain stratagems have been unsuccessful, family secrets come to light. And in the final days of the program, the kids surprise everyone.

Six weeks into the program and our three experts are seeing mixed results from their interventions. Two families have really benefitted from the combined advice given.

Emily & Sam: both are doing well; Janine, their mother, speaks of a more ‘pleasant’ life being lead.

Corey: this eloquent little boy assesses himself, describing ‘the old Corey: bonky, distracted and incapable of doing schoolwork’ and ‘the new Corey: calm, fine and capable of doing schoolwork.’

However, the other two families are still facing uphill battles.

James: Once more the camera shows us James in full flight, throwing objects, crying and shouting. His mother speaks of the situation as ‘being in a rut.’

Seth: still ‘playing up’ and frustrating his parents. It appears that the ‘powerful suggestions’ given to them are not being picked up at all. But in interviews, the parents speak of Seth’s behavior as being more moderate and reasonable, how he has ‘changed a lot’ and is ‘really helpful’ when it is clear from the film footage that this is not the case! A typical scene in which Ryan and Emma are trying to encourage their son to try different foods rather than simply ‘junk food’ proves this: anger and defiance from Seth and frustration from his parents.

‘Are you telling me that everything is perfect?’ (Professor Dadds)

An ‘honest space’ needs to be created here, so an open dialogue can emerge. Professor Dadds suggests that Emma feels ‘blamed’ for her son’s behavior and this needs to be discussed frankly or no progress can be achieved. Uncomfortable truths are emerging to challenge the families; some of the problems the parents have ‘brought with them’ from their own childhoods.

‘I feel like I’m the one carrying the load’. (Emma)

‘You need to cry and you need to tell me stuff…’ (Professor Dadds)

And now we see Emma break down in tears, reflecting on the difficulties she and Ryan face: his work commitments, which mean frequent late hours, leaving her with Seth’s issues; her unhappy feelings about her own childhood family struggles, with a single mother who was often angry and ‘lashed out’ at her children. Emma feels she’s acting exactly as her mother did, and this therefore means she is incompetent - ‘a bad mum.’ Professor Dadds tells her that self-blame, not poor parenting, is holding her back and he gently coaxes her into realising that this is not a sound strategy.

WEEK SEVEN: Fine tuning praise and discipline

The mantra is re-expressed: parents must work as a team. And so we see Emma and Ryan embark on a dual role in Seth’s re-education. Arriving home early from work, Ryan is ready to play his part and the family all engage in a game together. The result is pleasant and convivial. Some progress has been made. ‘The journey only begins now,’ declares Professor Dadds.

Corey: A combination of medication and strategies has brought wonderful, unexpected results. ‘We’ve never seen that level of calm,’ declares Corey’s mother. We can certainly see how the team-work of Kathryn and Jade is paying off. The time is right for Corey to re-enter the social world of other children; in the past he fought and attacked other children by whom he felt threatened. Consequently, he has been ‘put into a feathered nest at home.’ His first social challenge is a play-date with family friends. We see him initially playing comfortably on a trampoline with other kids. But old reputations are hard to shake; Corey is blamed for bumping into one of the children; there are tears and this ‘sets off’ the other child. Corey declares his innocence vehemently, but there is, thankfully, no expected tantrum and abuse.

‘What the medication has done is enhanced his ability for the thinking part of the brain to keep regulated, the emotional part of the brain, if you like’, says Professor Kohn.
What ultimately happens to children who are on medication for their behavioral issues?

In the long term, people do come off this medication, and this is what will ultimately happen in Corey’s case, says Professor Kohn.

Emily & Sam: When eleven-year-old Emily began the program, she could barely read a sentence; she was of most concern to educational expert Dr. Hornery. The film now shows us Emily enthusiastically constructing and reading aloud lengthy, complex sentences. She is now ‘a different girl’, excited about learning and excited about getting work correct. Both she and her brother have come a long way in a short space of time – academically.

While the medication is improving their ADHD, it is not helping with their defiance. After school, home life remains a battle-ground. Home video-footage shows Janine – who is a gentle and compassionate mother – really struggling with the ‘time-out rule’ - a strategy that sees the children consigned to a part of the house for a designated period so they can learn to control their behavior. But sticking to this successful discipline is backed up with a reward, for example, Janine spending ‘quality play-time’ with the children.

James: In a telling discussion between his parents, Leila assesses part of James’ underlying behavior stems from the connection between herself and Stuart. The instruction from the experts is to ‘problem-solve’ the home routine to minimize chaos. When they try to discipline James, he has a ‘default position’; a tantrum. It’s Professor Dadds’ guess that ‘something happened when James was about one or two years old that he learned: throwing massive tantrums gave him so much power, and he’s never grown up beyond that.’ Medication as ‘a cognitive enhancer’ is recommended by professor Kohn and Leila agrees, declaring she ‘can’t go any further with James.’ Stuart, however, want to leave this option ‘on hold,’ fearing that medication is a very serious step to take, and the family have not yet completed Professor Dadds behavioural intervention.

Professor Dadds extrapolates on the last resort need for medicating certain children with these disorders.

‘...the long-term outcomes mean much unhappiness and trauma for those who suffer ADHD (and who aren’t treated with medication). Ultimately, society as a whole will pay for a lack of focus on poor childhood socio-educational outcomes.’

WEEK EIGHT: Reinfocing change

‘This is where the best of medicine meets the best of psychology.’ (Professor Dadds.)

Every family is now at a critical point in their journey.

Seth: Emma is working to control her reactions to Seth’s conduct. Breaking the cycle of a problematic family situation means the child gets better and the parents are freed up from the awful burden they’ve carried through their lives. This means good news on the home front, but Seth’s behavior is still troublesome at school. Ironically, on the same day he receives a reward for ‘Reading Improvement’ – a delightful occurrence – the school principal threatens to throw him out of class for bad behavior. This ‘mixed message’ throws Emma back into ‘fight mode.’ She must stay calm to avoid a crisis. A phone call to Professor Dadds - who seems to be available always - tells us he has already spoken to Seth’s school principal and pleaded a case for retaining Seth in class. Seth is allowed back into the classroom, but he is treading on very thin ice.

Corey: In the past, as we know, anxiety lead Corey to bite and stab other children at school. But if children like Corey are to be effectively treated, they will need, over time, to be slowly exposed to a ‘high risk situation’ where there will be shoving, noise, discomfort, or their issues cannot be addressed. Now we see him practising with his parents to return to a judo class – a step back into the world of activity groups. We see Kathryn and Jade rehearse him in the protocol of the class: bowing, lining up, taking turns, waiting. In such circumstances, children will often be noisy, boisterous, or pushy and Corey needs to learn how to react and to feel safe. This is where Corey first begins to socialize, obey instructions and feel comfortable asking questions. And it’s a success!

Emily & Sam: Janine, flushed with the success of the ‘time-out rule’ still has to confront the biggest hurdle: the morning routine. This time of day is hard for children with ADHD and even though the children, from the time they wake up, have a two-hour period to prepare for school, they still cannot be ready on time.

Solution: ‘Beat the buzzer!’

Luckily, Professor Dadds has a solution: a schedule in which each morning activity is allocated a specific time period denoted by a buzzer sounding. The exercise is tried and Janine adheres very closely to the rules, the schedule is completed successfully with ‘oodles of time to spare!’
James: Leila and Stuart have not made their call on medication, but Leila is taking charge of discipline, working out a system of punishments and rewards. And when Stuart loses focus, Leila takes him to task, to ‘take more part in the emotional training for James.’ Taking Leila’s urgings to heart, Stuart has decided to form a family band. He has co-written a song about the family, called ‘Good Life.’ With James on his drum kit, Leila and her little daughter on vocals, an older brother on keyboard and Stuart on guitar, the session works well; teamwork in progress!

Seth: The last piece of the puzzle is whether sleep deprivation is causing his defiant behavior. ‘Anyone who is sleep-deprived finds it difficult to use the thinking parts of their brain; they’re much less attentive,’ says Professor Kohn, and ‘the problems we have with sleep apnea and ADHD do overlap.’ At Seth’s next ‘Learning Links’ session, Dr. Hornery comes face-to-face with the results of a bad night. His behavior is clearly holding back his learning, but instead of more education, Dr. Hornery surprisingly recommends less. The rationale is that for a period of time, Ryan and Emma ‘have a bit of fun’ with Seth, rather than focusing too intensively on extra learning activities.

The experts agree that it is important for parents to have fun with their children and for parents to treat themselves, now and again, to ‘a nice date’. We see Ryan and Emma and Janine and Darrell enjoying a night out at a restaurant; Kathryn and Jade have made the ‘date’ into a family outing, Stuart and Leila skip the date night to work on their parenting. James is still un-medicated, but with a projected retreat set aside for all the families to meet and discuss the program, Leila and Stuart want him on his best behavior; Leila suggests that James be put on Ritalin for the time being.

WEEK NINE: Relapse prevention

‘Change is never real and permanent until something goes wrong and you get through the disaster.’ (Professor Dadds.)

The arranged retreat begins with a group session with all the parents, in which the possibility of relapses in childrens’ behavior are discussed. Professor Dadds begins with the most important question of all at this point in the program:

‘We know that of all the families we see, about one in three are going to go backwards. So one of the things that’s important to think about is: What’s coming in my child’s life that is going to be a critical time and it might go backwards?’

The answers:

Janine and Darrell: ‘Next year; high school for Emily.’

Kathryn and Jade: ‘Sending Corey back to school.’

Leila and Stuart: Medication or no medication? Administering Ritalin to James sent them backwards in treating him.

The next question: What determines if the change lasts?

The answer: The amount of ‘emotionaliness’ in the family; if things escalate, that’s what causes the problems. Once again, the careful parental training of nine weeks needs to be focused upon.

Meanwhile, Dr. Hornery has been working with the children on a surprise presentation. Each child is asked to stand up, one at a time, before everyone and share some of the learning they have achieved over the weeks.

Corey: He proudly displays a toy he has made and talks about ‘calming down and listening’. His interaction with the other children is amiable and good-humored. While school is still considered a bridge too far for him yet, Kathryn has enrolled him in a weekly get-together for home-schooled children. They feel they are now ‘in a new place.’

Seth: He takes the microphone and proudly announces that he is now on ‘Level Ten Reading’. The family intervention program has really helped him. Before intervention, a shopping expedition was a nightmare; now other people have been noticing his pleasant behavior in shops and in the supermarket. Still on the waiting list for his Childrens Hospital sleep study, his behavior has nevertheless been changed - without medication.

Emily: She declares ‘My writing is better; I am writing longer sentences. My twos, tens, nines, elevens tables are getting better. I feel good; school is easier.’ Janine is very moved by her daughter’s newfound self-esteem. She tells us ‘the school is super-happy with her improvement.’

Sam: This little boy proudly declares ‘I can write all my numbers’. His teachers are now saying they can hardly notice any misbehavior. He has recently received a reward for a particular school task. This, says his mother ‘has spoken volumes about how far he has come from where he was.’

James: James recites a poem on the promise of a reward of free ice-cream! The experts still feel that in his case, the whole family still needs further observation and his medication needs regular use; the trouble was that it was only sporadically administered and thus very unsuccessful.

Our documentary is almost over. There’s an evening concert, in which James and the family perform their rehearsed song - a resounding success. The concluding observations belong to Professor Dadds, who reflects:

‘At the moment ADHD is seen pretty much as a medical disorder, treatable by medication, but the National Health and Medical Research Council recommend kids with ADHD be assessed with a medical and psychological approach…’

- and this is precisely what this experimental and complex program of nine weeks has done - and what a difference it has made to all the families.
* Biographies

Professor Mark R. Dadds

Professor Mark Dadds is Principal Research Fellow of the National Health and Medical Research Council of Australia, Professor of Psychology at the University of New South Wales, Sydney Australia, and Foundation Chair of Parenting Sciences at the Institute of Psychiatry, Kings College, London. Since 2005 Professor Dadds has worked closely with Royal Far West Children’s Health Scheme, in particular Dr John Brennan, to establish a collaborative clinical research centre focused on developing state-of-the-art treatments for children and adolescents with behavioral and emotional problems. He has developed and directed several national intervention programs for children, youth and their families, at risk for mental health problems. These programs have been implemented in each state in Australia and in Canada, the USA, Belgium, and Holland. In the last decade he has been awarded over $4,000,000 in research funding for his work in clinical child and family mental health. He has been National President of the Australian Association for Cognitive and Behavioral Therapy, Director of Research for the Abused Child Trust of Queensland, and a recipient of several awards including an Early Career Award from the Division of Scientific Affairs of the Australian Psychological Society and a Violence Prevention Award for the Federal Government via the Institute of Criminology. He has authored four books and over one hundred papers on child and family psychology. In the last few years he has given invited keynote addresses to international conferences in Mexico, Canada, the UK, the USA, Denmark, Hungary, Austria, and Australia, including multiple invitations to the World Congress of Cognitive and Behavioral Therapies. He has won the Australian Psychological Society’s awards for Early Career Research in 1991 and in 2005 the Ian Matthew Campbell Award for excellence in Clinical Psychology.

Professor Michael Kohn:

Associate Professor Michael Kohn is a pediatrician with over twenty years experience in the assessment and management of conditions affecting the health and development of children, adolescents and young adults. Professor Kohn has contributed to a number of major textbooks and written over seventy scientific articles around the assessment and management of ADHD, nutrition (cholesterol) and eating disorders (anorexia, bulimia and obesity).

Dr. Samantha Hornery:

Samantha Hornery is a Manager and Educational Support in School Age Services at Learning Links. Learning Links is a charity which aims to enable children with disabilities and learning support needs and their families and communities, to realize their individual potential. She trained as a primary education teacher originally, but quickly found her niche in the areas of learning support and has spent the rest of her career helping children with learning disabilities learn. Dr. Hornery has a Bachelor of Education (Primary – Sydney University) and Doctor of Philosophy (University of Western Sydney) in effective reading.
interventions for children with learning difficulties. Samantha has worked as a special educator in a variety of schools and private settings working with children with learning disabilities. She is currently undertaking an intervention research project as part of her postgraduate Doctoral degree in the Educational Excellence and Equity (E3) Research Program, Centre for Educational Research, examining the impact of a volunteer-based reading program being implemented in schools across Australia. Throughout her career she has sought to improve the educational outcomes of children with learning disabilities by providing advice, programs and training for families, professionals and most importantly children.

Marc Radomsky – Series Producer/ Director/ Writer

With 18 years in television, Marc Radomsky has made over 200 programs for International and local broadcasters, winning nine awards and receiving numerous nominations. Most recently “Outback Kids” was nominated for Best TV Series in the Inaugural 2012 AACTA awards, “Law & Disorder” won the 2010 Logie award for Most Outstanding Factual Program, and “Tackling Peace” won the 2010 Provincia Di Milano Award at the FICST International Festival in Milan. “Tackling Peace” also received a 2009 AFI nomination for Best Documentary, and an Honorary Mention at the 2009 Gold Panda awards in China.

*The Production Team speak of the making of ‘Kids on Speed’*

‘Kids on Speed?’ blends the best of observational documentary with intelligent social experiment factual TV (Outback Kids meets Jamie’s School Dinners). It also has elements of science as we explore the inside track to a practical evidence-based program through which the workings of the brain, drugs and various treatments and therapies are explained clearly. We don’t shy away from controversy and the series is a tough, entertaining analysis of a society moving towards becoming increasingly medicated, but for the wrong reasons.

This series was always going to be challenging. We were looking for families with kids suspected of having ADHD, but not yet diagnosed or medicated. On top of that, we wanted families to open their homes to having a camera crew follow them for a full nine weeks, as well as commit to attending weekly parent interventions at UNSW, and weekly learning sessions for the kids.

Doing a series on ADHD brought us face to face with the stigma and the controversy, and initially we met skepticism on all fronts. Getting the trust of the kids, their parents and siblings, the experts and the schools was critical to being able to deliver a credible series, conceptualized to record authentic fly on the wall observational material in the family homes, as well as in the weekly interventions run by Professor Dadds and his expert team.

We also decided that our series experts would not be merely observers, but that they would have skin in the game, as we tested their methods in a real life social experiment that challenged them to deliver tangible change with a challenging five kids who had defeated all previous doctors or specialists. With quite desperate families already under considerable pressure, we needed to be able to respond immediately and remain highly flexible to cope with the ever-changing nature of our characters’ journeys over the nine-week intervention. Our duty of care was always front of mind and Series producer and Director Marc Radomsky was on a 24/7 call, with camera crews ready to move or change plans with immediate effect.

But with the four selected families spread out on all points of the greater Sydney compass – from Penrith to Newport, and Liverpool to Ryde, and with UNSW as the central hub - coordinating the shooting schedule for our four small camera crews, and ensuring that families arrived at their appointments on time was a nightmare. Sydney traffic jams and parking shortages took a daily toll. Crews and families could spend 3-4 hours travelling per day.

Working with boisterous, disruptive and hyperactive kids was always interesting. Trying to keep up, or indeed keep the kids in focus, and inside the frame tested our camera skills to the limit. In the first session...
at the uni, young James discretely muted one of the psychologists radio mics – causing our sound recordist to pull his hair out. James at times also decided to pull down the fixed cameras that we had installed at home. Corey’s new kitten decided that our brand new light bag, carefully hidden behind the lounge room couch, was a more comfortable toilet than the kitty litter, and when it came time to wrap, we discovered that a rather smelly present had been left in the bag.

The stories of the kids in our series are some of the most compelling we have ever encountered. As program makers we felt intense obligation to tell these stories candidly, comprehensively and as authentically as possible, doing justice to the enormous trust placed in us by families and experts alike. Based on the access we were able to gain and the trust we were able to build, we knew we were making a unique series with enormous power. One that will hopefully debunk some of the pervading misinformation surrounding ADHD, and open up a frank, long overdue and necessary debate amongst Australians about the ironic lack of services that is curiously curbed.

This program offers all Australians the opportunity to gain a better understanding of how ADHD and associated conditions work and can be treated. We hope that it provokes discussion around the broader social issues surrounding this disorder and to assist audiences to make more informed decisions regarding the use of medication and its alternatives.

*Marc Radomsky sets out his purpose in deciding to make this documentary:*

As a storyteller interested in social and character-driven subjects, ‘Kids on Speed?’ was an exciting and challenging project. I’m inspired by real people battling to overcome the many obstacles imposed upon us all by systematic, political and social machinations. I believe it’s important to see and hear alternative arguments when it comes to the more controversial issues we face as a society.

I also enjoy the challenge of taking what are often deemed “worthy” subjects - worthy because they affect people profoundly and in the telling, usually require flying in the face of established practice of one kind or another - and turning these into television that is engaging, entertaining, confronting and informative. It comes down to how the stories are told, and the relationships and trust that I build with people in order to tell their real stories.

ADHD certainly is an issue worth exploring. It’s one of the most misunderstood and heavily stigmatized disorders facing society today. Proper diagnosis is difficult and expensive and the actual medical cause as yet unknown. Parents and clinicians find themselves under pressure from the community to get “disruptive” kids under control. Often times, a diagnosis of ADHD can be made on the basis of a single appointment without consideration of a number of other conditions that have similar symptoms, and which muddy the waters. Medication is often prescribed in instances where it may not be really appropriate. The controversy surrounding the use of amphetamine based stimulant medications to treat young children with ADHD is well documented, as is the heated and often bitter resultant debate. Calling our series “Kids on Speed?” is a deliberate salvo into this fracas – our point of difference being the question mark making this inflammatory statement a question.

We are neither “pro” nor “anti” medication in our series thesis – we are seeking to uncover and clarify the controversy, and we support our experts in the appropriate use of medication in instances where it is deemed a last resort necessity. This is prescribed only once they have undertaken the detailed and intensive diagnostic process recommended in the latest NHMRC guidelines – a full two-week assessment across the home school and social environments of the child – guidelines which aren’t yet common practice in Australia.

Adding insult to injury, a diagnosis of ADHD - prevalent in about 7% of the population - comes with the withdrawal of additional educational support at school. And nor can families claim a rebate from Medicare for the necessary professional and clinical help their child needs. But a child with a diagnosis of Autism - thankfully prevalent in only 0.5 % of the population - receives all necessary support and subsidy.

This shortsighted approach to ADHD has long standing ramifications. If left untreated ADHD can have extremely poor social outcomes. As a society, we need to look at the resultant costs of not treating ADHD early, and offering kids with the diagnosis and the additional support that they sorely need. And we need to also be very cautious when it comes to the blanket use of stimulant medication to treat ADHD.

From a character driven inside track observational point of view ‘Kids on Speed’ seeks to uncover the various aspects of this heated debate. Through the journeys of our families and the three experts treating them across the nine-week intervention, we join together to confront the controversy and challenge the stigma head on. Hopefully the series goes some way to clearing up a lot of the confusion and misperceptions that so unnecessarily continue to traumatize kids with ADHD and their families.
*Let’s look into some of those sensational headlines:

1

Zombie kids: why more children are on ADHD drugs

The Sydney Morning Herald, October 5, 2013
Amy Corderoy – Health Editor

Both sides agree there are insufficient resources for affected children.

Martin Whitely was surrounded by zombies. A teacher at one of Western Australia’s top private schools, he watched in horror as one by one his previously boisterous boys lost what he describes as their “life spark”.

Whitely was watching a microcosm of a phenomenon being seen across the world: the rise of ADHD diagnosis, and medication.

“They were whacked out,” he says of his 14- and 15-year-old students. “They were really quite compliant, which made classroom management easy, but they weren’t succeeding academically and they didn’t relate to their peers.”

The experience lit a spark in Whitely, who went on to become an ardent campaigner against ADHD medications.

Yet figures revealed by Fairfax show medication use has continued on a slow but steady march. Western Australia briefly reversed, and then greatly slowed. NSW now prescribes at almost double the rate of Victoria.

The ADHD debate in turn has become a microcosm of the broader issues which are plaguing psychiatry: a lack of resources for the most unwell sitting uncomfortably beside fears of a drug-company-driven creep towards medicating behaviours inappropriately.

Child psychiatrist and University of Adelaide professor Jon Jureidini believes that only between zero and 5 per cent of ADHD prescribing in Australia is done properly.

For it to be done thus, drugs must be accompanied by other treatment, parents must have it explained that there is no proof medication will improve the long-term outcomes for children, as well as knowing that the drugs are treating behavioural symptoms, rather than an underlying condition.

“It’s good to set a high bar when you are giving mind- and brain-altering drugs to children,” he says. “The problem is that people think that they can deal with complex behavioural disorders without any training in psychology.”

And there we come to the nub of the problem for people concerned about over-medication. Do you place greater emphasis on social and cultural issues that may be underlying the rise in ADHD - children being forced to spend more time sitting in school, a greater proportion living under the poverty line, parental demands - or focus on the potential biological factors that medication might treat?

Brain imaging studies are pointing to differences in the brains of children with the disorder: slower development, abnormal growth in the regions controlling communication.

Yet it is still diagnosed using behavioural symptoms such as having trouble concentrating, following through on instructions or doing homework and being easily distracted.

A published “pros and cons” list issued by the committee updating the criteria for the Diagnostic and Statistical Manual of Mental Illness, which will allow diagnosis with fewer symptoms, said they were “not empirically derived” and had potential to decrease the accuracy of diagnosis.

And when population studies of ADHD diagnosis have been done, they raise troubling questions. One, of nearly a million Canadian schoolchildren, found boys were 30 per cent more likely to be diagnosed with the condition, and 41 per cent more likely to be medicated, if they were simply the youngest in their school year.

UNSW Psychology Professor Mark Dadds says the trouble is ADHD involves symptoms that can be caused by many things, and interpreted differently by different people.

“Unfortunately what has been happening [in some cases] is parents take their child to a paediatrician and say “we can’t cope” then they go and make sure it’s not a toxicological issue, a head injury or disease and then they say ‘ADHD’ and medicate them,” he said. “And there are also some parents who are manipulating the system a little bit and exaggerating their child’s problems, in conjunction with clinicians.”

New National Health and Medical Research advice, which he helped develop, tries to tackle this by saying ticking boxes is no longer enough: clinicians must take into account a child’s social and cultural circumstances, examine them physically, and ask what their wider needs are.

“Some kids are getting the diagnosis inappropriately but there are also many many children who are suffering problems that aren’t diagnosed,” he says. “It’s hard to believe that of the 5 per cent goes to child and adolescent mental health. And mental health already gets a minuscule share of the pie. It’s incredible, the neglect.”

And that’s the nub for those arguing there is no serious problem with ADHD prescribing: Australia doesn’t have a problem with over-treatment, but
under treatment.

For many public hospital psychiatrists the fears of people like Whitely seem far removed from their reality.

UNSW conjoint professor of child and adolescent psychiatry Florence Levy is scathing of those she sees as attacking the motivations of psychiatrists from the sidelines for political reasons, while not having to make tough decisions.

In a letter published in the current edition of the Australian and New Zealand Journal of Psychiatry, she says: “In truth, the ‘coalface’ problems faced by small numbers of public child psychiatrists are enormous, but I believe over-prescription of medication to be the least of them.”

With only about 277 child and adolescent psychiatric beds in Australia, and around 44,000 state-funded public patients, they see children slipping through the cracks.

Given the number of children with serious psychiatric needs in Australia, you could say that Victoria’s low rates of medication use means they are under-prescribing, Levy says.

But even Levy admits that the decision to medicate can be subjective, with Victoria more heavily influenced by the psychoanalytic tradition while NSW is more biologically focused.

She sees the answer in doing more fine-grained research, and is currently attempting to get funding for a project examining which children are likely to develop that zombie-like response to medication that so disturbed Martin Whitely.

But in the end she says medication may be the best option and should not be shut down by political considerations.

And from the United States, we have:

A Nation of Kids on Speed
Six million children in the U.S. have already been diagnosed with ADHD. Plenty more will follow.

By PIETER COHEN AND NICOLAS RASMUSSEN

Walk into any American high school and nearly one in five boys in the hallways will have a diagnosis of attention-deficit hyperactivity disorder. According to the Centers of Disease Control and Prevention, 11% of all American children ages 4 to 17—over six million—have ADHD, a 16% increase since 2007. When you consider that in Britain roughly 3% of children have been similarly diagnosed, the figure is even more startling. Now comes worse news: In the U.S., being told that you have ADHD—and thus receiving some variety of amphetamine to treat it—has become more likely.

Last month, the American Psychiatric Association released the fifth edition of its Diagnostic and Statistical Manual of Mental Disorders—the bible of mental health—and this latest version, known as DSM-5, outlines a new diagnostic paradigm for attention-deficit hyperactivity disorder. Symptoms of ADHD remain the same in the new edition: “overlooks details,” “has difficulty remaining focused during lengthy reading,” “often fidgets with or taps hands” and so on. The difference is that in the previous version of the manual, the first symptoms of ADHD needed to be evident by age 7 for a diagnosis to be made. In DSM-5, if the symptoms turn up anytime before age 12, the ADHD diagnosis can be made.

It’s also easier to diagnose adult ADHD. Before, adults needed to exhibit six symptoms. Now, five will do. These changes will undoubtedly fuel increased prescriptions of the drugs that doctors use to treat ADHD: stimulants such as Ritalin and Adderall.

Even before DSM-5, doctors were already on track to prescribe enough stimulants this year for each American man, woman and child to receive the equivalent of 130 mg of amphetamine (about 40 five-mg pills of Adderall) and an even greater amount of the very similar drug Ritalin. In this era of excessive prescribing, we seem to have forgotten the cautionary history of amphetamines in America—a history that shows how overprescribing stimulants leads to widespread dependence and addiction.

Since their introduction by the pharmaceutical company Smith, Kline & French in 1937, amphetamines have been prescribed for maladies that had more to do with societal expectations than genuine mental illness. American soldiers received stimulants during World War II to boost morale and improve performance in combat.

Meantime, back at home, amphetamine was heralded as the first antidepressant, and shortly thereafter, as an ideal weight-loss pill. One 1955 advertisement for AmPlus amphetamine tablets assured users that they would be “beachable by summer.” Decades would pass until research demonstrated the lack of long-term benefit for most cases of depression and weight loss, but the lack of proof didn’t hold doctors back from liberally prescribing stimulants to millions of housewives in postwar suburbs.

By 1969, doctors were prescribing the equivalent of 120 mg of amphetamine for each American—a high-water mark of per-capita consumption we are only now about to surpass. By then, the addictive potential of prescription stimulants had attracted intense scientific and public scrutiny as evidence grew that many patients were becoming dependent on the
drugs. Thirty percent of patients in one study conducted in New York state admitted to using their medications recreationally. Millions of people without prescriptions easily obtained diverted pills.

In 1968, the National Academy of Sciences organized an authoritative investigation into the stimulants’ true benefits and risks. The consensus: These drugs had limited efficacy and real harms. Medical experts discouraged the use of stimulants for both depression and obesity, but the warnings had little effect on doctors’ prescribing habits until the Controlled Substances Act of 1971 mandated that stimulants be placed in a tightly controlled category of medications, referred to as Schedule II.

Doctors were free to prescribe the drugs but had to report each prescription. Almost overnight, prescriptions for stimulants to treat depression and obesity plummeted: Medical use dropped 90% between 1969 and 1972.

Just when it seemed that amphetamine’s days were numbered, doctors began to embrace the drug for treating Hyperkinetic Reaction of Childhood—what we now call ADHD. (It became the official name in 1987.) Concern about dependence and addiction, along with the watchful eye of the U.S. Drug Enforcement Administration, kept prescriptions for ADHD at low levels during the 1970s.

But by the 1990s, experts and advocacy groups for ADHD, some funded by pharmaceutical companies, began to argue that stimulants did not lead to addiction when treating children for the disorder, and that the stimulants actually decreased the risk of future drug abuse. Their main argument was that ADHD itself is a significant risk factor for future substance abuse, and that stimulants, by treating the underlying illness, also reduced the likelihood of future drug use. Concerned parents were told that starting their children on stimulants when young would decrease the risks of future trouble with alcohol and drugs.

The problem with this reassuring message is that it was based on flimsy evidence. Experts had relied on studies of children treated with stimulants by their personal physicians, compared with children who had ADHD but did not receive stimulants. These community studies were fraught with confounding variables and were only suggestive.

Three months ago, the only randomized trial to study future substance abuse by ADHD kids refuted the notion that stimulants, when taken in childhood, have a protective effect. Investigators found strong evidence that ADHD itself in fact predisposes children to later substance abuse—but no evidence that stimulant medication reduces this rate any better than treating ADHD with behavioral approaches. Further evidence that stimulants do not protect children from addiction was provided in a comprehensive review published last month in JAMA Psychiatry.

We still do not have a single randomized trial to help determine if starting stimulants as an adolescent or adult further increases the risk of future substance abuse, although the long and checkered history of medical stimulants would suggest it does. Certainly, the risks from recreationally using stimulants are already well-documented.

In 2010, Adderall was second only in popularity to the painkiller Vicodin as a prescription drug of abuse among high-school seniors, according to the National Institute on Drug Abuse. Adolescents often perceive prescription drugs as safer than illicit ones, but abusing prescription amphetamines can lead to seizures, psychosis and life-threatening heart disease.

Stimulants can certainly benefit some young children with truly disabling ADHD. However, history has already taught us that overprescribing stimulants to millions of Americans leads to dependence, addiction and overdose. By medicating children for wiggling in their chairs, losing their homework and shouting out answers, we are not teaching them vital coping skills to manage their behavior. Instead, we are teaching them to take a pill. One day, we’ll look back and wonder: Why did we do this? Again.

Dr. Cohen is an assistant professor of medicine at Harvard Medical School. Dr. Rasmussen is a professor of the history of science at the University of New South Wales in Sydney, Australia, and the author of “On Speed: The Many Lives of Amphetamine” (New York University, 2009).

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The following article from the Internet site ‘Healthy Living’ also examines this situation:

Myths, Misconceptions, and Stigma Tied to ADHD

ADHD is a true medical disability

Attention deficit hyperactivity disorder (ADHD) requires a clinical diagnosis: A doctor makes the call based on your self-reported symptoms and medical history. Because there is no blood test or X-ray that gives solid proof of its existence, some people may have a hard time believing that ADHD is a real disorder, or that there is a medical cause for many of the disorder’s symptoms.

Children with ADHD have been called troublemakers and spoiled brats, and undiagnosed adults may go through life labeled lazy or dumb. Skeptics may think, “Doesn’t everyone lack focus sometimes? You just have to push through it.” But in reality, it’s not that easy for ADHD patients, says Adelaide Robb, MD, an associate professor of psychiatry and behavioral sciences at the George Washington
There is no such medical condition as ADHD.

ADHD is a medical disorder, not a condition of the child’s will. A child with ADHD does not choose to misbehave.

ADHD is caused by bad parenting. All the child needs is good discipline.

ADHD is not caused by bad parenting. But parenting techniques can often improve some symptoms and make others worse.

ADHD is a life sentence.

Although ADHD symptoms usually continue into adulthood, the person learns ways to cope with the symptoms. People with ADHD have plenty of energy, are creative, and can often accomplish more than people who do not have the condition.

Having ADHD means the person is lazy or dumb.

ADHD has nothing to do with a person’s intellectual ability. Some highly intelligent people have ADHD.

The diagnosis of ADHD is confirmed if certain medicines (psychostimulants) have a positive effect on what seem to be symptoms of ADHD.

Children without ADHD respond to psychostimulants similarly to children with ADHD. A trial of medicine is not used to diagnose the condition.

Medicine for ADHD will make a person seem drugged.

Properly adjusted medicine for ADHD sharpens a person’s focus and increases his or her ability to control behavior.

Medicine prescriptions for ADHD have greatly increased in the past few years because the condition is being overdiagnosed.

ADHD is estimated to affect about 3 percent to 7 percent of all school-age children in the United States. There is little evidence to support claims that ADHD is overdiagnosed and that ADHD medicines are overprescribed.

Psychostimulants are no longer useful after puberty.

Teens and adults with ADHD continue to benefit from medicine treatment.

Children with ADHD are learning to use the condition as an excuse for their behavior.

ADHD is a disability. Children with ADHD have to learn ways to deal with their symptoms (inattention, impulsivity, and hyperactivity) that cause them to have difficulties in life.

Children outgrow ADHD.

About 70 percent of children with ADHD continue to have symptoms during their teen years and about 50 percent have symptoms into adulthood.

If a child has ADHD, he or she can always be diagnosed in the doctor’s office.

A child may not always show symptoms of ADHD, especially in an unfamiliar setting. Evaluating a child from one office observation may result in failure to recognize or diagnose symptoms.

University School of Medicine and Health Sciences. “People who really have this condition don’t just hate doing their paperwork. They consistently get in trouble at work because they don’t do it; they just can’t do it,” she says. “It’s very frustrating to them because they know exactly what they want to do but they can’t convey that information, no matter how hard they try.”

The chart on this page, can help you sort the truth from fiction. And if you feel that negative stereotypes about ADHD are affecting your self-esteem or relationships with other people, talk to your doctor about ways to manage these feelings.

Here is Professor Michael Kohn, quoted in The Medical Observer, discussing the role of a number of health professionals in assessing and diagnosing potential ADHD, among other childhood problems:

Time to pay attention

The Medical Observer, 24th Oct 2012 by Joanne Findley

Our understanding of ADHD and how to respond to it is becoming clearer and clearer, writes Joanne Finlay.

It’s our most common neurobiological disease, with some 11% of Australian children aged 6–17 years diagnosed
with attention deficit hyperactivity disorder (ADHD).

In today’s technology-dependent world, where the web, mobile phones and electronic games constantly demand youngsters’ attention, the ability to focus is an increasingly valuable skill. Young people are expected to maintain attention across tasks, and at the same time they are under pressure to perform.

“This combination is leading them to be more symptomatic of attentional and organisational difficulties – more kids are being labelled ADHD,” says Associate Professor Michael Kohn, paediatrician, medical researcher and a member of the expert working group that developed new clinical practice points (CPPs) for ADHD, released by the NHMRC last month.

Professor Kohn sees the CPPs – which provide guidelines for the diagnosis, assessment and management of children and adolescents who exhibit behaviour symptomatic of ADHD – as a breakthrough in the primary care of ADHD.

“GPs can now be the gatekeeper – not just the conduit – for whatever intervention or treatment is being requested by families or schools,” he says.

“The CPPs clearly define where the line is drawn, providing answers to questions like: How do you do an assessment? How do you formulate treatment? And if medication is used, what will be the first line of management?”

It’s an exciting time to be treating ADHD as our understanding of the disorder and how to respond to it becomes clearer, says US medical researcher Dr Philip Shaw, an Earl Stadtman Investigator with the National Human Genome Research Institute, who spoke recently at the Neuroscience Research Australia institute in Sydney.

He says ADHD is the most heritable of all childhood illnesses. A study of 200 twins showed 80% inheritance.

“But while it is largely genetic, it is also a brain development disorder,” he says.

Recent research by Dr Shaw and Canadian colleagues, based on magnetic resonance imaging (MRI) of cortical thickness of children at different ages, indicates ADHD can be viewed as a disruption in typical neurological development.

“There is now a good body of evidence that ADHD is a brain disorder and that the most affected areas are the prefrontal cortex, basal ganglia and cerebellum.”

When cortical maturation of children with ADHD at ages five and 12 was compared with that of normal children, their brains were found to mature more slowly.

“By age 12, there are very obvious differences,” Dr Shaw says. “The higher attention problem scans were associated with slower cortical thickening.”

Whether this can be corrected by the use of psycho-stimulants has recently been the subject of study by the US National Institutes of Health, where research analysed their impact on neuroanatomical development.

Emphasising caution in drawing conclusions about the impact of psycho-stimulants on the developing cortex, Dr Shaw says there is some evidence that the outcome in terms of development of the cortex structure for children who took stimulants was the same as for normal children.

“Psycho-stimulants remain the treatment of choice for kids with ADHD – there are good studies which estimate the risk-benefit ratio is very much in favour of taking them,” he says.

“But stimulants aren’t the whole answer. If a kid with ADHD has lots of other problems, then that requires a complex approach involving lots of different treatments.”

GPs have an important role in the diagnostic phase. It’s vital to ensure enough adults are consulted from different settings, and that there is feedback from teachers and peers.

“They need to remember that there is a broad range of possible explanations for symptoms of ADHD, such as anxiety or learning difficulties,” says
Professor Kohn.

While the new research from the US relies on the use of MRI scans and recognises ADHD as a brain development disorder, both Dr Shaw and Professor Kohn believe brain imaging using either MRI or quantitative electroencephalography (qEEG) has no place as a diagnostic tool.

“It might be used one day, but that day is years away,” says Dr Shaw.

Professor Kohn’s view is that “brain scans in clinical practice remain more a commercial tool”.

“They address parents’ needs for something visible as an explanation rather than providing a reliable basis for diagnosis or treatment,” he says.

Research done last decade at Westmead’s Brain Dynamics Centre in Sydney, with the help of an Australian Research Council grant, tested hundreds of children with ADHD and did detailed statistical analyses comparing clinicians’ ratings. Professor Kohn was a member of the Westmead team.

“The outcome recognises the heterogeneity in kids with ADHD symptoms. We were able to accurately and objectively identify markers which could be used to subdivide children and adolescents who were labelled with ADHD.

“This approach identified objective and reliable means to improve the accuracy and consistency of diagnosis and enabled personalised approaches to treatment,” he says.

The team developed a new integrated neurological assessment tool, WebNeuro, that examines markers relevant to ADHD (sustained attention, impulsivity, intrusions, inhibition and response variability) and indicators for associated conditions.

WebNeuro includes, for instance, a facial recognition test.

“One of the conditions that also presents with attentional difficulties is autism. The facial recognition test is most helpful in identifying those with autism: the kids in the autistic spectrum just can’t get it,” Professor Kohn says.

What this and other research clearly shows is that, before clinicians reach an ADHD diagnosis, they need to consider symptoms carefully and exclude any other better explanation for the presenting difficulties.

Dr Shaw says it’s important that GPs show compassion towards the children and their parents.

“Recognise ADHD is largely genetic, that the symptoms are real and that we know how to diagnose it,” he says. “Diagnosis is very reliable; we know that it is an impairment and that there are kids who are really struggling.

“We also know that once you identify the symptoms, there are really good treatments.”

“Excerpts from Clinical Practice Points on the Diagnosis, Assessment and Management of ADHD in Children and Adolescents; NHMRC, 3 Sept 2012 ADHD and anxiety Associate Professor Michael Kohn’s research focuses on the subgroup of young people diagnosed with ADHD who also have anxiety.

“This is a really important area because there are some young people who are being prescribed stimulants like Ritalin when their most significant problem is anxiety,” he says.

“Though stimulants may improve attention, they can make anxiety symptoms worse and exacerbate the underlying difficulties.”

The so-called ACTION study, a multicentre national study that investigated the use of a non-stimulant drug (atomoxetine), confirmed that this drug – originally designed to treat mood symptoms – was effective in modifying core ADHD symptoms on the ADHD rating scale (Connors ADHD-RS), as well as decreasing anxiety symptoms.

“There is a sub-group of ADHD patients who are diagnosed with both ADHD and anxiety. Why that’s important is that anxiety is not normally measured when ADHD is assessed. In our study 30% of ADHD children and adolescents had co-morbid anxiety,” says Professor Kohn.

“The important thing is that anxiety may not best be treated with a stimulant medication.”
Curriculum relevance

‘Kids on Speed’ is primarily a text most suited to students of VCE Psychology, but it may also function as an effective supplementary text in VCE subjects such as:

- the VCE English Context ‘Encountering Conflict’ and
- VCE Media Studies.

*VCE Psychology units 1, 2, 3 & 4*

Broadly, the VCE Psychology Study Design sets out in its Rationale, the Aims of this study, which are to enable students to:

- ‘understand the historical development of psychology and the contemporary status of psychology as a field of study;
- understand the ways that biological, behavioural, cognitive and socio-cultural perspectives are used to organise, analyse and extend knowledge in psychology;
- understand, compare and evaluate psychological theories and concepts;
- communicate psychological information, ideas and research findings;
- understand the application of psychology in personal, social and organisational contexts;
- critically examine psychological challenges that arise in their own environment and across their own lifespan, particularly in relation to personal development, good health, mental wellbeing, social interaction, communication and lifelong learning;
- develop an inquiring and critical approach to alternative opinions and explanations;
- develop the ability to use evidence to justify beliefs;
- develop skills in scientific inquiry and investigation;
- understand and apply ethical principles that govern the study and practice of psychology.’

‘Kids on Speed?’ therefore addresses a number of the above course aims.

Further, the Key Skills across Units 1-3 (see Study Design PDF) would indicate that this documentary is an appropriate tool for:

‘evaluating the validity and reliability of research investigations including potential confounding variables and sources of error and bias’;

and

‘using research literature to demonstrate how psychological concepts and theories have developed over time;

- process and interpret information, and make connections between psychological concepts and theories;
- apply understandings to both familiar and new contexts;
- evaluate the validity and reliability of psychology-related information and opinions presented in the public domain;
- analyse issues relating to and implications of scientific and technological developments relevant to psychology.’

UNIT 1: Introduction to Psychology

Areas of Study 1 & 2 - Key Knowledge

Most specifically, students are introduced to the scope of psychology – its specialised fields of study and its application in a variety of contexts and settings. Students investigate aspects of visual perception to consider how psychologists approach the study of the mind and human behavior.

These Areas of Study focus on:

- ‘changes in the interaction between biological, cognitive and socio-cultural influences and learned behaviours that contribute to an individual’s psychological development and mental wellbeing at different stages;
- Students consider how classic and contemporary studies contribute to our understanding of changes that take place across an individual’s lifespan. They draw upon one of these theories to research one lifespan stage.
- They use the major perspectives in contemporary psychology to explain cognition and behaviours associated with particular stages of development, taking into account heredity and environmental influences from biological, behavioural, cognitive and socio-cultural perspectives.’

UNIT 2: Self and Others

‘Kids on Speed?’ most specifically addresses areas of research relating to:

‘techniques of qualitative and quantitative data collection: observational studies; self-reports; surveys; questionnaires; interviews.’

- and social psychology.

Area of Study One: Interpersonal and group behaviour.

‘Understanding the interplay of factors that shape the behaviour of individuals and groups can help explain the cause and dynamics of prejudice, stereotyping and discrimination, and can contribute to changes in attitudes and behaviour.’

Students:

- ‘consider the findings of key classic and contemporary research as a means to explaining the formation of attitudes, and individual and group behaviour. They examine research methods appropriate to measuring attitudes and behaviours and consider associated ethical issues in the conduct and use of such research.’ ‘Kids on Speed?’ may be a suitable learning tool for evaluating and understanding familial dynamics in determining therapies/treatments for childhood behavioral disorders such as ADHD and ODD.
UNIT 3: The conscious self.

The Study Design informs us that this Unit focuses on:

- ‘the study of the relationship between the brain and the mind through examining the basis of consciousness, behaviour, cognition and memory.

Advances in brain research methods have opened new ways to understanding the relationship between mind, brain and behaviour. Students study the structure and functioning of the human brain and nervous system, and explore the nature of consciousness and altered states of consciousness including sleep.

The brain continually receives and processes vast amounts of information from its internal and external environment. Memory involves the selective retention and retrieval of this information and it plays an important role in determining behaviour. Students consider the function of the nervous system in memory and investigate the ways in which information is processed, stored and utilised. They apply different theories of memory and forgetting to their everyday learning experiences.

Students analyse research methodologies associated with classic and contemporary theories, studies and models, consider ethical issues associated with the conduct of research and the use of findings, and apply appropriate research methods when undertaking their own investigations. ‘Kids on Speed?’ provides a series of case studies in which brain function is altered by both medication and physical strategies to address poor behaviour and learning outcomes.

UNIT FOUR: Brain, behavior and Experience.

Once more, this documentary applies to certain aspects of this Unit, which focuses on:

- ‘the interrelationship between learning, the brain and its response to experiences, and behaviour: The overall quality of functioning of the brain depends on experience, and its plasticity means that different kinds of experience change and configure the brain in different ways. Students investigate learning as a mental process that leads to the acquisition of knowledge, development of new capacities and changed behaviours. Understanding the mechanisms of learning, the cognitive processes that affect readiness for learning, and how people learn informs both personal and social issues.

Students build on their conceptual understanding of learning to consider it as one of several important facets involved in a biopsychosocial approach to the analysis of mental health and illness.’

Area of Study 1: Learning

‘This area of study explores the characteristics of learning as a process that plays a part in determining behaviour. Students study the neural basis of learning, and examine different types of learning: classical conditioning, operant conditioning, observational learning and trial-and-error learning. Behaviour not dependent on learning is also explored. As students analyse and evaluate the contribution that classic and contemporary studies have made to this field of study, they consider the techniques used to gather data and the associated ethical implications. Students apply appropriate methods of psychological research and ethical principles when undertaking their own research investigations.’

Links to the National curriculum for Psychology

Currently, VCE Psychology is not part of the National Curriculum framework.

VCE English/ EAL contexts: ‘Conflict’/ ‘Encountering Conflict’

Year 11 English Contexts often paraphrase or utilize those proscribed for Year 12. For example, Units 1&2 Contexts such as ‘Conflict’ have a strong connection to the ‘Encountering Conflict’ Context in Year 12 VCE English.

Whilst the various articles and study guides inform us that ‘Conflict is a natural element in the world and although we may not notice each and every single time it presents itself, conflict is a part of our everyday lives’, ‘Kids on Speed?’ is a text that functions most appropriately upon inter-personal conflict issues.

The five children who are the subject of Professor Dadds’ trial program have already experienced a variety of conflicts:

- conflict in the school environment over anti-social behaviour and poor learning skills;
- conflict over relationships with parents and siblings in the home.

The parents, too, have had their share of conflicts:

- to prescribe or not to prescribe medication for behavioral difficulties;
- how best to deal with violent, emotionally explosive, potentially dangerous behavior within the family.

So how has conflict with their children shaped the lives of the four families we see?

We observe how children with a variety of behavioral problems are anti-social, potentially violent, have poor learning abilities and outcomes, drive the family group into emotional stress and leave parents distraught and at a loss as to how to solve these problems.

And are these conflicts ultimately resolved?

A controversial question. It appears that the nine-week trial intervention program has achieved much for the four families, but with all such trials, the long-term efficacy of such program depend on a variety of variables.
The Australian National Curriculum states, for the study of English, the following Aims:

‘to develop students’ knowledge of language and literature and to consolidate and expand their literacy skills. More specifically it aims to support students to:

- understand how Standard Australian English works in its spoken and written forms and in combination with other non-linguistic forms of communication
- learn Standard Australian English to help sustain and advance social cohesion in our linguistically and culturally complex country;
- respect the varieties of English and their influence on Standard Australian English
- appreciate and enjoy language and develop a sense of its richness and its power to evoke feelings, form and convey ideas, persuade, entertain and argue
- understand, interpret, reflect on and create an increasingly broad repertoire of spoken, written and multimodal texts across a growing range of settings
- access a broad range of literary texts and develop an informed appreciation of literature;
- master the written and spoken language, forms of schooling and knowledge;
- develop English skills for lifelong enjoyment and learning.’

‘Kids on Speed?’ addresses all the above aims. Furthermore, Section 4.4 of the ACARA document ‘Shape of the Australian Curriculum: English’ refers to the broad use of the term ‘texts’:

‘Texts provide the means for communication. Their forms and conventions have developed to help us communicate effectively with a variety of audiences for a range of purposes. Texts can be written, spoken or multimodal and in print or digital/online forms. Multimodal texts combine language with other systems for communicating such as print text, visual images, soundtrack and spoken word as in film or computer presentation media. Texts provide opportunities for important learning about aspects of human experience and about aesthetic value. Many of the tasks that students undertake in and out of school involve literary texts, information texts, media texts, everyday texts and workplace texts.’

Further, the National Curriculum framework speaks of ‘Strands’ of Learning, and for the purposes of studying this documentary, Section 5.3 informs us that ‘Literature’ is a broad-based term that encompasses the following:

‘Students’ engagement with and study of literary texts of personal, cultural, social and aesthetic value. A significant feature of this strand is the attention it pays to texts that are judged to have potential for enriching students’ lives and expanding the scope of their experience.’

* VCE Media Studies Unit 1

‘Kids on Speed?’ functions most appropriately, according to the VCE Study Design for this subject, for Unit 1 most specifically, as the following references indicate:

UNIT 1: Representation and technologies of representation

‘In this unit students develop an understanding of the relationship between the media, technology and the representations present in media forms. They study the relationships between media technologies, audiences and society. Students develop practical and analytical skills, including an understanding of the contribution of codes and conventions to the creation of meaning in media products, the role and significance of selection processes in their construction, the role audiences play in constructing meaning from media representations, and the creative and cultural impact of new media technologies.’

Area of study 1 – Representation

‘This area of study focuses on an analysis of media representations and how such representations depict, for example, events, people, places, organisations and ideas.

Students learn that media texts are created through a process of selection, construction and representation.

Representations of events, ideas and stories, which may appear natural and realistic, are mediated and constructed in ways that are different from the audience’s direct experience of reality. Students develop an understanding of how media representations are subject to multiple readings by audiences who construct meaning based on a range of personal, contextual, social and institutional factors.

Representation involves the selection of images, words, sounds and ideas and the ways in which these are presented, related and ordered. Media codes and conventions, together with such factors as degrees of intended realism, the cultural and historical context of the production and institutional practices, help shape a product’s structure and meaning. Media products are approached in terms of how they are constructed for different purposes, their distribution and the ways audiences may read representations within them.’

Key Knowledge in this subject, focuses on:

- media representation and its relationship to the selection and construction of reality in various media forms
- the nature of codes and conventions evident in media productions, and the meanings they create
- the nature and role of audiences in reading media representations
• notions of ‘realism’ in media texts
• representations within the context of values such as those related to
gender, age, ethnicity, culture and socioeconomic status
• the influence of institutional and social practices on the nature of representations, and their
availability and accessibility
• representations within the context of media history and culture, including the emergence and
development of stereotypes, styles and generic conventions within media.'

Endnotes

3. Additional biographical material on Professor Mark. R. Dadds: http://www.zoominfo.com/s/#!search/profile/person?personId=14099889&targetId=profile
4. Additional biographical material for Dr. Samantha Hornery: http://www.samanthahornery.com/about-samantha/