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**ADHD in the aspect of procedure/therapy based on the health care system  
in Poland**

Problems concerning diagnosis of treatment/procedure of mental disorders affecting children are the subject of interest of child psychiatrists, psychologists, educators, and speech therapists working in different medical and non-medical institutions. Because of a shortage of child psychiatrists (about 8 in a macro region and about 150 in the whole country) and neurologists interested in treatment of those disorders (sometimes they are forced to do this), non-medical professions play a large role in dealing with ADHD. The interdisciplinary character of psychiatry has always been emphasized, so one should be glad of this fact. On the other hand such a lack of balance taking place among those occupations is surely a flaw of the system. Why? If in a macro region there are 7 child psychiatrists working in Psychological Health Clinics for children, it is obvious that because of many duties they limit themselves to recognizing ADHD, eventually to pharmacotherapy and writing proper certificates for children. Alas, apart from good professional literature they do not have any satisfactory ideas about the way children function in other environments, including school. There is no time for instructing and even for professional meetings and conversations with specialists of other occupations. Some chosen outpatients clinics in big cities work with a staff of 1 child psychiatrist and 2 psychologists. After having cut time devoted to diagnostic dealing with other units than ADHD, there is not enough time for these types of disorders. For example in 600.000 area of cities there is now 1 child psychiatrist within public (gratuitous) health protection, offering 6 workdays for about 4 hours a month. In this period, statistically half the time is devoted to ADHD itself. Experienced psychologists work privately. But the institutions are not eager to employ the new ones. Psychological treatment is financially part of medical service. However, it is necessary to have 1 psychologist to run Psychiatric outpatients clinics for children, and this is the end of the problem. Maybe one could think

that there is some hope in the actions taken by instructed educators, teachers, who conducting school lessons and dealing with children affected by ADHD, could try to develop professional therapy of those children. But it would be necessary to give some money for additional working hours and instructing those persons. On the other hand, I have heard of the opinion that a teacher, except for the ability to conduct lessons, should not take on therapy. As I will mention later, children with ADHD can take advantage, among the others, of corrective-compensative activities. There was some hope connected with appearances of Nonpublic Health Centers, which were well-paid by National Health Service being able to assign some finances to additional therapy and courses of instructions. But political change in the Health Ministry resulted in the cutting of subsidies and a lack of consent as to creating new centres. Paradoxically, in the present system of financing there is no thread for clinics and scientific institutes, within which specialist outpatient clinics can be created, as it is for example in Medical Academy in Warsaw (Dr T. Wolanczyk). How does the psychological side function? In each of the larger cities one can find Psychological-Pedagogical Guidance, which most of the time has to estimate children's abilities for a certain school. It is recommended by teachers or kindergarten teachers. Moreover those guidances make psychological examinations recommended by physicians. They also take to psychotherapy. They give decisions as for individual education, integrated education. It requires medical certificate from a physician specialist (psychiatrist, neurologist, peadiatrist). Individual education most often takes place in school, moreover a child participates in chosen lessons (including educational lesson). Teachers are paid for those additional lessons. In integrating classes children with some problems/disorders learn with healthy ones. In such a class except for a teacher there is also a supporting teacher, having proper qualifications. In school, in each age-group there should be an integrating class, while in, for example, 200.000 City there are only two such schools. Special schools are for children with mental handicaps. Besides, children can not receive promotion in certain schools/classes. There are also day-rooms for children with problems/psychological disorders. A physician working in outpatient sclinics, except for treatment, has to give certificates about the health state, which are required by Disability Board, applications for a grant of nursing, to send to

Curative-Rehabilitative Center and more seldom to psychiatric ward. The visit in outpatient clinic lasts about 15 minutes on average. The sociotherapeutic day-rooms are most often financed by City Centers of Social Support, in which there are therapist (psychologists, educators) working part-time. Psychological-Pedagogical Guidance is an educational institution. It employs on average of 14 psychologists, 14 educators, and 3 speech therapists. It gives opinions and certificates. The certificates are followed by money for them. They concern: special school, integrating class, individual education. In those cases specialist medical certificates are required. In the case of ADHD from a psychiatrist. These integrating classes, in which the rate of healthy children to ill ones amounts to 3 for 12 to 7 for 7, are the most often for children with joined deficits (dim-sighted and with partial deafness). Each school has its own school educator. He is responsible for contacts with Psychological-Pedagogical Guidance, with Psychical Health Centre for Children, with the police, for solving problems taking place in schools, in the course of education. Dealing with a group containing only children with ADHD is not effective because of big difficulties in controlling impulses and children's reactions to them.

Ministry of National Education takes control over activities of Psychological-Pedagogical Guidances (590 in Poland).

. In education teachers and tutors take to helping actions – which support pupil's development and help pupils when they have problems learning; psychologists and educators support those educational activities of teachers and parents, they organize and inculcate different forms of psychological-pedagogical help for pupils, intervene in the most difficult cases; speech therapists diagnose and conduct a therapy of children and the youth with dysphaemia; other specialists also participate in those activities, e.g. professional advisers, physicians or social employees.

They conduct in schools, kindergartens, psychological-pedagogical dispensaries and institutions such forms of help as:

- supporting educational function of a family,
- therapy of developmental disturbances and dysfunctional behaviours,

- prophylaxis of problems of children and the youth,
- supporting effective learning,
- developing abilities connected with social communication
- conducting pro-wholesome education,
- didactic-compensative classes,
- specialist classes: corrective-compensative, logopedical, sociotherapeutic and other classes having therapeutic character,
- therapeutic classes,
- compensative classes,
- psychoeducational classes for pupils, parents and teachers,
- advice for pupils,

and in health section: among the others psychological health centres;

in social help section: among the others specialistic family centres, centres of support, day-rooms and environmental clubs, educational centres;

in justice section:

- family courts and curators, family diagnostic-consultative centres;
- in the structures of Catholic Church: family guidance;
- in non-government organizations: preventive-therapeutic centres;
- in the units of the self-government: city family centres, communal family centres;

in private institutions: specialist offices.

Based on the data we can say that in every fourth statistic primary school and gymnasium there is an educator. One should worry about a small number of

psychologists, speech therapists employed in kindergartens, where those specialists have especially a lot to do as for preparing children their school duties. The data witness that almost the whole burden of organizing of specialist classes (corrective-compensative classes) lies on public psychological-pedagogical guidances.

Didactic-compensative classes are organized for children who have serious delays in certain educational classes. Therapeutic and compensative classes are organized in primary schools and grammar-schools for children requiring long-lasting specialist help or intensive educational help. Recent decreasing a number of children attending therapeutic and compensative classes will burden Psychological-Pedagogical Guidances. It will prolong terms of waiting for reception by specialists in dispensaries and cause small possibilities to provide those children with direct help of those guidances. In the whole country in school year 1999/2000 there were 590 public psychological-pedagogical guidances. This number also included 34 specialist guidances involved in the activity concentrated on specific, homogeneous character of problems.

We can mention the following tasks of psychological-pedagogical guidances in the aspect of therapy for children with ADHD:

- support of many-sided development of children and the youth, efficiency of learning, acquiring and developing of ability from the range of social communication, - giving psychological-pedagogical help to children and the youth from risky groups, - therapy of children and the youth with developmental disturbances and dysfunctional behaviours, - support of educational function of family, - helping parents and teachers to diagnose and develop abilities and strong sides of pupils. It's interesting that headmasters of psychological-pedagogical dispensaries attach to much importance to diagnosis, but less importance to therapy. The problem is also in expensive courses while employees are not well-paid, which also lessens a possibility of getting professional help.

Children with ADHD can take advantage of:

- corrective-compensative classes

- -integrated education
- individual education.

It's obvious that the last possibility should be used in exceptional situations (a big thread of aggression and disorder). The organ which grants finances to classes appointed by psychological-pedagogical guidances, is self-government.

The interesting statistic data:

- the number of children's psychiatrists in Poland: 150
- the number of psychiatric outpatient clinics for children: 90
- the number of outpatient clinics of ADHD: 1 (At Warsaw- Dr Wolanczyk)
- children's psychiatric wards: 39
- day's psychiatric wards for children and the youth: 16
- rehabilitative-curative centres: 16
- psychological-pedagogical guidances:590 (non health institution).

In each of those categories we don't realize our own instructions, not mention the European ones.

To improve the present situation we have to establish a new system of psychiatric protection, treatment and prophylaxis of psychiatric health and proper social rehabilitation, the net of dispensaries and day's wards should guarantee the access to treatment in each region, lack of possibility of treatment in day's and ambulatory system is a cause of limitation of access to treatment, on the other hand causes the fact that in hospital wards there are children who don't require hospitalization.

One should add that the policy of National Health Service in the range of refund of psychotherapeutic services, so important in therapeutic plan towards children and the youth, led to liquidation of many very good centres, lack of access to

psychotherapy in social health service and complete privatization of those services.

The situation is even worse because of change in specializing process in the area of children and the adolescents' psychiatry which made it additional specialization, not, as it used to be, basic one. This fact causes the situation that one has to become a psychiatrist first, and only then a children's psychiatrist. This is a reason that a physician being interested in children's therapy spends almost the whole period of special training in different psychiatric wards for adults. It's not difficult to come to the conclusion that it leads to quitting primary way by most interested doctors.

A certain role in ADHD therapy is played by Rehabilitative-Curative Centres the number of which amounts in Poland to 15. Especially for children with behaviour disturbances in the course of ADHD and in connection with existence of family pathology. In such a centre there are on average 45 children. There's a specialist of psychiatry of children and adolescents, two psychologists, nurses, educators, including a class therapist. Therapeutic classes together with routine physician's visits take place in the afternoon, while till the afternoon children go to school. Learning takes place in small classes, it means 12 children with an educator. Reception to the centre is based on sending to sanatorium treatment on a questionnaire accepted by National Health Service. The rehabilitative-curative term lasts 6 weeks. Children take advantage of different laboratories of interests to make their spending of free time more pleasant and useful thanks to more directed attention. The participation in those classes of practicing of social skills takes place under control of an educator and therapist, who defines and modifies the schedule of classes.

### **The rules of dealing with an overactive child. Practical instructions.**

(Authored by: Lucyna Orzechowska)

1. Maximum limitation of number of impulses.

2. Regular course of life.
3. Regularity, organizing. The importance of the final stage of a certain activity.
4. The consistency of requirements – hierarchy of importance in execution of them.
5. The example of oneself in solving difficult situations or conflicts – calmness and self-control in solving problems. Concentration on problems, not emotions.
6. One short command instead of “speeches”.
7. Using the order rather than the prohibition.
8. Teaching clear norms of community life.

Dealing with a group containing only children with ADHD is not effective because of big difficulties in controlling impulses and children’s reactions to them (by Orzechowska).

### **The scenario of dealing with parents of overactive children.**

(Authored by: Lucyn Orzechowska)

#### **Meeting 1.**

Organizing-integrating

1. self-presentation of conducting participants
2. my biggest problem – expectations of participants towards meetings
3. talking about parents’ needs which are possible to realize during the classes
4. organizing establishments.

#### **Meeting 2.**

Educational

1. mini lecture on character and causes of psychomotor over activity

### **Meeting 3.**

Supporting

1. talking about exemplary situations and behaviour of children considered by their parents as burdensome
2. participants' sharing with their own experiences as for solving concrete problems
3. working out under a leader's control proper methods of dealing with an overactive child

### **Meeting 4**

Educational

1. minilecture. Basic rules of interpersonal communication.
2. Exercises.

### **Meeting 5**

Supporting

1. my child is exceptional. Parents' statements emphasizing those characteristics of the child, they are proud of
2. "I am good enough as a parent". Working on parents' feeling of guilt and low self-estimation.

The attitude based on the method of non-instructive therapy concentrated on the client by Rogers in Axeline assumptions (1947) is really interesting:

1. It is required to create a relationship full of warmth and friendship as quickly as possible.
2. It is necessary to accept a child the way he or she is, not should be.

3. The relation should have permissive character, giving a child an opportunity of unlimited expression of emotions.
4. It is necessary to recognize and reflect child's emotions so that he or she can achieve insight into their nature.
5. A child is responsible for changes.
6. Child's desires should fix a direction of therapy.
7. The rate of therapeutic work during a session should be accommodated to child's needs and abilities.
8. Limitations in the process of therapy should be a consequence only of security requirements and responsibility.

My concept concerning the meetings with parents of overactive children within the visits in the outpatient clinic is similar.

1. awaiting a child as a person we want to help (being interested, complete acceptance as a person)
2. "surprising" of a child with one's interest and acceptance
3. nice conversation with a parent, which helps us gather needed data
4. waiting till parents stop expecting a quick inclusion of sedatives through informing them about a need of performing additional examinations first (EKG, EEG blood examination)
5. an attempt of using the following statements: supportive, educational, paradoxical – a goal: desire to persuade parents with a simultaneous attempt of changing their unwelcome behaviours.

Then it's possible to take advantage of quite quick meetings in the outpatient clinic when there is often no possibility to provide children and their parents with proper therapeutic techniques.

In Polish conditions they also described the efficiency of cognitive ADHD therapy and behaviourist one. Physicians in outpatient clinics also use a hand-book concerning how to deal with ADHD, written by Dr Walonczyk and the others, who clearly talk to parents and teachers of children with ADHD. The author of presentation also with some success employed at children's Imipramina (the most often), sometimes Moclobemid. Those medications were given with acceptance of parents. For two children methylphenidate was brought from abroad with acceptance of native consultant. The author is working on the method of multidisciplinary dealing with ADHD. Being employed in different centres and outpatient clinics he is planning meetings with an advisory group of employees of Psychological-Pedagogical Guidances, with educators and teachers, he has current contact with children's parents and during consultations in wards of multispecialist hospitals for children he has contact with pediatricians.

I'm trying to work out an optimum influence on those environments being aware of quite difficult access to earlier specialist advice and to next visits.

Now something about therapy in another clinics.

For several years now it has been undertaking psychotherapy for ADHD children at the Therapeutic Centre for Children, Department of Psychology, University of Warsaw. Although the opinions on the efficacy of psychotherapy applied to those children are not encouraging and literature suggests that the only effective impact is that of parents' education and to a limited extent the behavioral – cognitive training for children, it is their opinion that it is worth searching for new ways of helping those children. Many studies confirmed that such children exhibit a specific interpersonal style which is characterized by that their social relations bear conflicts, satisfying neither themselves nor their partners, and their behaviour is disturbing, controlling and aggressive. Basing on the above data it may be surmised that a typical relation of the ADHD child with adults is characterized by few situations of mutual "harmonization" which is a condition for entering into such form of contact which developmental psychologists define as "episodes of mutual involvement". Mutual involvement

is expressed in the interest in the same area of reality and synchronising the partners' activities, it plays a particularly important role in the development of the child's competencies. It might say that the hyperactive children described herein could properly perceive the emotional communications and searched for a positive emotional exchange with the partner. Yet, accomplishment of their aims at domination and relieving the tension sometimes became more important to them than maintaining the contact. The methods of this therapy were based on an observation chart was prepared, describing the phenomena occurring in the child – therapist contact. It consisted of three parts. The first part was aimed at describing the communications transmitted by the child to the therapist. Part II was to describe communications conveyed by the therapist to the child. Part III was aimed at evaluation of contact reciprocation.

The same Department also treated two groups of boys (aged 8-10 years), 3 and 4 each. The therapeutic method was based on the principles of Behavioural-Cognitive Therapy for children ("Stop and Think" by Kendall and their modification).

Their modification of the Kendall's program consisted in:

- I. Introduction of tasks and activities based on the principles of R. Barkley's neuropsychologic theory which explains the mechanism of psychomotor hyperactivity. This theory, addressing the deficits typical of psychomotor hyperactivity., allowed them to address these cognitive (psychic) functions which required further improvement under therapy. Barkley states, that the essence of deficits accompanying ADHD is an inability to inhibit impulsive reactions and to implement other mechanisms of self-control of behaviour.

The training consisted in 8 sessions lasting 1 hour and taking place once weekly, having an invariable structure. Each session consisted of two separate parts: structuralised tasks aiming at development of specific executive functions and free play. Every session began with the same scheme: welcome, definition of mood of every participant, presentation of a plan of activities and ended with a general farewell to all boys. They began the training with writing down an agreement and establishing the rules obligatory for all participants, then they introduced gradually elements of affective education and final sessions were devoted to the development of cause-effect thinking, planning abilities and

anticipation of possible consequences. The therapeutic program ended with a common picnic for children and their parents, creating an occasion for exchange of impressions and doubts. Parents could learn about the course of sessions and observe their children interacting with their peers and therapists. Every child had his individual therapist and remained in close contact with him/her.

The main conclusion which the authors drew from these sessions is the conviction that a combination of directive and non-directive elements is both possible and profitable. They convinced, that when working with hyperactive children we must accept his/her symptoms and stay in contact with the child even if it is running around the room, rides a bicycle, jumps on mattresses or lies under them. Every such situation should be used to transmit him/her important experiences. Their experience and literature data suggest, that when working with hyperactive children, it may be profitable to change the profile of activities from training, which teach some new abilities to more individual needs of every child, where the child gains positive experience