THE WINSTON CHURCHILL MEMORIAL TRUST OF AUSTRALIA

Intervention Programs for Children with Attention Deficit/Hyperactivity Disorder and/or Prevention of Antisocial/Delinquent Behaviour

Report by

Linda Houston
2001 Churchill Fellow

Conducted in USA

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INTRODUCTION

This research project took place from January 17th till March 6th, 2001. It involved the study and observation of a number of schools, programs and research centres throughout the United States that were targeting young people with ADHD and/or antisocial/delinquent behaviour.

I would like to acknowledge the following people;

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And to others too numerous to mention who left me with many thoughts and challenges to bring back to Australia. Many thanks to Jamila, Tom, Jean, Deborah, Jeannie and all the other wonderful people I met.

A very special thanks to Edmund Rice Educational Services for their support and encouragement and without whom this trip would not have been possible.
I would also like to thank the Winston Churchill Memorial Trust for giving me the opportunity to enrichen both my personal and professional life from this wonderful experience. I hope that my passion becomes a driving force for the betterment of Australian children.

EXECUTIVE SUMMARY

The study took place in a variety of sites in the United States during a seven-week visit from January till early March, 2001. The aims of the study were to;

> *.....enable me to observe and modify for the Queensland and Australian setting, exemplary programs/projects that are providing quality outcomes with a 'preventative intervention' focus for children with ADHD (Attention Deficit Hyperactivity Disorder). The study will focus on best practice in working with parents, teachers and students with ADHD with particular attention to children who are most at risk of developing antisocial/delinquent behaviours.*

Initially seven programs/centres were chosen based on research indicating their alignment with the aims of the research. However, once I began the study I found the people I met were very open and willing to support my research by introducing me to further programs that would enhance my findings. Consequently a number of further programs/centres were visited and provided a richer insight into the wonderful work being done in the States for this population of young people (those in italics represent unplanned site visits).

The vast amount of research in this area was too difficult to collate and thus I have attempted to draw on that research that I found to have the most implications for the Australian school settings. The following report will provide a background to the project followed by implications and recommendations for the Australian setting. The final section will give readers an outline of the individual programs visited together with some of my initial thoughts and reactions to them.

- **Child Development Center (School/clinic program)**
  Irvine, CALIFORNIA

- **Social Work Prevention Research Center. Raising Healthy Children project.**
  ***Incredible Years program*.**
  Seattle, WASHINGTON

- **Oregon Social Learning Center- Linking the Interests of Families and Teachers,**
  ***Treatment Foster Care Program* and Adolescents Transition Program.**
  Institute on Violence and Destructive Behavior- First Step to Success.
  Eugene, OREGON

- **International Learning Disabilities Conference.**
  Churchill School and Center.
  Project Reach Youth.
  New York City, NEW YORK

- **Riverview School**.
  Cape Cod, MASSACHUSETTS

- **Catalytic Coaching, ADD Centre of the Family Therapy Institute of Alexandria**.
  Washington, DC

- **Success Oriented Achievement Realized (S.O.A.R.)**
  Haywood County School,
  Pursuit Program and Operation Aspire.
  Balsam/Waynesville, NORTH CAROLINA

Contact details;

Linda Houston
31 Kilby St.
Crestmead
Qld. 4132
(07) 38036417
linkob@iprimus.com.au

Special Education teacher at
Centre Education Programme
108 Mudgee St.
Kingston
Qld. 4114
(07) 38086800
Fax (07) 38086268
centred@lrv.net.au

Postal address; P.O. Box 4
Woodridge
Qld. 4114

A PERSONAL BRIEF

The beginnings of this project have a long history and begin with the birth of my first son. As a young teenage single mother, he was the most important thing in my life and for many years I marveled in the joy that each day could bring. Without a benchmark for 'normal' I cherished the challenges he presented and thought they were part of this wonderful experience called motherhood. And then he started school.....

From the first day of school it became apparent that Adam (to protect his privacy) did not quite fit into what was considered 'normal'. For the next ten years I experienced a vast array of emotions such as anger, frustration, guilt and pure heartache as I watched my child lose his spirit as he struggled to belong to an environment that did not value his 'difference'. At 15 he was diagnosed with Attention Deficit Disorder (without hyperactivity) and I held out the hope that finally I would find some research and literature that would assist me to help Adam in preserving some sense of self-worth. This was not to be. Instead I was to become an advocate for my son, and the many other children who suffered from this disorder, as I tried in vain to persuade professionals that special consideration and individual treatment were necessary. Throughout these years the pain that Adam suffered had begun to take a huge toll on him and one that to this day he has not managed to overcome or come to terms with.

As an adult with ADD, his life is far from perfect; in fact it is still far from 'normal'. He constantly attempts to escape his feelings of failure without much success. His future is bleak and I still walk with him, although sometimes needing to close the door, as he struggles to live with the debilitating effects of a simple (and treatable) neurological disorder.

My journey, which began with him, was to take a more determined path as I set out to 'right the wrongs' of a system that had let him down. I completed a Bachelor of Special Education as a mature aged student specialising in Learning Difficulties in the hope that I could bring to other parents and children the very help that I had sought for Adam and I for so many years. After finishing the degree I began my teaching career at an unusual setting called Centre Education Programme, an alternative school for young people who, for a variety of reasons, had been excluded or denied access to mainstream education. Not surprisingly, a large number (30-40%) had ADHD. Here were the children with 'broken spirits' who personified Adam and I set out (in all my enthusiasm as a new teacher) to use all my skills and knowledge to try and give them hope and dreams.

With three years of teaching (and a lifetime of being a 'teacher') behind me, there have been many rewards. To many the young people I work with are often viewed with 'fear' by society, as they are the troubled youth of today, the rebels and antagonists. However, they have a lot to offer society in terms of their candid honesty, their creativity, their intense loyalty, their sense of justice, their absolute 'realness', and their own personal

gifts. I have achieved great personal satisfaction from working with these special young people and from learning from them about such things as 'honesty' and 'realness'. I am constantly challenged to see the world through their eyes and driven to challenge the world to see and value them.

Despite the rewards I have had a growing awareness that more could (and should) be done for these young people. At the end of the day they were still experiencing more negative than positive outcomes, our interventions were merely reactions to the challenges and issues they were presenting. I believed and had hope that there were more systematic, effective ways of providing these young people with the skills they would need to become independent, valued members of society.

BACKGROUND TO THE PROJECT

During the early stages of planning this study project, my research was focused on children with ADHD and programs that catered for them. When looking at the research it became clear to me that prevention programs that focused on 'antisocial behaviours' would have valid application in any program that catered for children with ADHD. What follows are my initial research findings that assisted me in developing the study and refining the study topic.

ADHD is one of the 'Disruptive Behaviour Disorders' referred to in DSMIIIR, as a set of 'externalised' behaviour disorders. These include Attention Deficit Hyperactivity Disorder, Attention Deficit Disorder (both defined in this report as ADHD), Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD).

In a comprehensive review of the literature on these disorders in 1992, Stephen Hinshaw found that;

- an extensive cormobidity existed between ADHD and ODD/CD (p. 894)
- peer rejection was high amongst children with ADHD and led to a multitude of negative social and academic outcomes
- high incidences of low self-esteem in children with ADHD often led to depression (external behaviour internalised)
- there were high incidences of school failure and delinquency in adolescents with ADHD.

A later study conducted by the Appalachian Educational Laboratory (1996) supported Hinshaw's finding that "children with (inadequately treated) ADHD (and LD) are at risk of developing antisocial behaviours including ODD, CD and delinquency"(Hinshaw, 1992). They also found that children with ADHD experienced high risks of expulsion from schools. Some alarming statistics that came out of the study were;

- 50-70% of children with ADHD develop ODD
- 20-40% develop the more serious CD
- 20-30% develop anxiety disorders
- 75% develop depression
- 23-45% have juvenile convictions
- 70% of juvenile offenders and 40% of adult prisoners have ADHD despite only 3-7% of the population supposedly suffering from the disorder.

The AEL concluded that the relationship between ADHD and antisocial behaviour was so strong that some considered ADHD to be a predisposing factor.

Given the strong support for viewing ADHD as a medical/neurological condition, it appeared that much of the work in this area was occurring in medical or clinical settings. However, the behaviours presented in the classroom and home settings were similar to those of children with antisocial/delinquent behaviour and thus it seemed a viable option to look at programs that were addressing this cohort of children. Many research centers in the USA were conducting research in the area of 'preventative interventions' for

'antisocial/delinquent' behaviour which, given the research findings, would encompass children with ADHD.

It has been my experience in Australian school settings that intervention for children with ADHD occurs when the young people develop behavioural problems that are too difficult to ignore and/or learning problems, both secondary to their initial diagnosis/disorder. It was my contention when considering this project that the cost involved in 'reacting' to the outcomes of this approach (i.e. learning difficulties, antisocial behaviour, juvenile delinquency, school dropout or exclusion, violence and crime) were huge and much would be gained from adopting a more 'proactive' approach such as 'preventative intervention'. Whilst acknowledging that given the neurological basis for ADHD, prevention was not a valid objective, I believed that prevention of the outcomes found in the research (Hinshaw, 1992; AEL, 1996) was possible.

Consequently, my initial purpose of researching programs for young people with ADHD was expanded to include the prevention of antisocial/delinquent behaviour. I believed that the findings would be richer in terms of intervention strategies being used and the value of the information would have more far-reaching interest for Australian educators (as well as my own particular place of work).

DISCUSSION

On a global scale it appears that the incidence of behaviour problems in children is escalating at an enormous rate. Studies in the U.S. indicate that anywhere from 7-20% of children meet the diagnostic criteria for Oppositional Defiant Disorder (ODD) or Conduct Disorder (CD) and that these rates may be as high as 35% for low-income families (Webster-Statton & Hammond, 1998). Although these figures do not take into account the number of children with ADHD, given the findings of the Appalachian Educational Laboratory (1996) that 50-70% of children with ADHD will develop ODD and 20-40% CD, clearly these population of children are indicated also.

In response to these alarming statistics, prevention of conduct disorders has been identified as one of the United States' highest priorities (NIMH, 1996). The increasingly high costs associated with delinquency, substance abuse, and escalating adolescent violence (Kazdin, 1985) is placing a burden on society that is becoming too large to ignore. Walker (et al., 1997) believe that,

> *"... the spread of poverty, deterioration of urban neighborhoods, collapse of the family infrastructure for socializing children and youth, involvement of caregivers with drugs and alcohol, failure to use good parenting practices of discipline and monitoring and all forms of abuse are producing thousands of at-risk children and families"* (Walker, Irvin & Sprague, 1997).

These and other authors (Reid, 1993, Coie, 1994) believe that antisocial behaviour is the single best predictor for juvenile crime and other associated negative outcomes; juvenile delinquency, depression, violent behaviour, drug abuse, and school dropout.

Here is Australia we are faced with the same issues as the United States in relation to the escalation of crime amongst our youth. In 1999 a report entitled "Pathways to Prevention" (Developmental Crime Prevention Consortium, 1999) was compiled as an initiative of the Commonwealth Government in response to the need to find and promote ways of preventing violence, crime and fear of crime in Australian communities. The report recognised the "high economic cost and the often devastating psychological impact of criminal victimisation" as well as links between antisocial behaviour and negative social outcomes (found in the U.S. studies). In fact the report was well aligned to U.S. studies that looked at the 'risk factors' and 'protective factors' in a child's environment that could predict positive or negative future outcomes. This seems to indicate little difference between American children and Australian children.

Overwhelming support is given in the research to the thought that schools alone cannot solve this difficult and complex set of problems. Antisocial behaviour in children affects all aspects of their life; home, school and community, and thus intervention and/or prevention needs to target all areas to encourage change. However, as the major socialising environment for young people, schools are in the position to design and implement intervention programs that can reach the young people, their parents and

perhaps the communities in which they are situated. Many educators would disagree with this stating that their primary role is to 'educate' children, but it could be argued that unless a child is able to function, as a positive member of a group/class then academic progress would be hindered. In schools today we are facing the results of the breakdown in societal structures and are unable to ignore the consequences of these.

Multimodal Treatment Study of Children with ADHD (MTA)

Over the last few years in U.S., the results of a landmark study on ADHD have begun to be disseminated widely. The study known at the Multimodal Treatment Study of Children with ADHD (MTA Cooperative Group, 1999), was conducted by a group of researchers who wanted to determine the most effective 'treatment condition' for children with ADHD. The importance of their findings is huge for professionals working with children with ADHD and has certainly guided my thinking in relation to recommendations for the Australian setting. I found that many programs in the U.S. were closely following the discussions arising from the MTA, which will hold implications for their service delivery. I would like to begin with an outline of the study and its findings, although many of the intricacies of the methods used will be omitted for ease of reading.

The study represented the combined efforts of investigators at 6 different sites across the U.S. and included 579 children aged 7 to 9.9 years who were diagnosed as having ADHD, Combined Type using state-of-the-art diagnostic procedures. (Children diagnosed with the hyperactive/impulsive subtype or inattentive subtype were excluded. This decision was made because the combined type is the most frequently diagnosed type of ADHD). Approximately 20% of the participants were girls and about the same percentage was African American. Following identification, participants were assigned randomly to 1 of 4 different treatment conditions. Fourteen months later, the participants were carefully evaluated so that the impact of the different treatments could be evaluated. The treatment conditions are described below.

Treatment condition 1 consisted of medication treatment alone. This began with a 28-day, double-blind placebo-controlled trial in which the effects of 4 different doses of methyphenidate (the generic form of Ritalin) were evaluated. A team of experienced clinicians compared parent and teacher ratings of the children's behaviour on each dose, and the best dose for each child was selected by consensus. Neither parents nor teachers were aware of when the 'real' medication was being received in order to obtain unbiased feedback. Following stabilisation at the 'correct' dose, children were carefully monitored over the fourteen months (monthly visits) to ensure optimal medication and dosage remained stable.

Treatment condition 2 involved behavioural treatment. This took the form of parent training, child-focused treatment, and a school-based intervention. Parent training involved 27 group sessions and 8 individual sessions per family and focused on teaching parents specific behavioural strategies to deal with the challenges that children with ADHD often present. The child-focused treatment was a summer treatment program attended for 8 weeks, 5 days a week, during the summer. The program employed

intensive behavioural interventions that were administered by counselors/aides who were supervised by the therapists conducting the parent training. The model used was one in which children were able to earn various rewards based on their ability to follow well-defined rules and meet certain behavioural expectations. Social skills training and specialised academic instruction was also provided. The school-based treatment had 2 components: 10 to 16 sessions of biweekly teacher consultation focused on classroom behaviour management strategies, and 12 weeks or part-time paraprofessional aide who worked directly in the classroom with the child. A Daily Report Card was used to link the child's behaviour at school to consequences at home. The card showed teacher-completed ratings of the child's success on specific behaviours and was reviewed by parents with rewards for a successful day provided. Over the 14 months, the family and child's involvement was gradually tapered off till it was reduced to once monthly or stopped altogether by the end of this period.

Treatment condition 3 involved a combined treatment that included all aspects of the medication and behavioural treatment conditions. Individuals supervising the two treatments conferred regularly and this was used to guide overall treatment conditions.

Treatment condition 4 was known as community care whereby parents were provided with a list of community mental health resources and made whatever treatment arrangements they preferred.

Findings

Children in all 4 groups showed significant reductions in their level of symptoms over time in most areas (ADHD symptoms, aggressive and oppositional behaviours, internalising symptoms, social skills, parent-child relations, and academic achievement). Some interesting results ensued and are summarised below;

- on both parent and teacher ratings of ADHD symptoms, medication alone was clearly superior to behavioural treatment alone (this was also true for the combined condition compared with behavioural treatment alone)
- combining medication and behavioural treatment was found to be superior to behavioural treatment alone on parent and teacher ratings of ADHD symptoms, aggressive/oppositional behaviours, internalised behaviours (parent ratings only), and on reading results
- both combined treatment and medication treatment were superior to community care for parent and teacher reports of ADHD symptoms, however, behavioural treatment alone was not. For other areas (oppositional behaviour, internalising behaviour, social skills and reading achievement) combined treatment was always superior to community treatment
- although medication alone was found to be the superior treatment condition, when combined with behavioural treatment children were able to be maintained on a lower dosage of medication. Interestingly, average dosage on medication alone was 38 mg/day which, in my experience, is much higher than most children are taking in Australia

- children on the medication alone treatment condition did significantly better than the community care condition although both were receiving medication. The medication alone condition resulted in higher doses (38 mg/day) but these were well monitored and usually consisted of methylphenidate alone. Community care children were on much lower doses (23 mg/day) and often on non-stimulant medication (antidepressants) or a combination of medications. Monitoring in the community care condition was not as stringent.

IMPLICATIONS AND RECOMMENDATIONS

- The results of the MTA study (which is still continuing and hopes to collect longitudinal data on the participants) have huge implications for the management and treatment of ADHD. Clearly the study implicates the high need for good medical management of the disorder together with, or even in absence of, psychosocial interventions (i.e. behavioural management, social skills training etc.). Despite the current 'media hype' in Australia on the overuse of stimulant medication for children with ADHD, it has been my experience that many of our children are currently not receiving medical treatment for their condition. Although there has undoubtedly been an increase in the prescribing of stimulant medication, perhaps it is indicative of better diagnostic procedures rather than overdiagnosis. In the U.S. the acceptance of adult ADHD has further increased the statistics on stimulant use.

  For children with ADHD who are receiving medical treatment, the MTA study appears to indicate that children receive the most benefit from medication when it is well-monitored and frequently evaluated by parents and teachers. It would seem that this finding indicates a need for cross-discipline communication in establishing the optimum dosage for individual children. Teachers are in an ideal position to observe and report on the behaviour of children and perhaps through the use of simple checklists could provide medical professionals with feedback regarding the efficacy of medication.

- Despite the growing body of research into the efficacy of medication treatment in children with ADHD, in schools we must rely on psychosocial approaches. In the behavioural treatment alone condition used in the MTA study, intensive behavioural interventions were applied in the home and school settings with some positive results. The Child Development Center in Irvine (CDC), California, uses a very similar approach to that used in the treatment condition, their 'point system' is based on the work of Dr. Pelham who was part of the MTA study team (see sites visited section). The limitations of this approach lie in the intensity of resources needed to provide such a program. In acknowledging this as a limitation I would also like to acknowledge that many special education funds are being used in schools to provide teacher aide time in classrooms that contain children with behavioural difficulties and could perhaps be used to establish more effective, research-proven models such as that used at CDC. Another limitation exists in the stigmatisation of placing a child in a unit/special school that identifies them as a 'behavioural problem'. I would argue though that children with ADHD are already labeled as behavioural problems within mainstream classes and to withdraw them to a unit/program/classroom that endeavors to address their needs and to change their behaviours should be considered a proactive intervention. It was also my experience when visiting CDC and talking to parents there, that they were fully appreciative of the support the school was able to provide for them and for the progress their children were making in terms of reductions in problematic behaviour.

  Psychosocial approaches to behavioural management have been used in schools for a long time and form a portion of pre-service teaching. If however, one looks at preventative intervention according to the model described by Larson (1994), illustrated

in Fig. 1, then much work is needed in the areas of 'secondary' and 'tertiary' interventions. Whilst I do acknowledge that this comment is made according to my own experience as a special education teacher in Australia, I believe that many of my colleagues would support this claim that we are generally under-skilled and poorly prepared to cater for children who require 'secondary' or 'tertiary' intervention practices. Larson proposes in his model that 80-90% of school discipline and behavioural problems will be solved through the implementation of 'primary' prevention practices and a further 5-15%, of the remaining problems, through more costly and labour-intensive 'secondary' intervention practices. For the remaining 1-7% of children with severe problem behaviours that resist traditional approaches and support, intensive case-management and wrap-around services are needed.

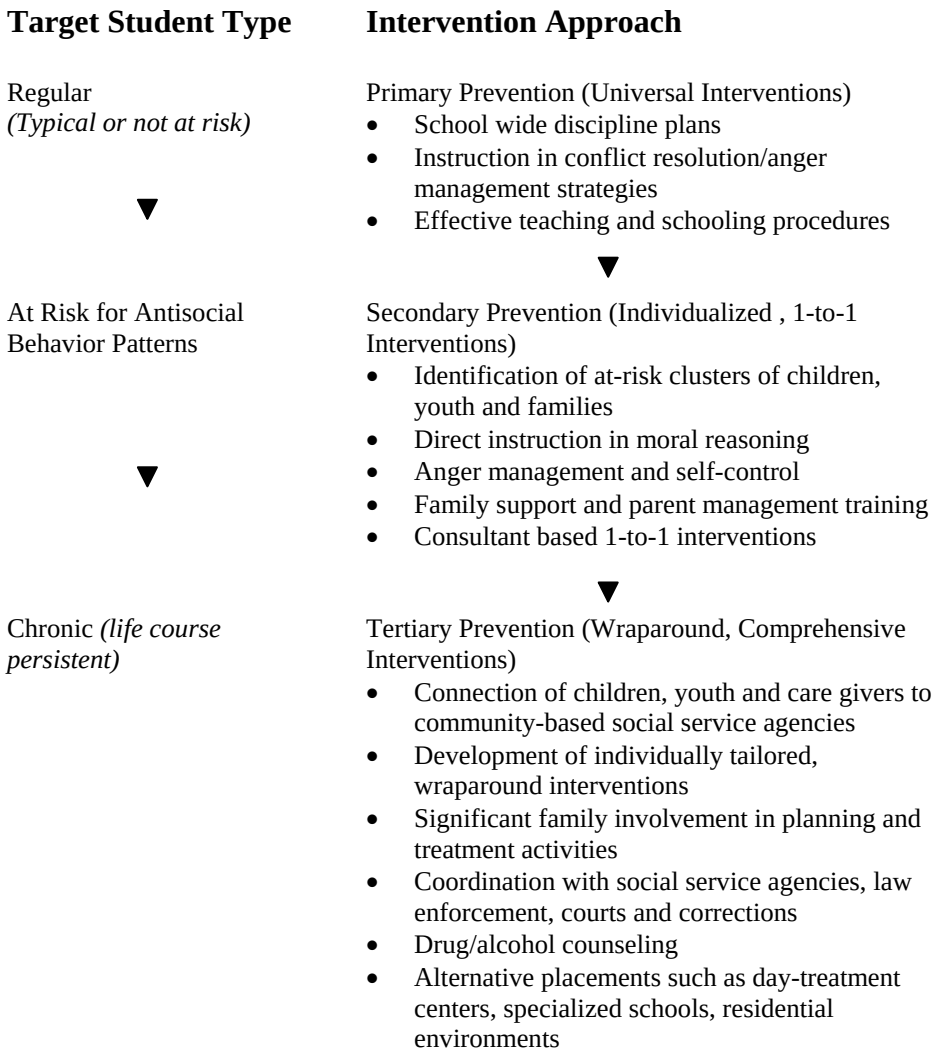

***Figure 1*: Correspondence Between Target Student Type and Universal-Selected Intervention Approaches (Larson, 1994)**

Whilst the cost of implementing a systematic, well-developed plan such as that proposed by Larson (figure 1) is evident, the benefits in terms of reduction of antisocial/delinquent behaviours and the prevention of additional problems (drug use, depression, school

dropout, criminal activities), make this a ‘cost-effective’ approach to dealing with these issues.

Currently our society (like the United States) seems to favour incarceration as a response to juvenile crime and violence. Walker (et. al. 1997) proposes that a satisfactory solution to these social problems will never be solved by incarceration alone and suggests a three-pronged approach involving detention, intervention and prevention. According to this approach detention would be used for serious habitual offenders who have a low likelihood of being rehabilitated. Intervention would involve school and youth service programs that teach skills, adaptive strategies and positive attitudes that assist in keeping at-risk students out of the juvenile justice system. Prevention would involve keeping potentially vulnerable students from becoming at-risk. To successfully implement this type of systematic approach would require a reallocation of resources from detention to intervention and primary prevention (Walker et. al. 1997).

- In my experience with children with ADHD (and as a parent of a child with ADHD), there is a need in Australia to provide better education regarding the disability to teachers, parents, community workers, and to the children themselves. As ADHD is currently not clearly defined as a 'disability' category within educational systems, systematic approaches to the disorder are not in place and often parents are receiving information from a variety of sources in a fragmented manner (i.e. doctors, teachers, friends, and most often the media). In recent years many support groups and voluntary organisations have been established to provide information and support to sufferers and their families, but it would seem that the ideal environment for such psychoeducational approaches to begin would be in the school setting. To facilitate such an approach, it would be necessary to provide inservice to teachers already teaching as well as to include the topic in pre-service teacher education.

  Many of the programs/schools I observed during the project exemplified 'best practice' in catering for and managing children with ADHD. Both Riverview School and the Churchill School and Center (see sites visited section) identified children with 'attentional disabilities' as part of their target group. Much could be learned from schools such as these in regard to curriculum development, behavioural management, parent and community education and classroom approaches. The challenge in Australia for implementing the findings would be in regard to our current school structures involving 'inclusion', in that most children with high-incidence disabilities, such as leaning disabilities and attention deficit disorder, are currently serviced in general education classrooms. It was my experience in the U.S. that many parents were choosing private, non-inclusive schools as options for their children in the belief that the 'least restrictive environment' for a child with ADHD did not exist in a mainstream classroom. Without going into the 'inclusion' argument at this point, I would like to quote a piece written by Janet Lerner who is the Editor-in-chief of "Learning Disabilities: A Multidisciplinary Journal". The piece was written as an introduction for the Learning Disabilities Association International Conference in New York in February 2001, which I attended during my trip.

"At a recent conference I heard the argument that children with disabilities have a civil right to be placed in a general education classroom. I think that students have a civil right to learn the skills they will need in the competitive world they will be entering. Accumulating research shows that students with learning (and attentional) disabilities require systematic and explicit instruction by teachers who are trained and highly skilled in delivering such instruction. This type of explicit instruction requires much more than placement in a regular classroom; it requires intensive work with a small group of students. We may be violating a student's civil rights with the single solution of placing a child with a disability in a general education classroom. Parents of children with learning disabilities have worked hard for many years to get the kind of small group instruction their children need. Let's make sure we do not lose it."

I too wonder if inclusion is the 'best practice' for a group of children who will clearly benefit from a different environment to that which general education offers. I would challenge the belief that 'inclusion' is always for the benefit of the child. Inclusion is often more 'cost effective' yet at the end of the day for children with ADHD the savings are consumed in reacting to the negative outcomes that occur.

- Robins (1981) proposed that conduct disorder is one of the most costly mental disorders to society (in Webster-Stratton, 1997). Research is actually showing that a large proportion of antisocial children remain involved with mental health agencies throughout their lives or become involved with criminal-justice systems. I believe that these findings implicate the need for a cross-discipline approach to intervention with children who have ADHD, ODD, CD or manifest antisocial behaviour patterns. It has been my experience as a teacher that at a classroom level teachers are struggling to 'manage' the behaviours exhibited by these children and are searching for 'management' strategies to assist them in doing so. Whilst skilling in management strategies is a valid approach and certainly worth pursuing in terms of inservice to teachers, I would suggest that a more global approach to intervention (or even prevention) would be more effective. I envisage such an approach as involving social workers, counselors, doctors, mental-health workers, juvenile justice workers, and educators working together to develop primary, secondary and tertiary prevention and intervention programs that are based on and driven by research (see Figure 1, Larson 1994). Such an approach would involve the establishment of liaison people who would be responsible for connecting the various agencies and coordinating their efforts to implement effective interventions. At the secondary and tertiary intervention levels, the role would also include 'case-management' for individual children. A number of the programs I visited managed to adopt such an approach such as the Treatment Foster Care Program (see sites visited section).

- Australia is a relatively small nation in comparison to the United States. With a small population and still evolving economy, the incidence of philanthropic funding for social agencies such as schools is much less than that enjoyed by the U.S. We have a long way to go before we can envisage the establishment of centres such as the Oregon Social Learning Center (OSLC) and Seattle Social Development Research Group (SDRG) (see

sites visited section). Whilst acknowledging that I make these comments from a position of relative unfamiliarity with Australia's economic status, my experience in schools has been that each year we struggle with dwindling funds as the educational budget tightens. However, I do believe that there are ways we could draw on the wonderful work being done in these research institutes in the U.S. that would be both cost-effective and valuable to Australian educators.

Throughout my study project, I was struck by the similarities between the American and Australian contexts, in terms of the issues and challenges youth are presenting in school settings. I do not believe it would be difficult to adapt the programs developed in the U.S. for Australian settings especially considering that even programs developed in Australia need to be adapted to suit different regions and/or communities. Whilst the ideal would be to duplicate centres such as OSLC and SDRG who would research and develop programs for Australian schools, perhaps we could draw on the research being done in the U.S. and use our funds to adapt and implement programs here. Given that the people implementing such programs in schools or communities would be teachers and/or social workers, I believe it would be important to involve such practitioners in the establishment of such a project. My vision would be that a project group would be established, possibly in each state, whose role would be to liaise with research centres in the U.S., also involving spending some time there, in order to;

- disseminate current research to schools, community programs and other interested parties
- learn about and observe in action programs developed in the U.S. in order to adapt them for Australian settings
- implement and evaluate chosen programs in Australian settings
- assist schools in developing a systematic, research-based approach to preventative intervention at local levels
- provide training and inservice regarding 'best practice' strategies in both reactive and proactive management of children with difficult behaviours.
- begin to develop an Australian research base in 'best practice' in the prevention of antisocial/delinquent behaviour.

Whilst acknowledging the costs involved in such a project, I wonder if the "reallocation of funds from detention to prevention" proposed by Walker (et. al. 1997) is possible? If so then a systematic approach such as this would be a valid means of prevention.

CONCLUSION

The research seems to indicate a grim picture in terms of the pathways and outcomes for children who display atypical behavioural patterns. Even without research, one only has to look at the changes in the structures of society over the last 50 years to see that the potential for challenges are evident. Technology has increased astronomically during this time yet the economic benefit has not been available to all. Whilst for many the benefits of technology have been huge (efficiency, cost reductions, global communication) for others they have been devastating as jobs become redundant and less unskilled labour is required. For many people technology has managed to remove their place in society without creating an alternative. The linear pathway from childhood and school to adulthood and lifelong employment enjoyed by many in years gone by, is not as attainable to many of our youth today. Most especially not to those deemed 'at-risk' due to economic, social and/or educational deprivation.

Youth unemployment is now a real issue. Many of the menial jobs that youth once filled, no longer exist. More and more skilled labour is required and increasingly schools are bearing the cost of including these skills in their already overloaded curriculum. Where once schools were required to educate young people academically (the three R's) and socially, now schools are required to provide education that addresses the huge number of societal issues (drug education, health education, career education, etc.). I remember a comment made during my preservice teacher education that proposed that teachers today were preparing students for jobs that did not yet exist. As schools struggle with the dynamic nature of society and their role in it, the relevance of curriculum is constantly reviewed and adapted. In this ever-changing environment sometimes 'children' get lost.

For children who suffer from ADHD the pressures that today's society places on them can have catastrophic effects to their sense of self-worth, given their limitations in terms of lack of organisation and self-control. Many people believe that ADHD is a disorder that has been a part of our human condition for many years but that the changes in the nature of society have created a 'disability' from the disorder. One could view impulsiveness as 'spontaneity' or 'decisiveness', hyperactivity as 'high-energy' or 'drive', and distractibility as 'alertness' but in today's society where meeting deadlines, achieving successful outcomes and being a self-motivated team-worker are rewarded, children with ADHD just don't make the grade. Yet where would we be today without people like the messy and disorganised Benjamin Franklin and the wildly impulsive and distractible Winston Churchill (both proported to suffer from the disorder)?

For these children, and the many others who lack the luxury of a stable, well-directed society, interventions are necessary to preserve their self-worth and to develop their positive traits and prevent negative outcomes. They are our future and we owe it to them.

SITES VISITED

Whilst my particular project was highly enriched by the vast research background I discovered in the area of 'preventative intervention' for at-risk antisocial children, I would like to continue from this point to discuss the programs/centres I observed and my thoughts on their relevance for Australian settings and to make recommendations for the future. In doing so, I would like to make mention that although I am aware that many intervention programs exist in Australia, finding research and evaluation of them is difficult and thus my report does not reflect a thorough knowledge of the Australian scene. Perhaps this is indicative of our need to be more systematic in our development, evaluation and reporting of the work we are doing here.

IRVINE, CALIFORNIA

CHILD DEVELOPMENT CENTER AND IRVINE PARAPROFESSIONALS PROGRAM

Background

The Child Development Centre (CDC) is a research based elementary school affiliated with the University of California (UCI) that caters for young people with severe ADHD and comorbid conditions. It was established in 1982 as a response to the work of Dr. James Swanson (Professor of Pediatrics, UCI) and a research team who had been looking at the etiology of ADHD and had come to realise that a multi-modal treatment plan was the most effective way to cater for these young people. Due to the complexity of the disorder it was found that medication treatment alone had not produced evidence of long-term effects on social adjustment or academic achievement.

Young people in the program are selected on the basis of a diagnosis of ADHD/ADD and/or Oppositional Defiant Disorder (ODD) together with additional (or associated) comorbid conditions. They represent the extreme cases often referred to as 'ADD-plus condition'. Referrals come primarily from the UCI-CDC assessment clinic as well as private pediatric practices in the area which specialise in treating ADHD/ODD. Although public school funding is available in the USA for clinical services for handicapped children, this avenue was not accessed due to the controversy around whether or not ADHD should be recognised as a learning disability under PL94-142. A decision was made to fund the clinical portion of the program through health insurance and personal payments of clinical fees which support the treatment staff employed by UCI. Likewise in addressing the educational component it was decided to avoid special education requirements and funding due to entry restrictions, (i.e. IQ achievement, test discrepancy), which often prevent children with ADHD from accessing services they need. Alternative arrangements were made with the Irvine Unified School District who assigned three teachers and a part-time principal to staff the school. At the present time the coordinator of the school is Dr. Ron Kotkin who also conducts the training course for paraprofessionals through UCI. Dr. Kotkin also contributes extensively to the research base in the area of behavioural interventions for children with ADHD.

The Program

The program established is an intensive school-based day treatment program that combines educational interventions- classroom behaviour modifications based on positive reinforcement and token reward system, with clinical interventions- group training for social skills development, parent training in behaviour modification techniques and family groups. A minority of children in the program are receiving stimulant medication (the standard medical treatment for ADHD) and those that do take part in double-blind dose-response assessment to determine cognitive response to the medication.

The school uses the state 'regular education' curriculum and modifies the environment in which this is taught to accommodate the unique needs of children with ADHD, including low student-to-staff ratio. The rationale for this approach to the curriculum is based in the premise that students with ADHD often have average or above-average intelligence but, as a result of attention problems, they "frequently have difficulty producing the quality and quantity of academic work expected for their grade level" (Kotkin, R. 1995). It has been found that with frequent feedback and reinforcement these young people are able to perform academically as well as their non-ADHD peers (Douglas & Parry, 1983; Pfiffner & Barkley, 1990).

An intensive social skills training program is also an integral part of the program and is conducted in small groups outside of the classroom every day for one hour. Generalisation of the skills is achieved through the reinforcement/token reward system that occurs in the classroom and on the playground. The rationale for the teaching of social skills arises from the research that shows children with ADHD often have poor peer relationships that become an antecedent to their disruptive classroom behaviour (Kotkin, R. 1995). Through social skill training, the children can learn pro-social behaviours that will enhance both their social interactions and their academic performance.

Parental involvement in the program will assist in achieving consistency of approaches to shaping undesirable behaviours but does not change the responsibility of the school to meet the educational needs of the student while he or she is in the classroom. Consequently the program relies on its own structures to provide an intervention that does not rely on parent participation but will be enhanced by it. When parents understand the rationale behind the approaches used in the classroom and are able to follow through and provide consistent home consequences, the child's progress is greatly enhanced and the parents find their home stress levels are reduced. Many of the CDC parents do attend a six-week course in parent training, where staff attempt through role-play to illustrate positive approaches to shaping undesirable behaviour and ways to give the frequent feedback and reinforcement that is needed by children with ADHD. Following completion of this course, parents are invited to attend bi-monthly family groups which encourage "information sharing, provide mutual support, develop parenting skills, and facilitate communication between parents and staff" (school brochure).

Paraprofessional Model

Whilst it should be clear to professionals that the approaches used by CDC are what is known to be 'best practice' in dealing with children with ADHD, difficulties often occur in trying to implement these practices in the general education classroom. Although many school psychologists are available to monitor and modify plans such as these for individual children, the difficulty of implementing them in a classroom with 25-30 children and one teacher becomes apparent. Compounding this is the child with ADHD's need to receive frequent reinforcement and feedback (Kotkin, R., 1995). At CDC this problem is addressed through an innovative approach in which paraprofessionals are trained in behavioural modification and social skills training and assist the classroom teachers by providing the necessary frequent positive feedback and immediate consequences necessary to shape new behaviours. The model has come to be known as the 'Irvine Paraprofessional Program' and has been selected by many organisations as a 'promising practice' in education children with ADHD (Kotkin, R., 1995).

Training is provided for selected instructional aides, either currently employed by the school district or undergraduate students. They complete a 30-hour course covering aspects of ADHD and behavioural modification theory and techniques. A 200-hour supervised field experience is an integral part of the course in which trainees are given the opportunity to implement classroom interventions with the guidance of a specialist in the area. Only trainees demonstrating competence in all areas are selected for the CDC program.

In addition to providing intervention in the classroom, the paraprofessionals (or 'behavioural specialists') conduct social skills training outside of the classroom on a daily basis. Generalisation of these skills occurs through the paraprofessional acting as a cue for the student in the classroom and playground. The teacher also reinforces appropriate use of social skills in the classroom.

Summary

The Child Development Center has been identified in the U.S. as a 'center of excellence' in the treatment of ADHD and related disorders of attention, behaviour and learning. Although the practices used in the program are not new to both educators and behavioural psychologists, many of the limitations of implementing these practices in general education settings have been overcome through the establishment of the Paraprofessional Program and the Day Treatment Center (school). With its strong research base and ability to provide data for further research, the model has potential to reach out to others working with these children and to make a real difference for children hindered by the debilitating effects of ADHD.

Thoughts for Australia

Although all pre-service teachers in Australia receive training in behavioural modification, implementation is hindered by many factors within the general education classroom, most especially student numbers. It has also been my experience that whilst the techniques of behavioural modification are beneficial to children who display minor behavioural problems, the intensity of reinforcement needed for the child with ADHD

makes it very difficult to maintain an effective behavioural plan in a general education setting. I believe the model used at CDC has great promise for young people with this disorder provided that schools (and communities) are willing to invest the resources necessary to establish such a program.

Although no specific category of special education funding is currently available for children with ADHD, many schools are being forced to provide teacher aide time as a reaction to the disruptions the children can cause to a regular classroom. I wonder if the same financial resources being used to 'react' in this way could be combined and used in a more 'proactive' manner to establish a program such as CDC. Given the potential for research that such a program would offer, perhaps universities could become affiliated with the school/s, as has UCI.

SEATTLE, WASHINGTON

SOCIAL DEVELOPMENT RESEARCH GROUP

The Seattle Social Development Research Group (SDRG) focuses on prevention and treatment of health and behaviour problems among young people such as drug abuse, delinquency, risky sexual behaviour, violence and school dropout. The two founders of the group, J. David Hawkins and Richard F. Catalano began in 1979 to develop the social development strategy, the theoretical basis for risk- and protective-focused prevention that underlies the group's research. The group is currently working on 10 research projects (including the Raising Healthy Children project) and has produced a large number of articles and books. They are a unit of the School of Social Work and a partner in the Social Work Prevention Research Center at the University of Washington in Seattle. The mission of the group is as follows....

- To understand and promote healthy behaviors and positive social development among children, adolescents, and young adults by
- Conducting research on factors that influence development;
- Testing the effectiveness of interventions'
- Studying service systems and working to improve them;
- Presenting science-based solutions to health and behavior problems; and
- Disseminating knowledge produced by this research.

In 1981 a project named the Seattle Social Development Project (SSDP) was established to test strategies for reducing childhood risk factors for school failure, drug abuse and delinquency. This project is still tracking the young people initially assigned to the control groups and is producing important findings for further research and intervention program design.

Research has shown that certain conditions in a child's life can predict problems such as drug abuse, delinquency, teenage pregnancy, and school failure. The SDRG has identified 'protective factors' and 'protective processes' that prevent people who are exposed to risk from developing health and behaviour problems. The SDRG's Social Development Strategy emphasises two key protective factors: bonding to prosocial family, school, peers and community, and clear standards and norms for behaviour. Three factors promote bonding to prosocial groups: opportunities for involvement in productive prosocial roles, skills to be successfully involved in these roles, and consistent systems of recognition and reinforcement for prosocial involvement. These factors protect against the development of conduct problems; school misbehaviour, truancy and drug abuse and are illustrated in the Figure 2.

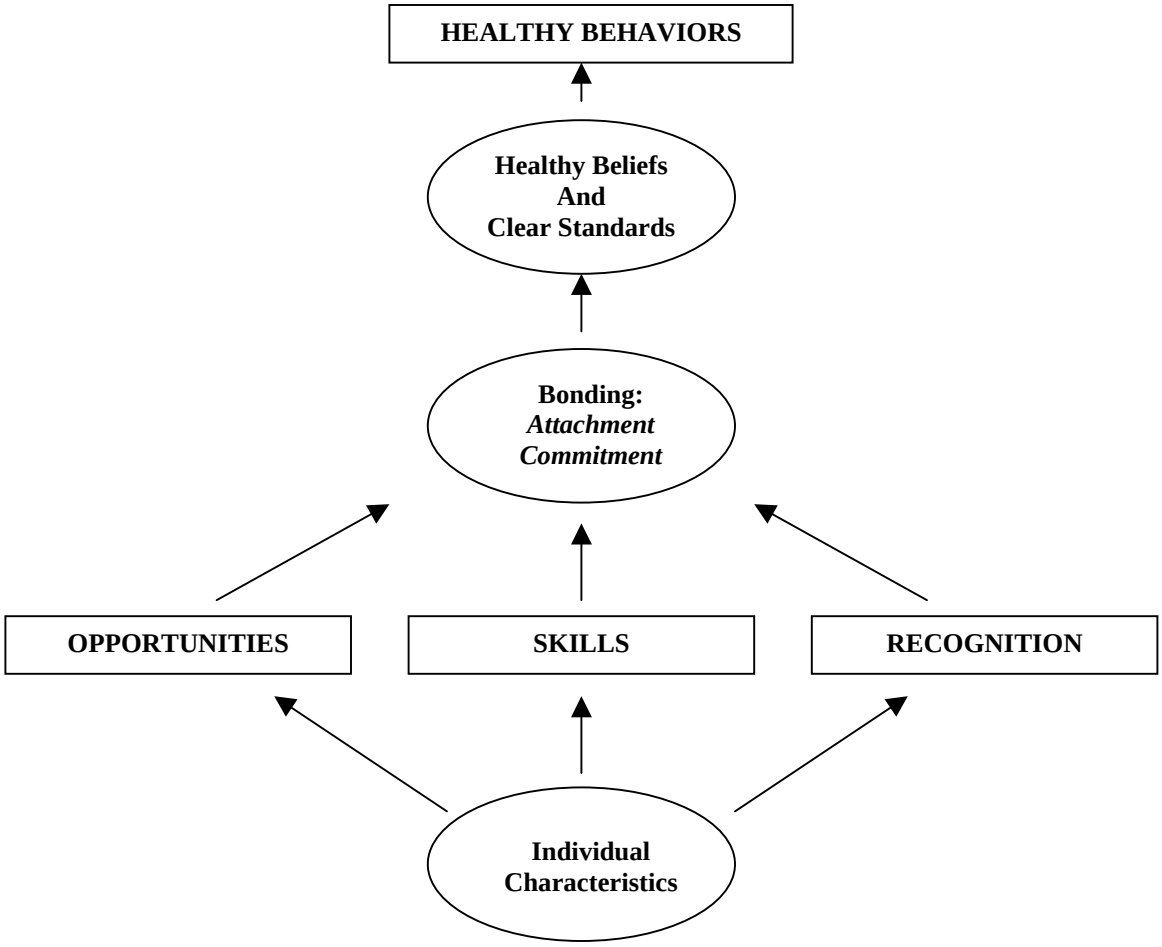

Figure 2: **The Social Development Strategy**

RAISING HEALTHY CHILDREN

The **Raising Healthy Children** project builds upon and extends the successful strategies of the SSDP, incorporating recent findings regarding effective intervention practices. The projects offers:

- Teacher and parent workshops to promote school success and family bonding (delivered schoolwide)
- Instructional and classroom management strategies for teachers
- Workshops in family management, methods to support their children's academic success, prevention of behavioural problems and involvement in drug use, are offered to parents
- In-home services for high-risk children.

The project aims to strengthen the protective factors of family bonding and commitment to school, and establish healthy beliefs and clear standards (see Figure 2). The schoolwide approach taken by the project involves teachers, parents, and peers in reducing the risk factors of early antisocial behaviour, poor family management, and

academic failure. The project will follow a panel of over 1000 first and second grade children through their high school years.

Among the programs offered to schools, parents and young people are;

How to Help Your Children Succeed in School- Preparing for School Success

A series of parent workshops offered to parents of 1st and 2nd grade children and focusing on family management, methods to support their children's academic success and prevention of behavioural problems and involvement in drug-use. This is coupled with the children being taught interpersonal and problem-solving skills by teachers, both in class and in summer or intersession workshops. This schoolwide approach endeavours to involve all parties, teachers, parents, and peers in reducing the risk factors of early antisocial behaviour, poor family management, and academic failure. It also endeavours to strengthen the protective factors of family bonding and commitment to school together with establishing healthy beliefs and clear standards.

Proactive Family Management (5 sessions)

This is another parent workshop offered in years 2, 3 and 4 that addresses communication, setting limits, discipline strategies, problem-solving and family conflict. Both of these programs can be followed up in the later years if required by parents through "One Step Ahead"- a program that helps parents to assist their children with homework, reading and math, and/or "Parenting for Respect and Responsibility"- a program that looks at the barriers and builders to building capable people and emotion coaching, based on the work of John Gottmann "The Heart of Parenting".

Home Based Services

Children from the initial panel of 1000 children who are identified by teachers or parents as 'focus of care' children in that they have not been assessed or granted any special education services but there is concern on the behalf of the teachers/parents as to their progress, become a part of the 'Home-Based Service". This service works with children up to year 7 in a form of case management for 12 weeks. Individual goals are set for the child in conjunction with the teacher/s and parent/s and a home-school liaison person from the RHC group works with the family and child to enable the goals to be met.

Preparing for the Drug Free Years

This program is offered in 4th, 5th and 6th grade in the form of workshops. The workshops involve parents and children working through topics such as; information giving, setting guidelines and using family meetings, teaching refusal skills (young people and parents), managing conflict and anger management, and providing opportunities for children to be more involved with their family.

Moving into the Middle School Years

In this program booklets are sent home to parents of children approaching the transition to middle school. Topics covered include, strategies for success, sexuality and relationships, problem behaviours and contracting. Home visits are offered to parents who feel the need to gain more assistance in any of these areas.

Stepping Up to High School

Packages are sent home to children approaching the transition to high school that look at areas of concern such as; dating, learning, limit setting, communication, problem solving and substance abuse. Home visits are offered to parents who identify (or are identified) that their young person will have difficulty with the transition to high school.

Letting Loose without Letting Go

This program is currently in the development phase and is a home based program that will target children in the 9th grade going into 10th grade. It will build upon the work begun in 'Stepping up to High School' in an effort to promote good communication between adolescents and parents/carers.

Although this program has essentially followed a particular group of children for research purposes, it would not be hard for a school system to adopt many of the strategies used in the interventions and implement them across whole-schools.

Summary and Recommendations

The RHC is an ongoing project that is responding to the immediate needs of school-aged children whilst also focusing on the future needs and issues that young people will encounter. It's strong research base and promotion of research findings makes it a very encouraging model for others interesting in prevention intervention. The cost to society of 'reacting' to the problems that antisocial youth present is one that cannot continue at its current rate. Clearly 'prevention' needs to be considered as a viable option. As one of the founders, Dr. J. David Hawkins said, "..... the promotion of positive youth and adult development and the prevention of health and mental health and other problems before they emerge is really becoming a possibility in our society at this point in history". Perhaps, 'at this point in history', it is time for Australians to step back and consider how we are managing these difficult youth and to be guided by programs/projects such as the SSDG and RHC in developing more 'preventative' approaches to the problems.

THE INCREDIBLE YEARS

Background

The Incredible Years are research-based, proven effective programs for reducing children's aggressive and behaviour problems and increasing social competence at home and at school. The programs consist of parent training, teacher training and child social skills training and have been selected as 'best practice' programs by the U.S. Office of Juvenile Justice and Delinquency Prevention. As such, the programs have been subjected to intensive research on their efficacy and have been recommended by the American Psychological Division Task Force as well-established treatment for children with conduct problems.

Long-term goals for the programs are; to develop comprehensive treatment programs for young children with early onset conduct problems, and secondly, to develop cost-effective, community-based, universal prevention programs that all families and teachers

of young children can use to promote social competence and to prevent children from developing conduct problems in the first place. Short-term goals are to;

Reduce conduct problems in children:

- Decrease negative behaviours and noncompliance with parents at home
- Decrease peer aggression and disruptive behaviours in the classroom

Promote social, emotional, and academic competence in children:

- Increase children's social skills
- Increase children's understanding of feelings
- Increase children's conflict management skills and decrease negative attributions
- Increase academic engagement, school readiness, and cooperation with teachers.

Currently in the U.S. many schools are adopting the 'Head Start' curriculum that addresses pre-school children's readiness for academic learning. Although Head Start focuses on cognitive development and academic readiness, researchers know that poor social skills and poor problem solving skills are also high indicators of risk factors for antisocial, delinquent behaviour (Asarnov & Callan, 1985: Rubin and Krasnor, 1986). The 'Incredible Years' were designed to support the 'Head Start' curriculum by including the areas of social skill development, problem solving skills and parent/teacher training. It was hoped that there would be a strengthening of the protective factors of parenting competence, children's social skills, and strong home-school involvement in an effort to prevent conduct problems. The effectiveness of the interventions were found to be most promising and the gains made were maintained over the following year (Webster-Stratton, 1998).

The Program

The child-training program is a comprehensive package containing a variety of media designed to be appealing to young children. These include videotapes, games, puppets, cue cards, stickers and fridge magnets. The program aims to strengthens children's social and emotional competencies such as understanding and communicating feelings, using effective problem solving strategies, managing anger, practicing friendship and conversational skills, as well as appropriate classroom behaviours. It is designed to be implemented both in school and at home with a suggested 18-20 week, two-hour group session in the classroom and follow-up homework activities. The home activities are designed to allow parental interaction and involvement in the program.

The parent training program is broken down into three major components, BASIC parent training, ADVANCE parent training, and EDUCATION parent training.
In the BASIC parent training two packages are available for early childhood (ages 2-7) and school age (ages 5-12). The programs focus on strengthening parenting skills and consist of components, which build upon one another. The early childhood package addresses such skills as; play/involvement, praise/rewards, effective limit setting and dealing with noncompliance, and handling misbehaviour, time out and preventative approaches. The school age package is similar in content but is aimed at an older age group and gives greater emphasis to strategies for older children, including logical consequences, monitoring, problem solving with children, and family problem solving. A

supplementary EDUCATION program focuses on fostering children's academic competence.
The ADVANCE parent-training package follows on from the BASIC program but focuses more on parent interpersonal issues such as effective communication and problem solving skills, anger management and ways to give and get support. All three components utilise videotapes as a means of modeling effective practices as well as ineffective examples for discussion.

Teachers today find themselves spending increasing amounts of time attending to students' aggressive, hyperactive and noncompliant behaviours in the classroom. If these behaviours are ignored, or if teachers give them negative attention, they will continue to increase leading to eventual school failure and antisocial behaviour. The teacher training intervention is focused on strengthening teacher classroom management strategies, promoting children's prosocial behaviour and school readiness (reading skills), and reducing classroom aggression and noncooperation with peers and teachers. Additionally the program focuses on ways teachers can effectively collaborate with parents to support their school involvement and promote consistency from home to school. Again the program utilises video vignettes as well as books, games and instruction manuals.

Summary and Recommendations
The Incredible Years programs are both well-researched and richly-resourced programs for schools to address issues of aggressiveness and antisocial behaviour. They have been designed to be used by teachers, teacher aides, psychologists, school counselors, and any other school personnel working with young children. The programs for children can also be used in a variety of settings or for a variety of purposes such as a small group of 'difficult' children in a withdrawal setting, or as a prevention program for the whole class. Certification workshops are also offered in Seattle to professionals wishing to train others in using the programs.

The richness of the program design makes this a very appealing program to use in Australia as a preventative education program. However, the video vignettes would perhaps need to be redesigned to reflect the Australian culture in order to assist parents/teachers to identify with the issues presented.

EUGENE, OREGON

OREGON SOCIAL LEARNING CENTER

Background

The Oregon Social Learning Center (OSLC) is a non-profit independent research center that was founded in 1977 by a group of staff who had been working together at the University of Oregon and the Oregon Research Institute. Their work was focused on the development and evaluation of research-based parent education and training programs. Since then the center has expanded its focus to include the studying of child and family development across time and thus has become a Prevention Research Center which is primarily funded by the National Institute of Mental Health. Much of the current research coming from the OSLC has a focus on 'prevention' in particular, the prevention of antisocial behaviour problems during childhood (also referred to as 'conduct disorders'). The center also works to identify factors which lead to problems at different stages of life, such as temper tantrums and misbehaviour in childhood, delinquency and substance use in adolescence, and failed relationships in adulthood. Currently the OSLC is involved in:

- Direct observation of child and family social interactions in home, school, and community settings
- Identifying family and peer group social interaction patterns and other factors related to the development of aggressive behaviour
- Designing and implementing interventions for children and parents to help encourage successful adjustment and discourage aggressive behaviours within the family, the school, and the community
- Applying advanced statistical methodology to the analysis of longitudinal data on child and family processes and outcomes, and
- Developing and improving child and family assessment techniques.

Three of the main projects that have been developed, refined and researched since the 1980's include, the Multidimensional Treatment Foster Care program, a state-funded program for adolescents with behavioural problems; Adolescent Treatment Program (ATP); and Linking the Interests of Parents and Teachers (LIFT) both parent training curriculums. These three programs will be looked at in detail.

LINKING THE INTERESTS OF FAMILIES AND TEACHERS (LIFT)

Linking the Interests of Families and Teachers was developed by numerous individuals at the Oregon Social Learning Center and was also inspired by activities and ideas from a number of outside sources/programs. The aims of the program were strongly guided by the research findings regarding 'best practice' in prevention of antisocial behaviour in children.

The program is a 'primary prevention' program that involves a school-wide (specific grades) approach to the prevention of childhood antisocial or problem behaviour. It is a school-based program that is designed for 1st and 5th grade children and their parents.

These particular grades were targeted as critical transition points into different school environments. The LIFT program was created to impact multiple settings in a child's life including both home and school environments, especially in the areas of parent-child and peer relationships.

Three components comprise LIFT. First, a six-week parent education and enrichment program is conducted in the school itself. All parents of 1st or 5th grade students are invited to attend. The parent program emphasises parenting skills designed to promote self-confidence and cooperation in children. The second component is a phone line put into each participating classroom ("The LIFT Line"). The classroom teacher leaves daily messages about classroom activities and homework assignments. Each parent is mailed a letter of explanation and a magnet with the classroom teacher's name and LIFT Line phone number. Parents can access these messages from their home phone and leave a message for the teacher should they have an individual concern or question. The teacher, in turn, has easy access to a phone and can return the parent's message in a timely fashion.

The final component is a ten-week social skill curriculum made up of 20 lessons and conducted in the classroom and on the playground. The curriculum has two equally important and complementary components. The first is skill-based and involves the children in the learning and practicing of peer relations and problem solving skills. Children in target classrooms meet twice weekly for ten weeks. The first weekly meeting is devoted to skill instruction, although lessons are designed to be interactive in nature and straight teacher lecture time is very limited. The second weekly session is run like a classroom meeting. Problem solving of individual and group issues is the focus. The second component of the school curriculum is an incentive system. This extremely important feature of the LIFT program aims to decrease behaviours considered detrimental to positive peer interaction. Children will be provided with incentives for positive play with peers in less structured, free-play situations. In particular, decreasing the level of peer rejection is seen as a critical step in reducing the risk of children developing 'friendship cliques' who are made up solely of at-risk children.

ADOLESCENTS TREATMENT (TRANSITIONS) PROGRAM

Background

Development and implementation of the ATP began in 1987. Funded by the National Institute on Drug Abuse, ATP was developed as a secondary intervention for at-risk middle school children. The program components focus on positive behaviour change in the parents' family management and parent-child communication skills. As the program is implemented under rigorously controlled research conditions, it is hoped to expand the program in the future with adaptations from the research findings and to cater to more urban, multiethnic settings.

The Program
The program involves both parents and teens in attending 12-week group sessions that assist teens to develop self-regulation skills and parents to develop family management skills. The session topics are as follows;

1. Setting achievable goals, neutral request and tracking children's behaviour
2. Behaviour change, reinforcement and contracts
3. Communication skills- paraphrasing, praise and reward systems
4. Communication skills- ignoring, reviewing and refining praise and reward systems
5. Limit-setting, review and refine past weeks
6. Monitoring, mild and consistent consequences for rule violation
7. Review of monitoring, tracking rules and giving consequences
8. Challenges of limit-setting, communication- de-escalation in limit-setting
9. Communication- family values and limits, more listening skills
10. Review of communication skills, family problem-solving (the neutral problem statement)
11. Negotiating, generating solutions
12. Review

Direct teaching, role-play and video vignettes are used to present the information and encourage discussion among group members.

Summary
The effect of the program in preventing long-term problematic behaviour looks promising to date. Parents were found to reduce observed negative parent-child interactions and children were reported by teachers as showing less antisocial behavior at school. The longer-term effects of the program are still under investigation using follow-up assessments. Project Alliance is a program that has been developed from the findings of ATP. It is a prevention trial with multi-ethnic youth and their parents drawn from a high-risk urban area in order to establish the generalisation and transfer properties of the program. Future findings from Project Alliance will have implications for programs such as ATP and will guide researchers in adapting programs to encourage generalisation of skills gained.

Researchers at the OSLC believe that a more comprehensive approach is needed to address the complex issues that parents and children face in today's society. One approach that is being considered is the establishment of a 'family resource room' in all middle and high schools that provides demonstrated, effective support for parenting and for young people through workshops, information materials and referrals to additional agencies if needed. It is thought that this type of approach would assist in linking communication between schools and families.

MULTIDIMENSIONAL TREATMENT FOSTER CARE

Background

This program also known as the 'Monitor Program' has been operated by the OSLC since 1983 and provides for troubled youth that are in need of out-of-home placements in lieu of placement group care residential treatment centers or juvenile justice facilities. Clinical observations had led researchers to conclude that although chronic delinquents profited from improved parenting, the parents of these 'repeat-offenders' had seriously diminished resources by this advanced point in the development of their child's antisocial behaviour (Chamberlain & Reid, 1998). The challenge therefore was to provide corrective or therapeutic parenting for these adolescents whose parents for one reason or another, could not do so.

The intervention program designed was based on a developmental model that specified antecedents for antisocial behaviour and delinquency during early to midadolescence including; lack of adult supervision, lack of consistent discipline, association with delinquent peers, and poor academic performance. It was also taken into consideration that the development of this antisocial behaviour led to increasingly serious delinquency, but also, "wore down and neutralizes the normative socialization forces that could potentially guide the youngster into more prosocial patterns of adjustment (Chamberlain & Reid, 1998). The families were no longer capable of supervising, mentoring, setting limits or negotiating with the young person. The challenge was to "re-create the powerful socialization forces of functional family life for these youngsters while protecting the community, the adults in charge of the youngsters, and the youngsters themselves" (Chamberlain & Reid, 1998).

The Program

(from the Treatment Foster Care On Line website)

There are four main components to the foster care model: consultation with foster parents, school-based interventions, parent training with biological families, and individual therapy with the child. The treatment team includes a case manager, whose responsibilities include coordinating the activities of other members, serving as a liaison to schools, other community and government agencies, and ensuring that a comprehensive treatment plan is developed and instituted. Also on the treatment team are a family therapist, an individual therapist, and the foster parents. It is the sum of the activities of all team members, rather than any one team member's activities, which lead to therapeutic effectiveness.

At the time of placement in the foster home, an initial behaviour management program is instituted. This program makes clear to the young person what the rules in the home are, clearly articulates what is expected from the youth, and specifies a system of rewards and consequences for compliance and noncompliance. Over time, as the individual youth's needs become clearer, the program is adapted. A variety of mechanisms are used to provide the young person with feedback about his/her behaviour, including star charts for young children, point charts for older children, behavioural contracting, and time out. The foster parents have daily contact with program staff to report behaviours that have occurred in the past 24 hours. They also have 24-hour crisis support from case managers

via pager and telephone, and attend a weekly meeting with other foster parents and case managers for group supervision and emotional support.

Parent training therapy with the biological family is initiated at the time the young person is placed in the foster home. In therapy, the biological family is given information about effective methods of planning. In initial sessions, the parents meet alone with the family therapist. They are taught techniques such as time out, problem solving, encouraging positive behaviour, and keeping track of behaviour. The child also initially meets alone with a therapist to form a therapeutic alliance. After the child's behaviour has been stabilised in the foster home and the parents have learned the necessary skills, the child and his/her therapist join the parents and the family therapist for joint sessions in which skills are practiced.

These family therapy sessions allow the young person to begin the process of reintegration into their biological family. Therapists emphasise the use of the skills they are learning in treatment in the home setting. Ultimately, the young person is permitted to have home visits, and the biological parents use the same behaviour management program that foster parents have been using. This provides for continuity of treatment environments. As the youth demonstrates ability to function prosocially in the foster home and the biological parents master the skills they will need, the duration of home visits is increased, from a few hours to weekend visits and even longer. Eventually, the young person is returned to the home of their biological parents, and an intensive 'aftercare' program ensures that the parents and the youth maintain the gains they have made in treatment.

Essentially, the TFC process is one in which the youth and his/her parents are separated in order to interrupt the family processes that maintain the youth's antisocial behaviour. The young person is taught new skills and is provided with a behavioural framework that helps him/her to succeed. The parents are provided with information about how to use effective discipline techniques, how to be consistent, and how to resolve conflicts without resorting to extreme behaviour. As the family members demonstrate mastery of these areas, there is less likelihood that they will resort to the dysfunctional interaction patterns of the past, and they are gradually reintegrated with the support of the program staff. Once the child returns home, support continues in order to ensure that the parents do not return to previous ineffective means of parenting.

Summary and Recommendations

In a five year study that compared the efficacy of TFC and traditional group foster homes, it was found that following treatment the group in traditional foster homes had an average of 5.4 arrests while those in TFC had an average of 2.6 arrests (Chamberlain & Reid, 1998). The improvement was believed to be due to the increased adult supervision and decreased contact with other 'deviant' peers. Although the program's intensity was somewhat expensive, it was also shown to actually cost 40% of what hospitals, group homes and other residential treatment centers cost, as well as the reduction in the costs of incarceration.

As we struggle in Australia to deal with these difficult youth, perhaps we can learn from a program such as TFC that has been developed from a strong research-base and has proven positive results. As family service and juvenile justice workers struggle with huge case loads and minimal child contact, a more systematic approach to catering for these children would be in everyone's best interests, most especially the children themselves.

INSTITUTE OF VIOLENCE AND DESTRUCTIVE BEHAVIOURS

The institute is a part of the School of Education in the University of Oregon. Its primary focus is children who display or experience anti-social behaviour, school failure, delinquency, violence, gang membership, and at-risk conditions. The institute endeavours to empower schools and social service agencies to address violence and destructive behaviour, at the point of school entry and beyond, in order to ensure safety and to facilitate the academic achievement and healthy social development of children and youth (Mission statement). The three main programmatic activities of IVDB are, research, instruction and public service. Faculty affiliated with the Institute conduct longitudinal and cross-sectional research studies that allow greater understanding of the antecedent factors in family, community, and social contexts that are associated with later violent, destructive behavior patterns. Instruction occurs through providing training/technical assistance to schools, families, and community members. This assistance endeavours to; empower key social agents to prevent violent, destructive behavior patterns among children and youth; to train professionals, paraprofessionals, and parents in the effective use of model prevention/remediation programs; and to communicate essential information and recommendations to legislators, policy-makers and agency heads who are in a position to act upon them. The institute is also strongly committed to public service through addressing Oregon's social agenda. They act as a resource to a host of local and state agencies concerned with children's healthy development.
Among the many well-developed programs that IVDB has designed and published is the First Step to Success program which follows.

FIRST STEP TO SUCCESS

First Step to Success in an early intervention program designed to address the needs of kindergarten children identified as being at-risk for developing or having antisocial or aggressive behaviours. It falls in the category of a 'secondary prevention' program (Walker, H. et. al., 1997, p.12) in that it provides intervention for individual/selected children through direct instruction as well as family/teacher support and training. The program incorporates the use of a trained consultant who works with students, teachers, and parents for approximately 50-60 hours over a three-month period. The major components of the program include;

- Kindergarten-wide screening
- Classroom-based CLASS curriculum, and
- HomeBase, which involves families in the intervention process.

In the screening phase a number of processes are employed including; teacher nominations of children using a standard definition of antisocial behaviour, teacher ratings of nominated students' behaviour using a standardised behaviour scale, and direct classroom and playground observation of students whose score exceeds the cut-off for the rating scale. If observations of the child indicate the need for early intervention, a trained consultant works with both the teachers (using CLASS) and parents (using HomeBase) to implement the First Step to Success program.

During the CLASS portion of the program, the consultant works with the teacher and the child. The child is taught appropriate replacement behaviours and rewarded for using these behaviours appropriately and consistently while the teachers observe and learn the techniques and skills necessary to implement the program. Throughout the day, the child accrues points toward his or her behavioural goal. If the child reaches the daily goal, he or she gets to choose an activity that the whole class can do and appreciate. Each evening, parents receive feedback about their child's daily progress. Once the classroom teacher feels comfortable (around day 6) taking full responsibility for implementing the CLASS module, the consultant begins working with the child's parents to enable them to implement the HomeBase component of the program.

After day 10 of the CLASS module, the HomeBase intervention begins and runs concurrent to the CLASS module. During the HomeBase phase, the consultant meets with the child's parents either in their home or another designated meeting space for approximately 45 minutes per week for six weeks. Parents are taught skills to enhance their child's adjustment and success in school.

The final phase of First Step to Success is maintenance. During this phase, concrete rewards are phased out and replaced with social reinforcement such as verbal praise, recognition, and other signs of approval.

Outcomes

Program data document that even without follow-up intervention, First Step to Success has long lasting effects of up to three years beyond the end of the intervention. These effects are visible across years in school, classroom settings, teachers, and peer groups (Walker et al, 1998).

Summary

All research, including that conducted in Australia (Developmental Crime Prevention Consortium, 1999), indicates that the earlier the intervention the more successful the outcomes. First Steps is a proven intervention program that holds promise for the prevention of aggressive/antisocial behaviour patterns in targeted children. Whilst it's implementation would be initially costly in terms of labour intensity, the literature supporting its efficacy would seem to indicate that in the long-term it would prove to be cost-effective in that it would reduce the need for more intense intervention at a later date.

NEW YORK CITY

CHURCHILL SCHOOL AND CENTER

The Churchill School was founded in 1972 as an elementary school for children with specific learning (and attentional) disabilities. Today the school has expanded to include a Middle School and High School thus catering for children from K-12. In order to facilitate this, the school and Center will be moving to larger premises in Manhattan's Eastside late in 2001. The need for expansion is indicative of the success Churchill School has in catering to this population of children. With small classrooms (12 children and two staff) and staff trained in 'best practice' in the teaching of children with learning (and attentional) disabilities, the school manages to provide individualised programs that encourage children to both reach their academic potential and restore confidence in their own intelligence. About two-thirds of Churchill graduates go on to mainstream independent public schools in 7th, 8th, or 9th grades.

A private not-for-profit school, Churchill receives much of its funding from school fees although also taking referrals from the Board of Education. Funds are then supplemented through the Churchill Center, which offers training and workshops to parents, educators and other professionals.

The Churchill Center was established in 1981 as the community outreach component of the Churchill School to disseminate the expertise of the school's professional staff in educating children with learning disabilities. Their mission is "to develop and provide model services and programs that enhance the lives and educational experiences of children and adolescents with learning and/or attention problems and to encourage the replication of these services and programs throughout the country". Center programs incorporate current research, proven methodologies, and involve noted leaders in education and mental health disciplines. Activities include;

- **The Churchill Center Advisory Service**
  - an information, referral and case management resource for parents and professionals who require guidance in selecting appropriate school or college placements and/or information about related support services for children, adolescents or young adults with learning problems.
- **The Parent Program**
  - a series of professionally led workshops for parents of children with learning and attention problems. The workshops provide insights and information parents need to enable them to deal effectively with their special concerns and decisions. Some topics covered include; 'Oppositional and defiant behaviours: Guidelines for diagnosis and treatment', 'Toxins: The environment and learning disabilities', 'How to address your child's sensory and motor needs'.
- **The Social Skills Groups**
  - these groups are led by experienced clinical psychologists and are designed to help children and adolescents acquire, practice and generalise age-appropriate social skills.

- **The Behaviour Management Workshops**
  - these workshops give parents of children with attention deficit disorders effective strategies to deal with noncompliant and erratic behaviours. The goals are to increase positive parent-child interactions, achieve compliance and reduce the general level of tension within the family.
- **The Churchill Curricula**
  - these curricula are unique humanities, language arts and science programs developed at The Churchill School for use in teaching students with learning disabilities. Curriculum manuals for Central Park, Project Heroes and the Project Heroes video are distributed by the Center and are used in independent and public schools across the country.
- **Professional Conferences, Workshops and Courses**
  - conducted by Churchill staff and other professionals these workshops provided mainstream and special education teachers, mental health and health professionals with the knowledge necessary to work more effectively with children and adolescents with learning and attention problems. Some topics for Summer 2001 include; 'The teacher as diagnostician', 'Writing skills connected', 'Study skills for success', 'Preventing academic failure', 'Preparing better readers: A strategic approach to content reading instruction'.
- **The Learning Disabilities Roundtable**
  - composed of representatives of local and national public and private organisations and educational institutions involved in learning disabilities, the roundtable provides a forum for the issues that concern its member organisations and is a vehicle for change.
- **Consultancies and Presentations**
  - these are arranged by the Center for schools and agencies that need information about learning disabilities and guidance in educating students with learning and/or attention deficits.

Summary

With its focus on ADHD and LD, Churchill School has developed a rich program that encompasses ‘best practice’ in education for this particular group of children. They provide an individualised, multi-disciplinary approach for each child and their family as well as reaching out to the educational community to share their expertise. Well-trained staff and a network of support in the community assist the school in providing an excellent service for the children who attend.

In Australia there appears to be a reluctance to segregate children with learning and attentional problems from general education. After observing Churchill School and their approach to learning and teaching, I believe that for some children they can be best served in a small, specialised environment such as this. Well trained staff, smaller classes, special curriculum and teaching approaches, all combine to provide the ‘least restrictive environment’ for a population of children who need ‘special care’.

PROJECT REACH YOUTH

Project Reach Youth (PRY) is a community based organisation that helps low income youth to learn and grow in a creative and supportive environment. Through the delivery of education, counseling and youth development programs, PRY reaches out to more than 7000 children, teens and adult family members throughout the greater New York area. Working from a Youth and Community Development model, PRY develops programs identified by individual Community Advisory Groups as relevant and necessary to individual communities. The advisory groups are made up of people from the community, leaders, youth and parents. PRY also forms alliances with other agencies to ensure a better and more comprehensive coordination of services.

The PRY in the New York borough of Brooklyn currently offers programs that include;

- Education programs
- Youth Development/Leadership, and
- Immigrant Services

Education Programs

- Early Childhood Education prepares children for school and socialisation.
- The Family Literacy Program encourages parents to take an active role in their children's learning.
- The Family Learning Center is an after school and early intervention program that assists young people with their homework and encourages family involvement in schooling. The 'Beacon' centers are situated in a number of elementary and middle schools throughout Brooklyn.
- Summer Day Camps give children the opportunity to learn, explore, and become confident learners. The camps are offered free to PRY communities.
- The STAR program provides career education and helps young people who wish to gain college entry.

Youth Development/Leadership

- Project Touch trains teens to work with elderly citizens. Often individual grants allow stipends to be given to workers.
- Project Express is PRY's academic and literacy program. Teens produce a magazine and publish their own prose and poetry in four quarterly publications.
- Project SAFE stands for 'Speak out on AIDS Facts and Education' and allows young people to work in a street outreach program as well as providing peer education in schools.
- Project PAUSE, which stands for 'Peers Against Unsafe Sex Everywhere' again provides young people with an opportunity to provide peer education in schools.
- Silence the Violence is another peer education program. Like Project PAUSE and SAFE, this program trains teens to educate other youth through workshops and theatre presentations on the particular issues.
- Project LIFE offers Brooklyn youth an array of programming to help them achieve positive life outcomes.

- Teens in Action participants organise community service initiatives and PRY's annual Youth Conference.
- Project A-New-WAY reaches youth that have dropped out of traditional schools and creates a setting where they can gain a high school equivalency diploma, participate in internships, and prepare for a career.
- Project LINK is a mentoring program that pairs young people with carefully selected adult mentors. The mentors are trained on relevant issues of child development, counseling and tutoring and provide one-on-one support and friendship to the child as well as serving as a positive role model.

Immigrant Services

- Early Childhood Education helps children from immigrant families to succeed in school.
- Project Crossover helps middle school youth to learn English, succeed academically and to adjust to their new home.
- Latinos and Asians Building Bridges (LABB) brings teens together to bridge cultural differences and address conflict among their peers.
- Adult Education programs help adults to acquire the skills needed to succeed in the workplace, become citizens, and support and nurture their families. English language classes, citizenship preparation, and parent support groups address common needs.

Summary

PRY is a well-established social service agency that manages to successfully reach the communities it serves. With its youth development approach it empowers youth to make decisions based on informed choices regarding their education and their future. Community involvement is high as PRY encourages community leaders and families to take an active role in providing pathways for their youth. The creativity with which PRY addresses issues relevant to the community is encouraging and has provided me with many ideas to bring back to the Australian context. Many of the projects that PRY has undertaken could be replicated in Australia and would be of value to our society and to individual communities.

CAPE COD, MASSACHUSETTS

RIVERVIEW SCHOOL

Riverview school is a residential facility for students aged 11-22 that provides an environment which fosters language development through an integrated academic curriculum. In the 2000-2001 school year, the 167 students enrolled represented 22 states and 8 countries. Although sharing common backgrounds of social and academic difficulties, the diversity in the student population is welcomed and each child is treated as an individual with unique strengths and weaknesses. The target population are young people who have a primary diagnosis of a learning disability and/or language disorder and include some of the following diagnoses; learning disabled, language impaired, mildly mentally retarded, perceptually handicapped, attention deficit disorder, developmentally disabled, mild cerebral palsy, and traumatic brain injury. By providing remedial and compensatory programming in a safe, supportive and structured environment, students are able to more fully reach their potential. The academic and residential programming are closely linked and work together to foster critical social, academic and personal life skills to enable the students to function as independently as possible. Likewise, the success oriented, non-competitive, individualised nature of the program helps to increase their self-esteem, self-confidence and their willingness to take risks.

The integrated curriculum is provided with a Team-based approach wherein students spend their day with a group of teachers, thereby facilitating a 'whole-child' approach. The curriculum is presented in a 'thematic' manner in order to assist students to generalise and comprehend the material they are studying. Through a collaborative model of service delivery, young people have access to therapists for specific needs such as speech/language and reading. The residential component focuses on life skills and leisure time activities. The social skills program is ongoing throughout the day and the hallmark of this program is the utilisation of 'Social Autopsies' (discussion to debrief and practice alternative responses) to remediate social skill deficits.

G.R.O.W. (Getting Ready for the Outside World)

Students in the G.R.O.W. program share a common background of lifelong social and academic difficulties. Their intellectual capacity tests between 70 and 100 and their primary diagnosis is a learning disability and/or language disorder. They are often described as those who 'fall through the cracks', having average or slightly less than average potential and achieving more consistently within a predictable structured learning environment.

By providing remedial and compensatory programming within a safe, structured, supportive, predictable, responsive, success-oriented, non-competitive environment, students are able to more fully reach their potential. The academic and residential programming are closely linked and work together to foster critical social, academic and personal life skills to enable the students to function as independently as possible.

Likewise, the success oriented, non-competitive, individualised nature of the program helps to increase their self-esteem, self-confidence and their willingness to take risks.

The G.R.O.W. program emphasises academic skill development in addition to daily living skills. Academic classes are centered around themes based on issues that the students encounter in the adult world and skills they need in order to become more independent. Themes include;

- Community safety and leisure planning
- Social competency
- Personal wellness
- Creating a sound future, and
- Building cultural confidence.

Other areas studied and woven into the themes are;

- Consumer issues, life skills and language arts
- Community access practicum
- Money management seminars
- Nutrition and food preparation practicum
- Personal and world awareness, and
- Prevocational experience classes.

Summary

Riverview is a unique educational setting in that it not only provides for a particular population of children (ADHD, LD etc.) but it also manages to improve outcomes for these children by impacting on all environments they live in. Generalisation of skills can be explicitly addressed due to the boarding school environment and many of the skills the children need are learned in the social environments of their dormitories.

As with Churchill School in New York, Riverview staff are well trained and conversant in 'best practice' for this particular group of children. They also take an individual, multi-disciplinary approach to education that manages to empower these children to view their disorder(s) as a series of challenges rather than problems. During my time at Riverview, I witnessed a group of young people who were strongly committed to their education and who believed in themselves and their ability to succeed whilst recognising their limitations.

Although we do not have schools like Riverview and Churchill School in Australia, I believe that there is a need for them. Many young people with ADHD and LD are not 'best served' in general education classes and schools such as these that provide teaching and learning environments best suited to these children, could be established in Australia.

WASHINGTON, DC

CATALYTIC COACHING

Catalytic Coaching is a private business owned by Sandy Maynard who is a Certified Master Practitioner of Neuro-Linguistic Programming and one of the leaders in Personal Performance Coaching. Sandy specialises in adults and adolescents with Attention Deficit Disorder and provides individual coaching (explained below) as well as workshops for people with ADHD and professionals and parents who are working with these people.

Professional coaching is defined by the International Coach Federation (ICF) as;

> *"..... an ongoing partnership that helps clients produce fulfilling results in their personal and professional lives. Through the process of coaching, clients deepen their learning, improve their performance and enhance their quality of life. Beginning with the client's desires, coaching uses reporting, exploring and a consistent commitment to action to move the client forward. Coaching accelerates the client's progress by providing greater focus and awareness of choice. Coaching concentrates on where clients are today and what they are willing to do to get where they want to be tomorrow."*

Academic coaching whilst following the principles of professional coaching has the added purpose of fostering success skills in an educational environment. It is an individualised process that facilitates goal clarification and achievement and stimulates/motivates students toward their scholastic goals by providing structure, support and feedback (Catalytic Coaching, http://www.sandymaynard.com).

This empowering approach to dealing with ADHD differs from therapy in a number of ways. These are listed in Figure 3 and summarise the approach and processes involved in coaching;

Coaching	Therapy
• Begins with the premise that the client is whole	• Begins with the premise that the client needs healing
• Primary focus on actions and future and forces affecting them now	• Primary focus on feelings and history and past issues
• Refers individuals with prolonged depression, sever anxiety, phobias, harmful addictions, and destructive or abusive behaviour patterns to mental health professionals	• Treats individuals with prolonged depression, severe anxiety, phobias, harmful addictions, and destructive behaviour patterns, as well as other conditions
• Gives advice only in areas of expertise and with client permission	• Usually does not give advice
• Encourages and requests proactive behaviour	• Counsels on becoming less reactive
• Works mainly with the conscious mind	• Works to bring the unconscious into the consciousness
• Assists clients to learn new skills and tools for personal growth and mastery	• Assists clients with untangling unconscious conflicts which interfere with choice

• Helps clients learn new skills and tools for personal growth and mastery	• Helps clients resolve old pain and terminate old coping mechanisms
• Listens to feelings as clues to how to get the client into action and leads the client to an action step	• Listens for feelings as symptoms of underlying dysfunction and follows the client on any valid exploration of their feelings
• Typically directs the client to return to action	• Often directs the client to go deeper into feelings
• Oriented toward solving problems through action	• Oriented toward exploring the psychic roots of the problem
• Focused on facilitating client to get done what they say they want done, the resistance may be interesting, but coaching is not concerned with the 'whys'	• Focus on inability to do something as an indication of a more serious internal problem(s) that will eventually have to be brought into the open and modified, after examining what use the inappropriate behaviour is to the client before removing it
• Focused on learning and developing potential	• Focused on healing and restoring function
• Main tools include accountability, inquiry, requesting, goal-setting, and strategic planning	• Main tools include listening, reflecting, confrontation and interpretation
• Deals mainly with external issues; looks for external solutions to internal blocks	• Deals mainly with internal issues; looks for internal resolution, derived from theories for conscious and unconscious functioning
• Helps with empowerment	• Helps with empowerment
• Asks 'how' questions	• Asks 'why' questions
• Seeking focus, strategy, motivation	• Seeking self-understanding
• Individuals who are designing their future, learning new skills and seeking more balance in their lives	• Individuals who are dealing with issues, emotional pain or traumas and seeking resolution and healing
• Alliance designed jointly by coach and client	• Nature of alliance largely designed by the therapist
• Discourages transference as inappropriate	• Encourages transference as a way of objectifying issues to be explored

***Figure 3*: Taken from Catalytic Coaching "Coaching the ADDer"**

Summary

The symptoms of ADHD (distractibility, impulsivity, and hyperactivity) as well as the deficiency in life skills associated with them (time management, organisation, self-control etc.) present many challenges to sufferers throughout their life. Coaching is means of assisting children and adults to select target areas of their life and to set out to make changes that will help them to function more efficiently and manage their challenges with less difficulty. It requires the client to be willing to be accountable to his/her behaviour and to want to change inside. The role of the coach is one of a 'supporter' who encourages the person to stay on track as well as identifying skill deficits and providing instruction when necessary. Unlike traditional therapy, coaching empowers the client to look within and recognise their own strengths and weaknesses and to be prepared to turn their weaknesses into strengths.

BALSAM, NORTH CAROLINA

SUCCESS ORIENTED ACHIEVEMENT REALIZED (SOAR)

SOAR began as a dream of Jonathon Jones (an adult with ADHD) of a program that would provide children with the opportunity to learn in a therapeutic manner through outdoor adventure activities. He began the program with his own funds setting up as a summer camp program that targeted youth with Attention Deficit Hyperactivity Disorder (ADHD) and Learning Difficulties (LD). The program has now grown to an enormous size and manages to reach many at-risk youth in a variety of ways.

SOAR offers success-oriented, high adventure programs for youth from 8-18 that assists in developing self-confidence, social skills, problem-solving skills, and a willingness to attempt new challenges and the motivation, which comes through successful goal orientation. The experiential learning activities offered on SOAR camps allow each young person to discover and develop their own learning abilities. This results in a young person who is aware of their own personal strengths yet more willing to confront areas of weakness. When young people with ADHD and LD begin to recognise their weaknesses as challenges and opportunities rather than 'problems', an empowering change occurs in their life.

During the application process, the intake officer (Karen) determines which, if any, program will suit the individual child. Part of Karen's role is to network these agencies/programs and to assist parents (whether or not their children attend SOAR) to build their own support network. The 80-page web site also allows interested parties to access whatever level of information they require. Karen is also responsible for evaluating each program and collating/presenting these findings. The evaluations are used to drive any changes that may occur in particular programs offered.

SOAR is accredited by the Association for Experiential Education (AEE). This provides good credibility for the program as well as assisting organisers to follow specific guidelines for running outdoor adventure programs. A total of 383 young people attended camps in 2000, some more than one. The camps concentrate on life skills, teamwork and character building by providing young people with challenges in a safe supporting environment that will facilitate growth. In recognising the uniqueness of each human being and the variety of experiences each young person brings to SOAR, three levels of instruction are offered through the year. Young people are grouped in Basic, Intermediate and Advanced groups according to their ages, ability levels and commitment to leadership. Such a structure allows the SOAR staff to challenge each individual at his or her specific ability level.

Instructors at SOAR are selected for those qualities of maturity, sensitivity and caring which enable them to relate well to young people and enhance the adventure program. All are highly trained professionals in such fields as special and secondary education, recreation therapy, counseling, outdoor and experiential education. Additionally all have first aid and CPR certifications together with advanced medical credentials such as

Wilderness First Responder. All staff that work with SOAR are also trained to understand ADHD and LD and in the use of strategies for bringing out the best in these children.

Some of the adventures offered at SOAR include;

- North Carolina standard (12 days) and Expedition (18 days)- includes wilderness backpacking, whitewater rafting and rock climbing. Young people are taught basic instruction in cooking and first aid, group initiatives and climbing instruction.
- North Carolina Horsepacking or Llama Trek (both 12 days)- following a course in team building activities, groups complete a horsepacking (or Llama trekking) experience in the Great Smokey Mountains. The camp is concluded with a rock climbing experience and whitewater rafting.
- North Carolina Academic Experience (26 days)- this academic based program is designed to develop learning abilities to provide a firm foundation for academic achievement. An individual remediation program is developed for each young person, one that takes into account the strengths and weaknesses that the young person brings to the learning experience. The program focuses on Language Arts or Mathematics as well as study skills instruction. The academic component is complemented by weekend adventure activities including rock climbing, wilderness backpacking, caving and whitewater rafting.
- Wyoming standard (12 days)- this ultimate Wild West adventure includes horsepacking in the Wind River Mountains of Wyoming, exploration of Yellowstone and whitewater rafting.
- Colorado standard (12 days)- designed for the young mountaineer, this course is set in the Rocky Mountain National Park. Instruction is offered in rock climbing, alpine snow climbing, backpacking and mountaineering. The group then sets off on a trek that utilises the skills learned.
- Florida Keys standard (10 days)- this tropical adventure includes swimming, snorkeling, kayaking and marine travel.
- Alumni courses are offered to young people who have completed previous SOAR camps and include camps to Costa Rica and Belize.
- Spring Semester in the Southwest (117 days)- is one of three longer courses offered at SOAR. Young people are offered diverse classroom settings such as the ancient cliff dwellings of New Mexico, the Saquaro of Arizona and the vast Canyonlands of Utah. Together with the academic portion of the program, adventure opportunities include backpacking, mountain biking, caving, climbing, whitewater rafting and exploring diverse Native American cultures.
- Weekend courses are planned during Spring and Fall that offer programs concentrating on specific life skills such as; concentration/communication/cooperation, time management, goal setting/problem solving, and organisational skills.
- Family Weekend programs offers parents and children the opportunity to learn more about themselves and each other through activities, adventures and discussion on topics such as communication, behaviour management and self-esteem development.

Summary
SOAR is a well-established and nationally recognised program that offers a wonderful challenging experience for young people who often find it difficult to be accepted into groups. Through explicit teaching and experiential learning it offers young people who suffer from ADHD (and LD) opportunities to reframe their perception of themselves into something more positive as well as developing the motivation to take risks and challenge themselves to overcome their weaknesses. With well-trained staff who are able to deal with the challenges that a child with ADHD can offer, the courses ensure that young people achieve success and recognise their strengths.

SOAR offers a number of scholarships each year to young people who do not have the financial means to complete a course. They also use some of their donated funds in the community through the support of two local community projects, Operation ASPIRE and Project Pursuit (see below).

OPERATION ASPIRE

This program caters for young people who are caught up in the juvenile justice system. It provides schooling for them and attempts to reintegrate them back into school. Young people complete two full days of academic work, one day of life skills such as cooking and budgeting, one day in the outdoors and one day completing community service requirements. In an effort to promote a sense of social responsibility, young people are also involved in a number of community projects that aim to assist others in the community less fortunate than themselves. One such project involves the young people in finding homes for and providing food for unwanted animals in the Waynesville area. Many of the young people in ASPIRE move on to Central Haywood High School to complete their formal schooling years.

CENTRAL HAYWOOD HIGH SCHOOL

Central Haywood High School is an alternative school for students in grades 9 through 12 located in the Smoky Mountains of Western North Carolina. The school serves 65 students who have either dropped out of school or were in danger of dropping out of school. Small class sizes and individualised instruction are the keys to student success with a student teacher ratio of 1:9. All students take the state and county mandated courses for graduation plus electives of creative writing, photography, advanced P.E., drama, art, criminal justice, journalism, parenting, service learning or music. As part of the school mission statement, CHHS pledges to, "meet the individual needs of students by working together to remove the stumbling blocks that prevent them from achieving their potential".

The 'service learning' component of CHHS is one were students can earn a volunteer service learning credit by performing volunteer services in the community. It has been found that students involved in the program display significant increases in self-esteem and report feeling more a part of the community as a result of their experiences. Additional benefits from the program have been an increase in motivation for academic tasks, improved attendance and more harmonious social relationships. Young people

themselves report that they feel 'useful' to their community and more responsible as a result of completing the program.

PROJECT PURSUIT

Project Pursuit is a nontraditional educational strategy that employs outdoor classrooms to teach important social skills such as communication, cooperation, conflict resolution, and teamwork. Students participate in whitewater rafting, rock climbing, high ropes courses, caving, hiking and camping. Stephen Mayfield (the Project Pursuit Director) leads groups of eight students in a rigorous program that helps them build confidence, problem-solving skills, and develop a positive attitude.

The establishment of the project occurred following the Haywood County CBA Task Force's finding that the priority juvenile justice youth problem was characterised by young people who; lacked self-discipline and the ability to accept discipline, had negative peer influence and/or a lack of access to positive role models, substance abuse, lack of respect for authority, poor self-image/lack of hope and life time goals. With a limited number of services in existence to divert these youth from adjudication, Project Pursuit was set up to, "....teach new skills and identify support resources for each client as well as to provide each client with the judgment and self-confidence necessary to avoid further penetration of the juvenile justice system". The project targets youth from Haywood County aged 10-16, who are evidencing ungovernable, undisciplined, or delinquent behaviours and are identified as adjudicated or 'at-risk' of becoming court involved. Currently, the juvenile court and three county schools are being served (including Central Haywood High School and Operation Aspire).

The project completes extensive evaluation to ensure that measurable outcomes are achieved following involvement. These behavioural changes are sought in the school, home and community of the young person.

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