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The antithesis of inclusion?

The emergence and functioning of ADHD special education classes in the Swedish school system

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The antithesis of inclusion? The emergence and functioning of ADHD special education classes in the Swedish school system

The neuropsychiatric paradigm has substantial impact on schools. The increase in the number of pupils being diagnosed with attention-deficit/hyperactivity disorder (ADHD) is an expression of the medicalization of deviance. There is also an increase in educational classes specially designed to meet the needs of children with ADHD. This is contrary to the notion of inclusion and in conflict with the Swedish school law. Thus, it is important to obtain knowledge about Swedish ADHD classes.

A questionnaire was sent to all Swedish municipalities (290, response rate 76%) regarding schooling for pupils with ADHD. As many as 40 Swedish municipalities have classes specifically designed for pupils with ADHD. Although the classes are said to be specifically designed for ADHD problems, they are not properly evaluated. Municipalities with ADHD classes also exhibit ambivalence towards these classes. The emergence, prevalence, and functioning of the ADHD classes is discussed in light of the notion of inclusive education.

Keywords: ADHD, inclusion, special classes, special education, school

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The overall aim of the study is to explore how Swedish municipalities organize schooling for students with attention-deficit/hyperactivity disorder (ADHD). The main focus is on ADHD special education classes, here defined as a type of educational group in which the majority of pupils have an ADHD diagnosis. We pose the following research questions, on two levels, in pursuit of the aforesaid aim:

At the national level,

1. To what extent are ADHD diagnoses of substantial importance within municipalities?
2. What is the prevalence of special classes (ADHD classes) specifically designed for students with ADHD?

At the municipal level, for municipalities with ADHD special classes,

3. How do the municipalities describe their ADHD classes with respect to educational management of these classes and educational conditions within the classes?
4. What are the experiences of having ADHD classes?

As background to the study, we will first provide an account of what seem to be two rather contradictory developments relevant to our area of inquiry. On the one hand, a neuropsychiatric paradigm of defining children's differences has emerged and has gained momentum, and, on the other hand, the concept of inclusive education has also enjoyed success. Both of these seemingly opposing tendencies are important contextual aspects to consider in interpreting the data presented here, and we will return to them in

the discussion section. This introductory section also contains an account of relevant prior research and a brief description of the Swedish education system, focused on special needs provision.

The emergence of a neuropsychiatric paradigm

At the same time that inclusion has emerged as a catch word for the education of children in different types of difficulties, children are increasingly being diagnosed with neuropsychiatric disorders (Swedish National Board of Health and Welfare 2012), which can be seen as an expression of the contemporary increase in the medicalization of deviance (Rafalovich 2005). The most common diagnosis today of behavioural health problems is ADHD (Hinshaw and Scheffler 2014). There are two important points that should be made with regard to this group of pupils. Firstly, pupils displaying the symptoms characteristic of the disorder have always proved difficult for schools and teachers to handle. Thus, children lacking in concentration and being impulsive or hyperactive challenge social order in schools. Secondly, such pupils have been categorized in different ways over the history of schooling, partly dependent on which professional group has had the right to define the nature of the problems involved (Wheeler 2010). Thus, both social and biological factors have, at different times, been involved in explaining the behaviours.

Today, a psychiatry that rests on a firm biological foundation has gained the power to define characteristics of behavioural problems, as well as the aetiology involved, with obvious consequences for schooling. As demands for academic performance have increased in schools, the rates of ADHD diagnoses and medication for the disorder have skyrocketed in several countries (Harwood and Allan 2014; Prosser 2008; Hinshaw and Scheffler 2014; Visser et al. 2014). These increases are

interpreted by some as reflecting structural changes related to economic competition and to a corresponding push for greater academic performance and higher productivity in schools (Adams 2008; Hinshaw and Scheffler 2014). Harwood and Allan (2014, 159) hold schools partially responsible for this development, stating that “schools have a hand in the very production of psychopathologies”. To sum up, the ADHD diagnosis has gained enormous influence on how children’s problematic behaviour is perceived in schools, but there are also researchers who challenge the relevance of this diagnosis.

The emergence of inclusive schooling

Several scholars suggest that the notion of inclusive education has challenged traditional special education (Clark, Dyson and Millward 1998; Nilholm 2006; Skrtic 1991).

Traditional special education has been dominated by a deficit perspective, meaning that characteristics of the pupil are seen as the explanation for school problems. Within this paradigm children with difficulties such as ADHD are supposed to conform to the educational environment (Prosser 2008) or, alternatively, are to be educated in segregated educational environments arranged in order to compensate for what are understood to be the individuals’ deficits (Ainscow 1998; Haug 1998). The emergence of inclusive schooling is based upon the thorough critique that the traditional approach has received (Clark et al. 1998). Instead of localizing educational shortcomings to individual pupils, explanations are sought, for example, in educational settings, structural inequalities, discourses, professional interests, and the system’s failure to accommodate individual differences (Skrtic 1991; 1995; Ainscow 1998). In this latter perspective, called a relational perspective by Persson (2008), inclusive education is presented as an alternative to separated and segregated settings (Booth and Ainscow 2002; Ainscow, Booth and Dyson 2006) and is characterised as being flexible to the

heterogeneity among students in all aspects (Prosser 2008). Some scholars view the right to participate in regular settings as a fundamental democratic right (e.g. Skrtic 1995; Haug 1998; cf. Nilholm 2006). It goes without saying that the movement towards inclusive education has enjoyed large success, and some would say that it is the dominant paradigm within the field (Clark et al. 1998).

Prior research

We have not found any population-based studies investigating the establishment, prevalence, and functioning of ADHD classes. The tendency in most research, rather, seems to be to investigate the school situation for students with ADHD on an individual level, irrespective of where the students happen to be. The Swedish Schools Inspectorate (2012) concludes in a literature review that there is a lack of knowledge about the school situation for students with ADHD in Sweden, as research is sparse. Research about the prevalence of ADHD diagnoses in schools and school areas sometimes provides some figures about ADHD student placements in special schools and pupil referral units (e. g. Wheeler et al. 2008); however, there are almost no descriptions of these school settings. Thus, there seems to be a lack of representative data concerning the extent to which such classes are established, why they are established, the experiences of having such classes, and how the learning environments within these classes are designed. It is well known that almost all students with ADHD have problems in school (Corkum, McGonnel and Schachar 2010; Miranda, Jarque and Tarraga 2006; Montague & Castro 2005), and this is not surprising, according to Prosser (2008), as the symptoms are the opposite of known success factors in school (Harwood and Allan 2014; Hinshaw and Scheffler 2014). A national survey in the United States (Schnoes, Reid and Harder 2006) showed that the majority of students with ADHD

spend most of their time in regular classrooms. The use of ADHD diagnoses for educational issues may be regulated by local policy decisions (Sgro, Roberts and Barrozinso 2000), and placements in ADHD classes may be based on a (claimed) need for a group-specific pedagogy (Norwich and Lewis 2007). Hinshaw and Scheffler (2014) claim that accountability is a force directing students with ADHD to special education classes, where there are more resources. However, as this short review suggests and as has been said, there is a lack of population-based research concerning where these children are educated and what education is provided them in Sweden and elsewhere.

It should be noted that there have been several interventional studies targeting schooling for this group of students. On the one hand, we have studies reporting small or no effects of interventions. While behavioural treatment and medication lead to better behaviour they have “minimal effect on academic achievement” (DuPaul, Weyandt and Janusis 2011, 38; cf. Miranda, Jarque and Tarraga 2006; Loe and Feldman 2007). Moreover, Miranda et al. (2006) found no evidence of long-term effectiveness of school interventions, which they suggest is due to the chronic condition of ADHD. On the other hand, Reiber and McLaughlin (2004) are more positive as regards the effectiveness of interventions for children with ADHD (cf. Daley and Birchwood, 2009). They reviewed the efficacy of a variety of classroom interventions that are directed towards the characteristic impairments associated with ADHD. They examined classroom structure, curricular and teaching modifications, peer intervention, token economies and self-management strategies, and they found all to be beneficial for academic achievement and to also result in better behaviours. One of their propositions is an individualized approach to each student with ADHD due to heterogeneity. This is clearly in opposition to claims of a need for a group-specific pedagogy (cf. Norwich &

Lewis 2007). Daley and Birchwood (2009) propose changes in classroom management and emphasize the importance of altering teachers' attitudes toward ADHD behaviours and treatments. Little is known, however, about teachers' attitudes, what they do, or their knowledge of ADHD, according to a review by Kos, Richdale and Hay (2006).

To sum up, mixed findings have been reported from interventional studies. It should also be noted that little is known about which accommodations work in regular school settings for students with ADHD (i.e. not in special settings such as the laboratory) due to lack of data (Hart et al. 2011). The interventional studies to date provide no firm basis for evidence-based practices for children with ADHD, whether in regular classes or in special classes, especially when long-term effects are in focus. Moreover, there is also a lack of evidence concerning the differential effects of these two different types of placement.

The Swedish compulsory school system and the place of special needs education within it

The Swedish state uses management by objectives to regulate the Swedish schools. The state also uses, among other things, the curriculum, teacher education, the Swedish Schools Inspectorate, and the Education Act (2010:800) as instruments for regulation. The legislation states that special support provision shall be provided primarily within the student's regular class. The head teacher can decide on another placement if an assessment shows that provision of special support within the regular classroom setting is insufficient.

According to the regulations a student is entitled to special education support irrespective of medical diagnosis. The criterion for receiving special provision is an assessment that shows that the student is at risk of not reaching the school's academic requirements.

Special teachers and SENCOs have a key role in schools' work with special needs provision (Lindqvist 2013). SENCOs often have an all-embracing responsibility for special needs provision (e.g. by completing evaluations, working with school development, supervising teachers, etc.), while special-education teachers mainly work directly with students, individually or in small groups.

Nearly all students attend compulsory school, with the exception of 1% attending special programs for pupils with intellectual disabilities (The Swedish National Agency for Education 2015). Between 2.3% and 3.1% of pupils in compulsory schools have their school placements in segregated locations most of the school day, according to estimates by Nilholm et al. (2007). The ADHD special education class is one such location.

Of great significance for the present study is the fact that the 290 municipalities (range 2,400–864,000 inhabitants, 2011) have a certain degree of freedom in interpreting state-governed policy.

Method

Participants

The questionnaire was sent to all 290 municipalities in Sweden, addressed to the chief education officer. The three largest municipalities in Sweden (Stockholm, Gothenburg and Malmö) are all divided in smaller administrative units within the education sector. The questionnaires were distributed to each of those smaller units. One of these large municipalities used a coordinator who compiled the statistics received from all units within that municipality. The total response rate was 76% (234 of 308 questionnaires). Included are answers from 22 of 27 units (response rate 81%) within the three largest municipalities.

The questionnaires were addressed to chief education officers, but the data-gathering for the questionnaire was sometimes delegated. Some of the questionnaires were answered by chief education officers responsible for elementary schools or by educational leaders of units responsible for pupils' health and special needs provision within municipalities. In a few cases in very small municipalities, the assignment was delegated to a principal or a special needs coordinator (SENCO). The respondents investigated within their municipalities and collected statistics from principals according to our guidelines (see procedure below).

The questionnaire

The questionnaire was designed to investigate the prevalence of ADHD classes in Swedish municipalities as well as the prevalence of special education classes in general. The first part of the questionnaire contains questions about the number of classes for different types of school difficulties. Ten different types of special education classes are described, including, for example, special education classes for concentration difficulties, for psychosocial problems, and for autism spectrum disorder. One type mentioned is the special education ADHD class, defined as a group of pupils the majority of whom have an ADHD diagnosis and spend a majority of their school time in a separate setting. Such a group can be a class with its own special education classroom within a school, or it can be a separate unit that is segregated from other school facilities, or it may belong to a school consisting solely of special groups (classes). The classes must have existed for more than one semester to be considered established and qualified as being a part of this study.

The first part of the questionnaire also contains questions about the use of medical diagnoses in schools as well as about the situation in general for pupils with

ADHD in the municipality. Municipalities that do not have any ADHD classes are told at the end of part 1 to go directly to the final (open-ended) question of the questionnaire.

The second and main part of the questionnaire is focused entirely on ADHD classes. There are 37 Likert-scale questions, four open-ended questions, and 22 questions with dichotomous response alternatives combined with a “do not know” alternative, where some of those 22 questions also call for statistics from the municipality. Several questions have an additional space for alternative answers to the fixed-response alternatives that are provided.

Procedure

The questionnaire was constructed as a web survey. The questionnaire form and the procedure for its distribution were designed in order to obtain a high response rate and valid knowledge. The procedure for collecting the data required rather large efforts on the part of the municipalities. An approval was therefore required, and obtained, from SKL (Swedish Association of Local Authorities and Regions). We employed an unusually long time for data collection based on our experiences from a pilot survey in which the questionnaire was designed and tested. The survey was distributed by SCB (Statistics Sweden) to the municipalities in May 2012, with a first reminder in August, a second in October (this time also using personal addresses together with e-mails to municipality registrars), and a third in November. The second and third reminders were sent to the municipalities after personal contacts, where a total of 134 chief education officers were contacted by phone. It was revealed during the second reminder that many chief education officers were unaware of our inquiry, probably due to priorities made in post registration procedures within municipalities. The procedure with contacts by phone was repeated during the third reminder. The collection of data was finally

terminated after ten months in February 2013.

In designing the questionnaire and the procedure for its distribution, we collaborated with several agencies and experts. Experts at SCB provided valuable comments, quality checks and help with distribution of the survey. Valuable comments on the survey form also were provided by experts from the Swedish National Agency for Education, researchers within special needs education, and experts from SKL (Swedish Association of Local Authorities and Regions). A procedure for collecting data from schools in the largest municipalities was designed in collaboration with a former chief education officer of one of the largest municipalities in Sweden together with a former principal of a comprehensive school and an officer responsible for a municipal unit working with special needs provision. The information asked for in the questionnaire required data gathering at two levels in each municipality: the comprehensive school level and the central administrative level. Guidelines were therefore sent to the chief education officer about the procedure for gathering data from the principals. This procedure was partly based on the occurrence of central meetings (only monthly in several municipalities), where principals and chief education officers come together. It was also based on the time required for the chief education officer to inform principals before the meetings as well as on the time needed for collecting data on the school level.

Results

Results are presented and organized in the same order as the research questions. The numbers in the headings below directly refer to the research questions (1–4).

National level

1. How are ADHD diagnoses viewed with regard to the provision of special needs support and school placement?

An ADHD diagnosis is of minor importance in most municipalities when resources for special needs support are distributed. Only 13 of 234 municipalities regard an ADHD diagnosis as being of large or very large importance for the distribution of resources. Four of those 13 municipalities have ADHD classes. Only 19 municipalities (8%) answered that they have a statement in their local documents concerning the necessity of a diagnosis to get special needs provision. There was no difference between municipalities with or without ADHD classes, as 8% of municipalities in both categories gave this answer. In 174 municipalities (74%) it is considered important to a large or a very large extent that students with ADHD have their schooling in regular classes (25/40, or 62.5%, in municipalities with ADHD classes; 148/192, or 77%, in municipalities without ADHD classes). Of the 40 municipalities with ADHD classes, 28 (70%) reported that students with ADHD have their schooling in regular classes to a large or a very large extent; of the 192 without ADHD classes, 184 (96%) reported the same.

1. What documentation exists about ADHD students' school situations, and how are supporting measures coordinated?

Only 123 municipalities (52%) provided data or estimates of the prevalence of students with an ADHD diagnosis (28/40, or 70%, in municipalities with ADHD classes; 95/192, or 49%, in municipalities without ADHD classes). This is in line with answers about documentation on the municipal level concerning the school situation for students with ADHD. This kind of documentation is gathered to a large or a very large degree on the

central municipal level in only 47 municipalities (20%), with higher figures in those with ADHD classes (35%) than in those without (17%). Also, a low percentage of the municipalities (50%) provided estimates of the proportion of students with an ADHD diagnosis who are male. Thus, a high proportion of the municipalities do not seem to give priority to this kind of documentation.

Additionally, most of the municipalities (82%) do not have any staff responsible for coordinating their schools' work with pupils diagnosed with ADHD nor any coordinating support for this group of pupils (11/40, or 28%, in municipalities with ADHD classes; 25/192, or 13%, in municipalities without ADHD classes).

2. What is the prevalence of ADHD classes?

Forty municipalities (40/234, 17%) reported that they have ADHD classes. It should be pointed out that the majority of municipalities (192) reported that they do not have ADHD classes. However, it should also be noted that several of them have several other types of special education classes. 88% of the municipalities with and 72% of the municipalities without ADHD classes stated that they are very sure/sure about the accuracy of their reported statistics concerning different kinds of special education classes in their municipalities. The municipalities or municipal units with ADHD classes have one or several (up to eight) special classes for pupils with ADHD. Most of these municipalities have only one (20 municipalities) or two (10 municipalities) ADHD classes. There are, however, also other conditions of substantial importance concerning the presence and number of ADHD classes. The smallest municipality within the category *municipalities with ADHD classes* has two ADHD classes and a population of 5,000 inhabitants. The same number of ADHD classes (two) can be found in a municipality (the largest with ADHD classes outside of Stockholm, Gothenburg

and Malmö) with a population more than 25 times that. Another example is that in the population range of 80,000 to 90,000 two of the three municipalities that have ADHD classes have only one ADHD class each, while the third has eight ADHD classes. It should be noted that there are several municipalities in this range with no ADHD classes at all.

Municipal level

3. Time period for establishment, class sizes and length of placement

Many of the municipalities with ADHD classes established their first ADHD classes after the year 2000 (in 16 municipalities). Eight municipalities established ADHD classes during the nineties and three during the eighties, with the oldest ADHD classes dating back to 1980. The answers show that the oldest classes were initially established for students who did not have an ADHD diagnosis but had similar behaviour patterns. The classes consist of eight pupils on average ($m=7.6$, $md = 7$), with a range from one student in a class to 15 students. On average, the placements last for five semesters (5.15), with a range from two and a half semesters to 10. One of the municipalities gives no specific figure but provides this description: “through the remaining time of comprehensive school [in Sweden, through ninth grade, 15–16 years of age] but are increasingly [re-]integrated into their regular classes”.

3. The initiatives to establish ADHD classes

Principals (26) and/or chief education officers (18) are considered to have taken initiatives to start ADHD classes in 31 of the 40 municipalities. This means that they were not initiators at all in nine municipalities. The initiatives to start ADHD classes were taken solely by chief education officers in six municipalities and solely by

principals in 13 municipalities. Other groups also contributed by playing vital roles in the initiatives to start the special education classes. Teachers participated in taking such initiatives in eight municipalities, followed closely by parents (7), social authorities (4), politicians (4), child psychiatry (2), and child early intervention centres (*barnhabiliteringen*) (2). Twelve municipalities do not seem to have any records indicating who took the initiative to start ADHD classes. Among the comments, there are answers such as “These classes were established in the eighties and nineties for students with major behavioural disorders”. It is noteworthy that there are no answers stating that the initiative came solely from groups outside the school (e.g. parents, psychiatry, social authorities, etc.).

3. Why were the ADHD classes established?

The respondents rated how strong 11 different reasons were considered when establishing the ADHD classes. The respondents answered each of these questions by marking either that it was not a reason at all, or that they did not know whether it was a reason, or that it was a (more or less / weak or strong) reason. The last option was chosen by marking one of the alternatives in a 5-point Likert scale. The establishment of ADHD classes is mainly based on four reasons (of the 11 options given). The most important reason, according to the questionnaire, is that ADHD pupils need *specific teaching methods*, as 33 of the municipalities either answered “Very strong reason” (17) or “Strong reason” (16). The second most important reason was *accommodations in work speed* (19 + 10), followed closely by *a calmer classroom environment* (15 + 14), and by the pupils’ need for *a special pedagogy* (16+10). These four reasons were also the only items for which no municipality used the response alternative “Not a reason”.

Other reasons received fewer answers indicating the reasons to be of great importance in establishing ADHD classes. Nearly a third (14) of the answers suggested that the pupils with ADHD disliked being in their former classes (4 + 10). The pupils' refusing to go to school was a less cited reason (3 + 2). Other reasons, cited to only a very small degree, were the ambitions of different stakeholders—such as teachers, parents, psychiatry units and early intervention services—to have the classes established. Only two of the municipalities used the alternative “Other”, but they did not specify the reasons that played a part in establishing the classes.

3. What characterises the learning environment within these classes?

A Likert scale was used in the questionnaire to collect data about staff and teaching. It is a 5-point scale (from ‘a very large extent’ to ‘a very small extent’) combined with the alternatives ‘to no extent at all’ and ‘do not know’.

Most of the municipalities have teachers with regular teaching credentials, or qualified teacher status, as it is known in the U.K., employed to a very large degree (24) or a large degree (10) in ADHD classes. Other professions are employed to a high extent (‘very large degree’ + ‘large degree’) in some municipalities, as follows: special needs coordinators (7+4), special education teachers (6+4), leisure time teachers (4+5), teacher assistants (6+3), social workers (0+1), and teachers without a teaching credential/qualified teacher status (0+2). Interestingly, seven of the municipalities report that they have no special needs coordinators or special education teachers employed in their ADHD classes. There are, on average, 2.2 pupils per full time employment (range 1–4.5 pupils/full time).

Structure is the most dominating feature of teaching in the ADHD classes, according to the questionnaires. Twenty-one of the municipalities rated this as

significant to a very large degree and 18 to a large degree (response rate 39/40). Three other features follow closely as also being highly significant: collaboration with parents (37, 25+12), teacher-directed instruction (37, 17+20), and social interaction between pupils and adults (35, 22+13). Individual seatwork (19, 2+17) and collaboration between pupils (7, 1+6) are prominent to a lesser degree. Special methodology characterizes ADHD classes in 26 municipalities (12+14).

3. How are the long-term effects of schooling evaluated?

A majority of the 40 municipalities (23) have no follow-up at upper secondary school for pupils that have been enrolled in the ADHD classes. Thirteen of the 14 municipalities that reported doing follow-ups answered an open-ended question about how the follow-ups are done. Four municipalities did not give a comprehensive description that clarifies how follow-ups are done. One municipality is in an initial phase of doing follow-ups, and one of the municipalities (a major city with several units) describes a situation in which follow-ups are done in some parts of the municipality but not in others. The remaining seven municipalities use questionnaires (1), provide special programs or groups for pupils with neuropsychiatric diagnoses at the upper secondary school where contacts continue (2), or describe individual follow-ups which may be combined with extra resources/support (4).

4. What are the experiences of having ADHD classes?

Two open-ended questions were used to gather information about experiences of the ADHD classes. One was a question about positive experiences (37 answers), and the other was about negative experiences (35 answers). Answers from these open-ended questions often contained several experiences (several answers containing more than

100 words).

There were a substantial variety of answers, of both positive and negative experiences. Found among the answers were 28 *different kinds* of positive experiences and 26 *different kinds* of negative experiences. On average, there were about two positively expressed experiences (78 expressions, average 2.1) and one and a half negatively expressed experiences (63/35, average 1.61) per municipality.

4. Themes based on positive experiences

An analysis of the qualitative data revealed three overarching themes among the open-ended answers reporting positive experiences of having ADHD classes. These are *positive conditions within the ADHD classes* (47 expressions), *progress among pupils* (25), and *positive effects in regular classes with a decrease in behavioural problems* (6).

Positive conditions in the ADHD groups contained four sub-themes. The sub-themes were *general aspects of the ADHD group conditions*, with 14 expressions (e.g. an individualized school situation, a lot of support); *educational aspects*, with 10 expressions (e.g. differentiated instruction and slower pace); *social aspects*, with 14 expressions (e.g. a safe and calm atmosphere within a smaller context); and *staff aspects*, with 9 expressions (e.g. gathering competence in one location).

Positive effects in regular classes with a decrease in behavioural problems (6 expressions) all had similar content, emphasizing that removing some students with ADHD made the school situation better for the other students.

4. Themes based on negative experiences

Three overarching themes were also found when analysing the open-ended answers reporting negative experiences. These were *negative effects for ADHD students'*

development (34 expressions), *problematic conditions within the ADHD classes* (16), and *negative attitudes* (11).

Negative effects for ADHD students' development contained four sub-themes. The sub-themes were *social exclusion issues* (28 expressions), with emphasis on ADHD students being isolated from peers without diagnoses and tending to remain in ADHD classes once transferred there; *problems with ADHD students' well-being* (5), with negative effects, for example, on self-esteem as a consequence of being transferred to an ADHD class; and *problems with low academic goal attainment* (1).

The second overarching theme, *problematic conditions within the ADHD classes*, involves two sub-themes: *negative issues with group constellations* (9 expressions), with remarks about “negative behaviours being reinforced”; and *problems with designing good education* (7), with a focus on difficulties recruiting competent teachers and on low-quality teaching.

The third overarching theme, *negative attitudes*, comprises two sub-themes: *negative attitudes towards pupils with ADHD* (8 expressions), indicating reluctance to welcome pupils with ADHD in schools; and *negative attitudes towards ADHD classes* (3), indicating negative attitudes from parents and from proponents of inclusive education as leading to tension as well as lack of undisturbed work with classes, as these are constantly questioned.

Discussion

In the remainder of the article, we will discuss 1) methodological issues, 2) the results in relation to prior studies, and 3) the outcome in relation to the two emerging trends outlined initially. Finally, some implications for policy, practice, and research are presented.

Methodological issues

The design of the data collection was successful, as it resulted in a high response rate despite the heavy burden on municipalities to collect data. The unusually long period of time allowed for answering the questionnaire was probably crucial for obtaining this outcome. Contacts with municipalities that did not participate revealed that some municipalities, mostly small ones, do not engage in research studies. This was based on the argument that they only have resources to participate in investigations mandated by the law.

The respondents seem to have followed our guidelines and the definitions we used to describe special classes for students with ADHD. The risk of receiving politically correct rather than true answers was addressed by ensuring confidentiality, and this was facilitated through the use of the web questionnaire format, as no registration was possible by the municipality registrars. There are no indications that this did not work as planned.

We believe that the development of our methodology should be seen as an important outcome of this study. Data was collected from two levels in each municipality and put together in the same questionnaire. This way of collecting data is not as time consuming as having contact with each school. Relatively few personal contacts with respondents were needed—often only one per municipality—to remind municipalities to answer the questionnaire. Most importantly, we seem to have obtained valid data, which is probably due to the sanctioned orders from chief education officers to participate in the investigation. The reason for this is that our design with the chief education officer in charge of collecting data probably prevents refusals to participate from head teachers and prevents them from providing incorrect data. In other words, there is a built-in risk, for example, that any incorrect information from a head teacher

will eventually be known to the chief education officer. It should also be pointed out that our follow-up case studies, consisting of ten municipalities that answered our questionnaire, revealed that valid and reliable answers had been provided in the questionnaire (Malmqvist and Nilholm, forthcoming).

Main findings in relation to prior research

One of the main results is that several, though only a minority, of the municipalities have established special classes for students with ADHD. Other results reveal a) a lack of documentation of these pupils in a huge proportion of Swedish municipalities, b) an absence of coordinators for students with ADHD in most municipalities, c) a lack of coordinated support for students with ADHD, and d) an absence of data of the prevalence of these students. Together, these results indicate a low importance for the diagnosis as an organising principle for special needs provision in most municipalities. This conclusion is further strengthened by our data, which shows that there are few ADHD groups meeting our criteria and that most students with ADHD have their placements in mainstream classes (cf. Schnoes et al. 2006). The fact that the majority of municipalities, with or without ADHD special classes, regard mainstream placement of students with ADHD as important (cf. Sgro et al. 2000), is another indication that the diagnosis as such is of low priority in most Swedish schools. This finding is in line as well with Swedish school regulations, which states that support shall be provided without consideration of whether or not a student has a medical diagnosis. Provision of special support in ADHD classes is used for only a small proportion of pupils with ADHD in municipalities having such classes. Placement in an ADHD class seems to be used when provision of special support in regular classes is not effective, indicating that the needs are too great to address without special educational arrangements closely

related to the ADHD diagnosis. The skyrocketing increase of students with ADHD, as shown in research in several countries (Hinshaw and Scheffler 2014), however, is *not* present in the responses from the municipalities. A majority answer that there has been no increase in the number of students with ADHD or that they do not know whether there has been an increase. The fact that many of the municipalities that have established ADHD groups have done so since the year 2000 may indicate an increase in ADHD classes, but we have no information over time concerning the establishment and/or possible closing down of ADHD groups. It is therefore impossible to draw any definite conclusion about structural changes in relation to how schools and municipalities deal with ADHD.

In some municipalities the initiatives to start ADHD classes came mainly from the schools (principals and teachers) and/or chief education officers. These results are in line with the broader picture of the increased use of neuropsychiatric diagnoses in schools, as presented in recent publications by Hinshaw and Scheffler (2014) and Harwood and Allan (2014). It is important to note that these two scholarly contributions, written from two indisputably contradictory perspectives, the psycho-medical and an educational perspective, both arrive at the same main conclusion—that the issue with ADHD would simply not exist without schooling.

Four reasons for establishing ADHD groups dominated. One may be interpreted as the students having trouble with work speed and another as classrooms not being calm enough. The other two reasons, the need for special methods and the need for special pedagogy, clearly relate to a group-specific pedagogical perspective as described by Norwich and Lewis (2007). This perspective legitimates the presence of ADHD classes, meaning that ADHD pupils require something different than other pupils in order to learn. Special methods are also said to characterize the teaching, according to

our results. The answers indicate that ADHD classes are more intensely teacher-led, have more structured teaching, and emphasize collaboration between students and adults. They further show that collaboration between students is rare in comparison with other kinds of work in the classroom. The overall description provided shows that most aspects emphasized as important in research within a psycho-medical paradigm are in use in the ADHD classes. Together with the small group size and the high proportion of adults, these groups offer an educational setting quite different than regular Swedish school classes. Experts in special education, however, work in these groups to a low extent, which is surprising given the aforementioned emphasis on the need for special pedagogy and special methods in ADHD classes. The emphasis on and claim for a group-specific pedagogy is also interesting in relation to the heterogeneity among students with ADHD, as shown in research within the psycho-medical paradigm (cf. Norwich and Lewis 2007; Reiber and McLaughlin 2004).

The outcome in light of inclusive education

It goes without saying that using special education groups for children with ADHD is difficult, if not impossible, to reconcile with most interpretations of inclusive education. However, one could argue, as do several of the municipalities that provide special groups for children with ADHD, that these groups provide an environment that is tailored to the needs of such children. Consequently, the groups could be seen as inclusive from the point of view of the pupils themselves in that they provide an environment in which the pupils can function. Nevertheless, we would hesitate to use the word inclusive for these educational solutions because they obviously segregate children with ADHD from other children. Thus, it is important to distinguish between what counts as an inclusive educational placement (involving placement in ordinary

classes as a necessary but insufficient condition) and what one considers to be a beneficial educational solution for a child. If we do not uphold this distinction we could consider special schools to be inclusive, which is obviously quite contrary to what is meant by inclusion by most scholars or in the influential Salamanca statement (UNESCO 1994). We would not go as far, however, as saying that these classes constitute the antithesis of inclusion. In our view, inclusion not only necessitates mainstreaming but it also means by definition that pupils are educationally and socially included, which may be criteria that are met in ADHD classes. It is obvious that the municipalities put a lot of resources into these classes, but our data do not permit us to draw any conclusions about whether pupils with ADHD are educationally and socially included in these groups. Additionally, the lack of long-term follow-up is distressing. It should also be pointed out that most of the municipalities with ADHD groups question whether ADHD classes are the best solution to the educational problems involved.

There are obviously other conditions more important than municipality size for the presence and number of ADHD classes, which our results clearly show. This indicates that the degree of neuropsychiatry's influence varies across municipalities. The same holds true for the distribution of ADHD diagnoses, with very large regional differences in Sweden (The Swedish National Board of Health and Welfare 2014). At present, we know little about the influence from neuropsychiatry, and its consequences for special provision in municipalities with or without ADHD classes. This has been studied more thoroughly in our follow-up case study (Malmqvist and Nilholm, forthcoming, also cf Hjörne Evaldson, 2015).

On a system level and in an international comparison, it seems that parts of the Swedish education system show some resistance to the emergence of the neuropsychiatric paradigm. Thus, most municipalities do not provide special groups for

children with ADHD and do not seem to use ADHD as a category for the organization of support. One explanation for this might be that Swedish law does not require a diagnosis for a pupil to qualify for extra support. A change in this educational policy, however, may lead to sudden dramatic effects. Hinshaw and Scheffler (2015, 77) describe, as one example, the dramatic increase in ADHD diagnoses during the nineties when “ADHD was included for the first time as a specific category of disability that could allow special educational accommodations or services” in U.S. legislation.

The question should be raised as to whether the use of neuropsychiatric diagnoses in schools is compatible with inclusion. If it is not, the resistance described here could be interpreted as a defence of inclusive education. As there is insufficient space to address this issue in depth, we will briefly point to two key aspects involved here. There are clearly biological underpinnings of differences in, for example, the ability to concentrate related to the real problems involved in meeting the needs of these children. Neuropsychiatric research contributes to our knowledge concerning this issue. But if we conceive of inclusive education 1) as the understanding of educational problems as involving several levels of analysis, and 2) as involving the celebration of difference, a diagnosis such as ADHD seems to be difficult to reconcile with the notion of inclusive education. There are two primary reasons. First, ADHD quite clearly places the educational problem within the pupil, not taking contextual aspects into account. Second, by definition ADHD does not involve the celebration of difference because the label itself expresses the opposite of what is valued in school (e.g. the ability to concentrate). It is therefore important to raise words of caution about use of the diagnosis as an educational classification, not least if inclusive education is defined as above.

Implications for policy, practice and research

It is obvious that the prevailing policy is interpreted differently in different municipalities. Moreover, it is quite clear that Swedish legislation implies that support should be provided in the mainstream for this group of children. Thus, it seems justified that national authorities should make municipalities with ADHD groups more accountable than is the case at present. This has been happening in recent years as authorities such as the Swedish Schools Inspectorate have worked against the use of special groups of different kinds. Even though this seems to take developments in a more inclusive direction, it also runs the risk of putting these pupils in educational situations which do not fit their needs. This is especially true if ADHD is a condition that for some pupils requires a (group-specific) special pedagogy that is not possible to use in classrooms with other pupils. This needs to be thoroughly investigated through research highlighting this issue, as the lack of knowledge about this issue is evident. Meanwhile it seems that the main task for both policy and practice is to balance the move towards mainstream placement with guarantees of each pupil's right to an adequate school situation.

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