**INV**-**018-S-U-S-STA-F-SPEC:** SENCO, urban, southern, state school, female, special school

## General introduction

**INTERVIEWER:** Can you just fill me in a bit on your experience? Because obviously you’re in a special school now, have you always been in special education?

**INV**-**018-S-U-S-STA-F-SPEC:** No. I started off in, um, mainstream. I started off in [XXXX] over in [XXXX], so a Catholic school. And I think my first… so I would’ve been fifteen, sixteen years ago…I had a boy in my class…called [XXXX]. And he always stood out because he was very tall, but well-set. And you could- his mum said to me one day, ‘You’ll know what type of day he’s going to have because you can tell by his hair.’ And if he was going to have a bad day- if he had a bad day his hair would be standing up on the – here – on the crown of his head, which was always really interesting. So you could tell. So, that gave a bit of an insight into…prevention rather than cure with him. Then I did some time at [XXXX] – realised that little people weren’t for me because they just, like, picked off the sequins on your shoes because they’re so little, aren’t they? [laugh] Or rubbed your legs. [laugh] Or wanting help to put their tights on. [laugh] And then I went to [XXXX] and I loved [XXXX]. And…my first year, I had a boy who had significant- well he had a behaviour mentor from the local authority when I started. And within two weeks that resource was…removed and he had to be- obviously be in school full-time because that’s his right, so we had him in school full-time. And then he went up to Year 6, but he came to me most afternoons when he was in Year 6.

**INTERVIEWER:** And were you acting as a SENCO there?

**INV**-**018-S-U-S-STA-F-SPEC:** No, I was just a class teacher. Um…and then I, um, did some…time- I then had- I went into Year 4 because the cohort was challenging. It was one of those year groups that had been challenging from Reception, so I went into Year 4 and I then took them up into Year 5 as well. And… and, um, at the end of Year 4, I had a child who came into my class who had ADHD and was not medicated because they were waiting for CAHMS. And he literally bounced around the room. My first meet of him was he’d locked himself in a locker and then couldn’t get out.

**INTERVIEWER:** Oh.

**INV**-**018-S-U-S-STA-F-SPEC:** So he’d got into the locker [unintelligible] and he’d put the latch over by hand but he then couldn’t- So obviously, we could open it – just – because it was- the locker had expanded with him in it. So that was my first. And then he wanted to jump out of the first-floor window because he just couldn’t he couldn’t sit still. He just couldn’t. He had no control. So over the summer of Year 4 to Year 5, they medicated him. Um…but there would be days he would refuse to take his medication – ‘You’re trying to poison me.’ So I worked with him and then…we had outreach from [XXXX]. We had [XXXX] come in to do outreach. And she spent a lot of time working with us with this young man and she said to me, ‘Oh, we’ve got a position coming up at [XXXX]. I’d really like you to apply for it,’ and then the rest is history. I came here as a class teacher and I taught Year 5 and took them to 6. And then I had a very challenging cohort in Year 5. Then I went off for a year for maternity. Then I came back and had another Year 6 cohort. And then…I had another Year 6 cohort and they were that challenging we only had six in the class…and four adults. Um…and then I went off and had [XXXX]. And then I came back and, um- So before I had [XXXX], I was doing my SENCO- I’d had my SENCO hat on, but the previous headteacher…was doing it as such. I’d sort of said I’d wanted to do it. Then I came- so I started to do my accreditation- my graduate- postgraduate course. And then I came back in 2000- January 2005 and become part of the senior leadership team. And yes, that’s me.

**INTERVIEWER:** Wow. That’s quite a varied career. A lot of challenging behaviour. But you obviously, well, have some enjoyment from it or sense of achievement. You get some rewarding days as well as the hard days.

**INV**-**018-S-U-S-STA-F-SPEC:** There is always something- I always say to staff when I work with them, especially if they’ve had a challenging day, ‘Okay, pick out one good thing and just hold on to that. And if it’s that they all came in at lunchtime. Or they all sat on the carpet for eight minutes and listened to Newsround because every class listens to Newsround after lunch.

**INTERVIEWER:** Oh okay, why do you do that?

**INV**-**018-S-U-S-STA-F-SPEC:** Just so they have an understanding of what’s going on in the world and news. Because I’ve worked with children here who- we went to [XXXX] and as we drove past [XXXX], sort of on your way to [XXXX], there was that big area of water and they asked me if that was the Atlantic. They’d never been out of the [XXXX] estate…until they came here. So lots of children [unintelligible] have never been on a school trip. So, yeah.

## ADHD as a disorder and its symptoms/The diagnosis and treatment of ADHD

**INTERVIEWER:** Ah, exciting. So I guess you’ve seen different, sort of, presentations of ADHD over your time. So you mentioned that one boy, um, but have you seen different behaviours from different children?

**INV**-**018-S-U-S-STA-F-SPEC:** Yes, so... [4 secs] Yeah, so the boy in mainstream was obviously- we were able to, like, have him in a mainstream school with a one-to-one and he did really well. Um…he wasn’t violent; he just couldn’t sit still. But here…you do see…the violence comes out. I think that’s probably because…a lot of these children are scared. You know, we’ve got a little boy who’s just started – in his mainstream school he was really violent to start. Because I guess – it comes back to what you’re looking at – they weren’t equipped to understand what his behaviour was communicating. And actually he was scared, so he was violent because he was scared. Since he’s been here, we haven’t seen any of that. Now he’s only been here four weeks, but – We just get refusal: ‘No, I’m not doing that.’ Okay, that’s fine. But then we’ve got…steps in place that will happen eventually or…rewards in place, because we can do that here. That’s now set up. So I’ve seen it. I’ve seen ADD as well, so not the hyperactivity. But you still have the same- sometimes the behaviour is similar, um, and the way you treat it. Um…I’ve got one boy at the moment who…CAHMS discharged him a couple of years ago and said he didn’t have ADHD. The first time I met him in June I was like, ‘He’s got ADHD.’

**INTERVIEWER:** What was it about him?

**INV**-**018-S-U-S-STA-F-SPEC:** He just swept through like the Tasmanian devil. [laugh] But he was like- He’s lovely. He’s so lovely. He- he cannot. If we’re outside in the playground in one straight line, he’s dancing- he cannot. So we’ve done class observations. He can’t sit still for more than twenty seconds, and even then, it’s- there’s a fidget.

**INTERVIEWER:** So is it always, kind of, physical movement that you’ve seen? Or any other, sort of, traits or behaviours?

**INV**-**018-S-U-S-STA-F-SPEC:** Here, yeah. And I think that, um…that’s hard to manage when you’ve got thirty other children or twenty-nine. In some schools you’ve got, you know, thirty-two in a class in, um, Key Stage 2. Then that’s hard to manage. Because they’re constantly fidgeting and moving and looking for sensory feedback. So even if it’s just rocking backwards and forwards, fidgeting, biting their fingernails, at their hair. They can’t concentrate on the task in hand. They constantly need redirection. And this young man constantly needs – we’ve tried to use a now and next board with him, and he can’t think about next because he can’t even- he can’t stop to think about the now. So he’s got no sense of danger. So he will just run out in the car park. And he’s not being naughty – inverted commas – he will just, ‘Oh, there’s my nan!’ Boom, gone. Woah, woah, let’s stop. There’s no stop and think, which is a worry. Because his nan says, ‘I can’t even take him-’ – he lives with his grandparents – ‘I can’t even take him to the supermarket and get out the car unless I’ve got hold of him.’ And he’s as big as I am and he’s Year 4. That’s the other thing I’ve noticed. It’s physical makeup you can tell as well. So we have other children here who- he’s tiny, one boy. Really tiny, to the point where they don’t know, if he doesn’t put weight on, whether they can medicate him because he’s so tiny. Small feet, he is just tiny. So we see that sometimes. Because they are always going, they just burn through…whatever they- burn through whatever they eat. So those children eat a high calorie diet.

**INTERVIEWER:** Yeah. And I guess obviously it’s, like you said, it’s a different environment here because you’ve got less children in the class or you’re set up to be more flexible. But can you describe a bit about the impact on other children in the classroom?

**INV**-**018-S-U-S-STA-F-SPEC:** So the children who- so we have children here with autism- the majority of our children also now have- we have children with autism, they are on the spectrum. They find it really hard if – the likes of the young man who started in September who has no stop, he has no off button – um, they find that annoying. And they can’t cope with that themselves so that then gives a problem in their reactions. You know, tables and chairs go, they get angry, they leave the classroom, they can’t learn, things like that. So for the other children it’s hard as well. So that’s why we have to work collaboratively not just for the young person – obviously the young person is in the centre of that support circle – but we have to think about the other children and the impact. And it’s the impact on everyone’s learning. So, yeah.

## Training and support for teaching children with ADHD

**INTERVIEWER:** So for you, what are your priorities with your staff? I mean I’m thinking obviously particularly about ADHD. If you are supporting one of the class teachers, what are they asking for the most? What do they need in a day-to-day?

**INV**-**018-S-U-S-STA-F-SPEC:** So we do a lot of coaching here. So we’ll go and do like ‘parrot on the shoulder’, so we won’t be looking at the lesson content as such – to a certain degree, yes. But we support our staff in- [8 secs] Are you going back down to the library? Yes, good. So for example with, um, we’ve got two NQTs; they’re having coaching from one of our more experienced members of staff, um, about how you can be eyes and ears across the classroom. Because whilst we only have ten or eleven children in a class…that’s a lot considering in a mainstream you may only have one child, maybe two, with those complex additional needs. So there’s one teacher, three TAs. So it would be about going in and modelling best practice. It would be, um, saying to a member of staff, ‘I can see you’re frustrated. Let’s look at it from the child’s point of view, you know, the eyes of the child.’ We would, um, we have a pastoral team as well that can go in and support. The children are referred down to the pastoral team so the pastoral team can do and assessment and say, ‘This is what this child would benefit from in the classroom.’ We sit down- we would sit down with the class team and say, ‘So okay, well we’ve tried this and this, and this has had absolutely no impact. But this has had a small impact. Right. It worked in weeks two and three but in week four it didn’t work but we’re going to keep going. Because we know that with a lot of our children here is that you’ll try something, and it’ll work and then they’ll push against it. And what they’re looking for is – subconsciously – is they’re looking to see if you’re consistent. So if you just keep going on, you know, whatever that intervention is, and then by week five they’re like, ‘Okay, yeah you are consistent,’ and that’s how we build the child’s trust with us. We also hold staff meetings – whole school staff meetings – once a week where we will talk about certain children. We will look at children who have, um, the highest number of violent or level three incidents. We will look at the children who we are deploying the most physical intervention on. We look at- we unpick everything. We do a pupil profile and we’ll do a positive handling plan.

**INTERVIEWER:** What does that mean?

**INV**-**018-S-U-S-STA-F-SPEC:** So we look at the three different stages of behaviour. So…um, if I knew your trigger was…little Johnny walking in and he had an ice pole, it’s about preventing that for you, but it’s also about teaching you the skills to understand that actually someone is going to walk in throughout your life and do something that you won’t like. It’s about building your resilience and your self-esteem and your skills. So, um…again [unintelligible] we do skills card. So, ‘I want you to work on your listening skills and this is what a good listener-’ and we write down: What does good listening look like? What is listening? Because sometimes children don’t even understand what that word means. So we would break that down, we would…reward them when they’re listening but we’d also take them out of the class and say, ‘Right, we’re going to go and look at someone else or another class, and I want you to tell me who you think in this lesson is listening. Okay, what are they doing?’ And we use it for other skills, so collaboration, teamwork, um, speaking as well for some of them. They’ve always had to be loud in their last school so they’re very loud here. And they all have their skills cards and they fill them up. They get stickers. And it’s something that other schools- well, the package has gone out to other schools and it works. And we don’t do it for every child but for children that need that. It’s about the basic skills that you and I would’ve taught our children before they went to school, eating with a knife and fork. So…we always say- we will say here that, um, every child is everybody’s responsibility. So we have to read their positive handling plan. So in that will say what their triggers are, what they like doing, um, what works as a good de-escalation. Sp when we look at physical intervention, it’s always about 95% de-escalation and 5% physical intervention. Change of face we use; we would employ that. We might say, ‘Well actually, [XXXX] isn’t really keen on, you know, [XXXX] or [XXXX] so actually when there’s a radio call – we know who it is because the initials come over the radio – I know I’m not the best person to go out to that child or actually, I have a really good relationship with that child so I’ll go. And that’s how we just work as a team.

**INTERVIEWER:** Yeah, sounds great.

**INV**-**018-S-U-S-STA-F-SPEC:** And…the support is there and if any adult just needs- sometimes you do need five minutes because of whatever’s going on at home, or you’ve been kicked or punched, um, people are there to step in. So, yes. And in terms of- so we will sit down- So when the new children come into us, every class team has an Education, Health and Care plan folder for their class. And…every member of staff is expected to read through the headlines of it, basically. We- I go out to team meetings. Team meetings happen at lunchtimes and when I’m not on duty I will go out to a team meeting and say, ‘Right, you’ve got a problem with [XXXX]. What could we do to help? What have we done? What could we do?’ Then out of that it might be that we need to make a referral to MASH. We might need to make a referral to Family Matters for support for the family. It might be we’re making a referral to CAMHS or if they’re already in the CAMHS system, I can contact a lady called [XXXX] or [XXXX]. Um…it’s, um, we send teachers and TAs out to mainstreams as well, just so they can see…that it happens out there as well. There are challenges in mainstream settings as well as here. Um…we send them to other special schools. We work with other special schools. All staff are trained in PI, so we look at what triggers would. We hold regular staff meetings and staff training. So, [XXXX] has run staff training. What does ADHD look like? What do I need to do? How do I need to not react?

**INTERVIEWER:** So if you were thinking about a teacher who was coming to start at your school, ideally, what would be the best preparation for them – in terms of thinking particularly about ADHD – what would be the best way of them, sort of, getting ready?

**INV**-**018-S-U-S-STA-F-SPEC:** So we would try to get them to come in. So if they were starting in September, we would try to get them to come in…a couple of times in the holidays and shadow…our more experienced staff. And even if the staff is a member of- the teaching assistant, you know, because we have some amazing teaching assistants here as well who have a lot of experience. So when, um [XXXX] started last year, she came in and she shadowed. We also would put myself or [XXXX] in the class and, you know, we’d sort of…not be joint teaching but…in a way I guess be team teaching. And then [3.5 secs] they would go into review meetings as well, so sit and talk to [XXXX], sit and talk to [XXXX] when she comes in about, you know, what works, what doesn’t work. Um…we do training courses. We’ve also got where we can go and send staff to [XXXX] which is based over at [XXXX] and they do courses. So that might be something else that you might want to look up and see what they offer. [3 s] So that is how we would- yeah. And then we check in with them. When [XXXX] started we checked in with her every night for the first three or four weeks: ‘Right, how’s it going?’ Um…and then…all of a sudden, she’s just- you know, she says she’s been here a year, but she feels like she’s been here forever! [laugh] But it’s that communication and that’s something that all staff will say here is a real positive of [XXXX] is that we communicate with each other. So that’s how- and actually when we have TAs in, we won’t necessarily assign them to a class to start with. We will say, ‘Okay, we want you to go and look at that class because they’ve got these positives and these children have these challenges.’ And then we might send her down to the lower end of the school, because we’ve got children now as young as Year 2. Last year we had a Year 1, and we go up to Year 6. So it’s just about showing good practice. And, you know, talking through, ‘Do you have an understanding of what ADHD is? Do you have an understanding of autism?’ We used to run training courses from here…in the days of outreach. We don’t do that anymore because outreach is over at [XXXX] – the person that used to run those works somewhere else now – but he would often use the information.

**INTERVIEWER:** Okay. So, if you were thinking about, you know, you wanted to send some teachers on an ADHD training course or wanted to get someone to come here to do one, what kind of information do you think is the most useful for people?

**INV**-**018-S-U-S-STA-F-SPEC:** I think they…certainly for us when we’ve had people in, they talk about ‘what is it’. Because… What is it? How does it present? And they talk through the brain and that’s something that [XXXX] does really well. She’s did a- I’m sure she’s got a master’s or something. She will sit and talk to staff about, ‘Right. This is the brain, this is what the brain looks like, these are the different elements, this is what happens here.’ And then we actually put that through into our physical intervention training ,where we talk about the fight, flight and freeze responses and how that works with the brain and the rest of the body, etcetera. So that’s what we look for – almost like the clinical side of it.

**INTERVIEWER:** Yeah. So you think it’s important to have the background of what it is and where it comes from?

**INV**-**018-S-U-S-STA-F-SPEC:** Yeah, absolutely. And not necessarily what causes it, but there is some of- And I think also the other thing to bear in mind, so I say to staff, ‘No, that child doesn’t have ADHD. They have early developmental trauma.’ Is it ADHD? Is it autism? And I said, I don’t know if I- We have a boy here now who…he was always very naughty in his previous school, and I use that in inverted commas. When he came here – oh he’s so naughty. He’s so naughty. But why? So he came into us in Year 3. We didn’t really see anything…until March and his behaviour started to…decline. His positive behaviour really declined. And we held him one day because he was chucking punches, and during the hold he passed out. He got really angry and then passed out. So this happened and we called an ambulance, and this happened several times. Mum’s very, very supportive. Mum’s a professional – worked for the local authority at the time. And a very, very long story cut short, it turned out he did have ADHD and autism but…the main diagnosis was epilepsy. And hydrocephalus, which is water on the brain. And that had all been completely missed. So what he was doing, he couldn’t, like- you and I, the fluid in our brains goes, you know, up and down, etcetera. He couldn’t do that, physically could not. His body couldn’t do that. So he would go into this rage and when he went ‘pffftt’ and passed out, it would release the water. So his body had learnt, ‘This is what I need to do.’ So the body’s very clever. Complicated, but clever. Then that’s what he had learnt. And he would literally build himself up and we would go in and do all these classroom observations on him and think, ‘There’s something missing here.’ And…he had his medication; he was on a high dose of medication for ADHD. And I’m thinking, ‘It’s not your classic- it’s not ADHD,’ because the level of violence that came out of that. So, I remember going to hospital in an ambulance one October afternoon and mum arriving and saying, ‘I’m not leaving until the consultant comes and talks to me. We have been here for six months.’ So that’s when they did the- sedated him, did an MRI, he fell asleep completely and had- whilst he was sleeping, he was having epileptic fits. And then they came back and said, ‘There’s water.’ So they manage the water – the hydrocephalus – through medication at the moment, not through putting a shunt in because of the risks of putting a shunt in at his age. Um…but every time he had an epileptic fit, he’d come around and he wouldn’t know where he was. He would sometimes wet himself. But then before he had them, he wouldn’t eat, and he wouldn’t drink. So, we always talk about Maslow’s hierarchy of needs here. He was hungry and he was thirsty. He’d have an episode, and then afterwards he would eat and drink and sit and chat like we’re chatting. It was almost like he would build himself up and down. So I think it’s about knowing that…you can’t just blame ADHD for everything. Because people- I remember ten years ago, um, having a boy in my class and mum said, ‘We’ve been to CAHMS, he’s got ADHD.’ And I said, ‘Well, there’s no ‘H’ to it.’ You know, he’s a bit like a sloth. [laugh] I get the deficit, you know, the attention deficit because he cannot concentrate, but there’s no ‘H’ there. But he was medicated with…whatever it was, [unintelligible], and he became really violent. We had three weeks; he was biting people, punching. And, um, our previous, previous, previous head said, ‘You have to take him off that medication…and get back to CAHMS.’ So they did, and they changed it for a medication for ADD. So much better. But that’s the thing about…that was about ten years ago when it was just diagnosed all the time. And actually, then there’s been more research into it and actually it can present like ADHD but actually it’s not. But whatever it is, still needs to be- needs to have some help. And we have children here who present as if they’re ADHD, and parents have tried everything with…food, you know, making sure the food’s right and this is right, etcetera, etcetera. And they put them onto ADHD drugs, and their behaviour gets worse and deteriorates. We’ve got children now who are on aripiprazole and risperidone, which is an antipsychotic drug. Because the ADHD medication didn’t work, but you’ve got to do something because there’s obviously something going on. So, um, I think from a training point of view, you need to know what it is. How you diagnose it, as well. What are you looking for? And…I also think from a training point of view is that- It’s really hard, because every child that comes in here – when I speak to SENCOs, not all SENCOs but – people are like, ‘They’re just naughty.’ He can’t just be naughty. There has to be a reason behind that behaviour, and I think it’s that understanding. People need an understanding. And actually, I think if you can put on a training course, you know, an adult who has ADHD and how they feel, actually. And then you could put also in there…how it feels to be a mum of a child with ADHD. It’s exhausting…for that parent and that family. You know, and actually the school’s only got them for six hours of the day. Yes, you’re trying to get them to learn but, you know, I see some real heartache in our parents here. They’re absolutely exhausted when they walk through the doors here in September with their child starting a new school. So, I think…as well as the classroom management strategies, there has to be an understanding of what it is.

**INTERVIEWER:** Yeah. Have you been on any sort of good training for ADHD?

**INV**-**018-S-U-S-STA-F-SPEC:** No, only what we do here really. Only what [XXXX] used to do here. I mean I speak to [XXXX] a lot.

**INTERVIEWER:** Yeah. And what’s her role exactly?

**INV**-**018-S-U-S-STA-F-SPEC:** She’s a senior…she’s a senior nurse practitioner. She works very closely with [XXXX]. So tomorrow, for example, [XXXX] is coming here to do a clinic. So, she’ll review four of her children and have the families here, two of which will be attended by our parent liaison. And she leaves at half past two and then I’ll do the last two of the day. And…we always give a school view as well as home. Because medication is taken at different times of the day…and some parents don’t like to medicate at weekends because…well that’s their prerogative. So she’s in tomorrow and she’s brilliant. She’s amazing. I’m sure of it. But she is great. She has a real understanding…of the children, but also of the parents as well. She has a passion to help these children and, um, I think that’s the other thing in a course – they need to know that it’s not chosen behaviour. And I think adults who don’t have ADHD, or don’t have children with ADHD, or work as we do here, it’s about knowing that…what they’re doing is not out of choice – they just can’t help themselves.

**INTERVIEWER:** Yeah. Sometimes the inconsistency of behaviour can confuse teachers. So sometimes they seem to be concentrating really well, so then they assume they can concentrate really well all of the time.

**INV**-**018-S-U-S-STA-F-SPEC:** Yeah. And it’s about knowing about, you know, when they get home, they’re utterly exhausted. Especially as they- I’ve worked with children who have, as they go into teenage years certainly, and they don’t want to take the medication and they’ve learnt to control it. But then they have these like, post – I can’t remember what the term is – but when they get home, they’re just exhausted. Because they’ve held it together for six hours, almost like being on stage, so when they get home they’re just completely like [exhale] So, yeah.

**INTERVIEWER:** You mentioned before as well as about teaching student teachers, so like at PGCE level – how to recognise ADHD or how to teach a class with children with ADHD. Um…do you think, you know, at the same level they should be learning, you know, ‘What is it? How do you recognise it?’

**INV**-**018-S-U-S-STA-F-SPEC:** Yes. Because they’re going to go in and do their training, aren’t they, within their PGCE? And they could have- I think the statistics are…one in ten?

**INTERVIEWER:** With ADHD?

**INV**-**018-S-U-S-STA-F-SPEC:** I’m sure it’s one in ten or is it-

**INTERVIEWER:** They reckon, on average, it’s one child in every classroom, so maybe about 5%. That would be the highest in the UK.

**INV**-**018-S-U-S-STA-F-SPEC:** Yeah. And I think if they had some background…to it, as well. Because it’s also about the differentiation. But I think they should. There should absolutely be that from the start of your teaching career – I wish I had had that. Um…and I did my training through the [XXXX]. And I did go and listen to a lady – she was the head of [XXXX] at the time, I don’t know where she is now – and she was doing all our PSHE and training, you know, how to teach PSHE, etcetera. And she actually came with a handout of…all the different common classroom, um, not illnesses that’s the wrong- but conditions. So there was dyspraxia in there, dyscalculia, dyslexia, ADHD. I mean it will have changed in the last- But she basically gave this handout out and it was brilliant. It gave her what the definition almost is and how you might see it presented. And that was really useful to have. ODD was in there; Tourette’s syndrome was in there. And actually since I’ve been here, I’ve seen all of that here. So that sort of thing when you’re training teachers – trainees – I think they need to know because…especially because once they finish…then they go on and do an NQT year, don’t they? And they could walk into a school [unintelligible] and have- yeah. I think so. Well [XXXX]’s an NQT.

**[XXXX]:** Hello.

**INV**-**018-S-U-S-STA-F-SPEC:** Hello. So obviously you worked here, so you had an understanding of children with ADHD. But on your course, do you think that’s something that – and your mainstream colleagues as well – would they have benefited from having training in?

**[XXXX]:** Special school?

**INV**-**018-S-U-S-STA-F-SPEC:** Well no, but when you were at [XXXX], there were people that were working in mainstreams, weren’t there? So like, [XXXX], [XXXX], etcetera. Do you think they would’ve benefited from a session or some training in: what is ADHD?

**[XXXX]:** Yeah. So we had, um, we had a…like, some sessions of, like, lectures at thingy, um, on special educational needs. But…I think you probably need to see it more…than just theory. So a lot of them wanted to come and look at our school, wanted to have a look at [XXXX]. Is it [XXXX]? Yeah. And [XXXX] and stuff. Because they feel like they would benefit better than just learning the theory side of it, because there’s not just one type of autism.

**INTERVIEWER:** Yeah. Maybe you could have videos of…snapshots in classrooms of different things going on.

**[XXXX]:** Like the way you lay your classroom out.

## Conclusion

**INV**-**018-S-U-S-STA-F-SPEC:** Yeah. Great. Well I think we’ve covered everything that I wanted to cover. Is there anything else that you can think of?

**INV**-**018-S-U-S-STA-F-SPEC:** No. Do you want to have a look around?

**INTERVIEWER:** Yeah.

[End of interview]