

THE ACTION KIT

From ADHD Is Trauma — Doubt the Label. Ask the Child. • Paul Stewart

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26. The Action Kit: The Sheet, the Doctor Questions, and What to Say

Everything before this page was argument. This page is equipment. It is built to be torn out, photographed and handed over: a sheet for parents to fill in before an assessment, a sheet for teachers to fill in before a referral, the questions to ask a doctor and what a good answer sounds like, the words for the moments when the conversation turns, one-page versions for the GP, the social worker and the grandparent, two letters, and the practical routes to the records and the file. None of it requires a qualification. All of it requires only that somebody in the child's life decides to ask the question the pathway skips, and has the words ready when the answer comes back.

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For parents — before or during any ADHD assessment

Fill this in before the appointment, not during it. The pathway will ask you to rate your child's behaviour; this sheet asks you to record your child's life, and to bring the record into the room in your own hand. Every line on it is a finding this book has shown the checklist cannot make. Where you do not know an answer, write "don't know" rather than leaving a blank — the gaps are information too.

- **Keep a two-week log:** setting, who was present, medication state if any, what the child was doing, what happened just before any deterioration, how they settled (Section 16)
- **Build the timeline:** when did the difficulties start — and what changed in the child's life in the months before that date (Section 4)
- **Note the pattern:** does the behaviour track tasks (boring, demanding) or people and places (a person, a house, a handover)? The second pattern is a reaction, not a deficit (Section 16)
- **Flag regressions:** return of wetting or soiling after dryness, sleep collapse, new fears, sexualised behaviour or knowledge — say them out loud to the assessor and ask for them to be recorded (Sections 3 and 9)
- **Ask the assessor directly:** "what screening for trauma and adversity will be done, and where will the result be documented?" The pathway mandates a heart check before stimulants; ask why the history check is not equally mandatory (Section 18)
- **Ask for the wider checks:** hearing, vision, sleep history including snoring, ferritin and thyroid bloods, a reading assessment — and note the child's birth month relative to the school year (13.6, 15.3)
- **Insist on multiple informants:** both parents where possible, grandparents, club leaders — and the child's siblings spoken to on their own (13.5, 16)
- **If already medicated:** observe in the middle of a school holiday, past the come-down, and ask where and with whom the child is calm without the drug (12.5, 16). Never change the dose yourselves — take this book's questions to the prescriber
- **If you suspect harm:** do not question the child and do not confront anyone — record what you saw and use the safeguarding routes in Section 27; professionals trained in forensic interviewing do the asking (Section 16)
- **Your rights:** a second opinion, copies of every report, and a documented answer to the question "what was looked for, and what was found?"

For teachers — before any referral

You are the first gate in the whole pathway, and nobody has trained you for it. Before the referral form, this sheet. It will take twenty minutes and it asks you to do the one thing the rating scale does not: place the behaviour in time and in context. A referral that arrives with this attached is a different referral — and a child whose reports you have read in date order is a child you now know something about.

- **Check the birth month first:** the youngest children in a class are diagnosed roughly a third more often, on teacher ratings alone — make sure you are not referring immaturity (15.3)
- **Write what changed and when:** describe behaviour and context — dates, settings, triggers — and never write a diagnosis (15.3)

- **Audit for bullying:** school-located symptoms have school-located causes more often than anyone checks; ask who the child avoids and where (Section 5)
- **Watch for the markers:** regression, sexualised behaviour, fear of going home, flinching, long sleeves in summer — these are safeguarding alerting features, not ADHD items (Sections 3 and 18)
- **Remember the halo:** one defiant incident inflates every rating that follows — score the behaviour you saw this week, not the reputation (13.4, 15.3)
- **Know your duty:** your safeguarding obligation exists before, during and after any diagnosis, and a label on the file does not discharge it (Section 18)

At the appointment: what to ask the doctor — and what a good answer sounds like

Ask these calmly, write the answers down, and remember the register: you are not fighting the clinician, you are helping them do the assessment the pathway forgot to require. A good clinician will recognise every one of these questions as fair. Hostility to them is itself information, and a second opinion is your right.

- **“What screening for trauma and adversity will be done — and where will the result be written?”** A good answer names a concrete step and commits to documenting the outcome either way (Section 18). “We’d know if something had happened” is not screening; it is the assumption Section 15 exists to dismantle
- **“What else will be ruled out before ADHD is accepted?”** A good answer includes sleep (and snoring), hearing, vision, ferritin and thyroid, reading, and the child’s age within the school year (13.6). Cheap checks, mandated nowhere — which is why you ask
- **“Which informants will you use — and what happens when they disagree?”** A good answer treats disagreement as signal, not noise: parent-teacher agreement runs around 0.28 (Section 2), and a child who differs across settings is showing you the pattern of Section 16
- **“How will my child’s unmedicated baseline be observed?”** A good answer includes a planned observation window — mid-holiday, past any come-down — and asks where and with whom the child is calm (12.5, 16)
- **“What is the diagnosis actually based on, given there is no test?”** The honest answer is: reported behaviour against a checklist. A clinician who implies a scan, a blood test or anything biological confirms it is wrong on the record (Section 10)
- **“What will response to the medication tell us about the diagnosis?”** The correct answer is: nothing — stimulants act on every brain (12.2). A clinician who says improvement will confirm ADHD has just failed the most important question on this page
- **“If we start, what is the plan to stop?”** A good answer sets exit criteria and a structured review date before the first prescription. A drug with no exit plan runs for a decade by default (12.9, 12.12)
- **“What is being offered in parallel — and what is the waiting time for it?”** A good answer names the non-drug route and its timescale honestly. If a controlled drug is available this week and a conversation is available next year, say Section 21’s sentence back to them and ask them to record your objection
- **“Which side effects will be tracked — and how will we tell side effects from the problem?”** Appetite, sleep, growth, mood, evening rebound (12.4–12.9) — and note the trap of Section 7: the side-effect list and the somatic-distress list are the same list, so tracking must be written, not remembered
- **“Will you write this sentence in the notes: what happened to this child was actively looked for, by these means, with this result?”** The whole book in one request. A yes costs the clinician two minutes. A refusal tells you where you stand — and belongs in your written record of the appointment

For adults at their own assessment, add two (13.3): “How will my childhood be corroborated beyond my own memory?” — records and collateral, because memory alone cannot carry it (Section 6) — and “Given most adult cases lack childhood onset in the cohort studies, what else are we ruling out first?” — sleep, mood, substances, overload, and the history nobody took.

What to say: nine real moments, three responses each

These are not scripts to recite; they are a register to hold — calm, sequenced, and on the record. Each moment gets three levels: the everyday reply, the reply when pushed, and the written version — because throughout this book, paper beats memory (Section 18).

The teacher says: “Have you thought about getting him assessed for ADHD?”

- **In the moment:** “Thank you for flagging it. Before any referral, can you tell me exactly what changed and when? Dates and situations — that’s what a proper assessment will need.”
- **If pushed:** “I’m not against assessment — I’m against half of one. I’ll be asking them to rule out sleep, hearing, reading, his age in the year, and what’s happened around him, so your dated observations matter more than any checklist.”
- **For the record:** Email the school: “Please send the specific incidents with dates and contexts, and confirm the school’s bullying and safeguarding checks around him have been reviewed before any referral.”

The GP reaches for the prescription at the first appointment.

- **In the moment:** “Before we talk medication, can we book the checks first — sleep, hearing, ferritin and thyroid, and a proper history — and have them documented?”
- **If pushed:** “I’m not refusing treatment; I’m sequencing it. There’s no test for ADHD, and response to the drug won’t confirm anything — so the checks have to come first.”
- **For the record:** “Please note in the file that I’ve requested the differential checks and a documented trauma and adversity history before any medication decision.”

The assessor says: “We’d know if something had happened.”

- **In the moment:** “How would we know? Most children never tell. I’d rather we looked properly than assumed.”
- **If pushed:** “In the landmark study, a third of adults didn’t report abuse that was hospital-documented at the time. ‘We’d know’ isn’t screening — what screening will actually be done?”
- **For the record:** “Please record that no active trauma screening was performed, and that my request for it is on file.”

A relative says: “He just needs discipline.”

- **In the moment:** “He’s not giving us a hard time — he’s having one. Punishing a signal doesn’t switch off whatever is sending it.”
- **If pushed:** “Discipline got years on the naughty-kid theory and it made things worse. We’re finding the cause, not raising the volume.”
- **The boundary:** “We’re handling this with his doctor and his school. If you can’t support that, it isn’t up for discussion at family events.”

At the school gate: “Medication saved my child.”

- **In the moment:** “I’m glad it helped yours. The drug works on every brain — which is exactly why it can’t tell me what mine has.”
- **If pushed:** “Nobody’s judging your family. My child changed suddenly, and a sudden change needs its cause found before a prescription.”
- **If it keeps coming:** “We’ve made our decisions with his clinicians. Let’s leave it there.”

Your co-parent refuses to discuss the possibility of trauma.

- **In the moment:** “I’m not accusing anyone. I want everything ruled out — including things that happened around him — the same way we’d rule out his hearing.”
- **If pushed:** “If nothing happened, the questions will show that, in writing, and we’re stronger for it. Refusing to ask is the only answer that can’t help him.”

- **For the record — and a caution:** “I’m asking the assessor for documented screening either way; I’d rather we did it together.” If you believe the other parent may themselves be the risk, do not debate it at home — use the safeguarding routes in Section 27.

The school says: “He can’t stay in mainstream without medication.”

- **In the moment:** “Please put that in writing.” — often the whole conversation ends here
- **If pushed:** “Medication is a clinical decision between us and his prescriber. The school’s job is support and safeguarding — I’m happy to meet the SENCO about both.”
- **For the record:** Email: “Please confirm in writing whether the school is making medication a condition of my child’s attendance or support.” Then contact SENDIASS. In the US, conditioning attendance on medication is explicitly unlawful (15.3).

The clinician says: “The medication working proves it’s ADHD.”

- **In the moment:** “It proves the medication works — and it works on everyone. What else has been ruled out?”
- **If pushed:** “The NIMH gave amphetamine to ordinary schoolboys in 1978 and got the same improvement. Response is not diagnosis — can we go back to the history?”
- **For the record:** “Please note my objection that treatment response is being treated as diagnostic confirmation.”

Your child asks: “Is something wrong with my brain?”

- **To a young child:** “Nothing is wrong with your brain. It’s been working extra hard to keep you safe, and we’re going to help it rest.”
- **To a teenager:** “Your brain isn’t broken — it adapted to things it should never have had to deal with. That’s strength, not damage, and with the right help it settles.”
- **At any age:** Never “bad”, never “broken” — the third identity of 13.4: “Something happened. It wasn’t your fault. The adults are on it now.”

More moments: the system, the family, the teenager

“The waiting list for assessment is two years.”

- **In the moment:** “Then what happens for him in the two years? I’d like the interim plan — school support doesn’t need a diagnosis, and neither does the log I’ll be keeping.”
- **If pushed:** “Safeguarding doesn’t wait for waiting lists. If what’s driving this is something happening to him, two years is not a neutral delay.”
- **For the record:** Written request: “Please confirm the interim support plan, and note that my timeline log and the school’s observations will be submitted at assessment.”

The school says the opposite: “He’s not ADHD, he’s just naughty.”

- **In the moment:** “Either way, something is driving it. What changed, and when? Naughty is a description, not an explanation.”
- **If pushed:** “The naughty-kid file and the ADHD file make the same mistake — neither asks what happened. I’m asking the school to help me answer that instead.”
- **For the record:** Request the dated behaviour log, the bullying check, and a safeguarding review — in writing, before any escalation of sanctions (13.4, 15.3).

The assessor lets the adults answer everything for the child.

- **In the moment:** “Could part of the session be with him one-to-one? He says different things when we’re not in the room — which is probably the point.”
- **If pushed:** “Seeing the child alone, and hearing several informants, is basic practice. The disagreements between us are signal, not noise (Section 2).”

- **For the record:** “Please document that I requested time for the child to be seen alone, and the outcome.”

“We don’t have time for all these checks.”

- **In the moment:** “Which of them can we book today, and which referral covers the rest? I’m happy to spread it over several appointments.”
- **If pushed:** “The pathway already mandates a heart check before these drugs. I’m asking for the same diligence about his life.”
- **For the record:** “Please note which checks I requested today, which were arranged, and which were declined.”

The other household won’t share information or engage with the assessment.

- **In the moment:** “The assessment needs both homes’ observations — can the clinic request them directly, so it isn’t between us?”
- **If pushed:** “This isn’t about our history. A half-informed assessment fails him in both houses.”
- **For the record — and the caution:** Tell the clinician in writing which information is missing and why. And if you believe the other household may itself be the risk, stop negotiating and use Section 27’s routes.

A relative suddenly says: “Something did happen once, actually...”

- **In the moment:** “Thank you for telling me.” Then stop. No pressing, no visible alarm, no interviewing.
- **Straight afterwards:** Write down their exact words, the date, and who was present — verbatim beats summary, and Section 16’s non-leading rule protects the information.
- **For the record:** Pass the written note to the assessing clinician — or, if it suggests current risk, to the safeguarding routes of Section 27. Professionals do the asking from here.

The pharmacist or school nurse mentions weight loss or poor sleep.

- **In the moment:** “Could you document that and send it to the prescriber? It carries more weight coming from you.”
- **If pushed:** “Appetite and sleep are exactly what the reviews are supposed to track — and exactly what gets waved through as ‘expected’ (Sections 7 and 12.9).”
- **For the record:** Ask for it in the pharmacy or school health record, and take the reference into the next prescriber review.

“You’re only anti-meds because of your own past.”

- **In the moment:** “My history doesn’t change his timeline. What changed for him in March — that’s the question on the table.”
- **If pushed:** “If my past made me alert to this, good — alertness is what found the school reports. Address those, not me.”
- **The boundary:** “We can discuss the evidence or we can stop. My biography isn’t the topic; his childhood is.”

Your teenager says: “I hate how the tablets make me feel.”

- **In the moment:** “Thank you for telling me — that matters, and it goes to the doctor, not in the bin. We won’t ignore it and we won’t just stop — we’ll do it properly.”
- **At the review:** “Please document his experience in his own words — children’s accounts of feeling ‘not myself’ are data, not noncompliance (12.12).”
- **The rule:** Never stop or change a dose unilaterally — rebound will masquerade as relapse (12.4). The prescriber conversation happens with the teenager in the room.

Your teenager says: “TikTok says I’ve got ADHD — I want the tablets.”

- **In the moment:** “What you’re struggling with is real, and we’re taking it seriously — seriously enough to find out what it actually is, not what an algorithm sells (Section 14).”
- **The offer:** “Full assessment: sleep, reading, iron, your timeline — and yes, what’s happened around you. If it’s ADHD after all that, we deal with it properly.”
- **The fact to share:** “Worth knowing first: the drug sharpens focus in everyone, so feeling better on it wouldn’t prove anything — and most people diagnosed as adults never had the childhood condition (12.2, 13.3).”

The school moves to isolation or exclusion.

- **In the moment:** “What support was in place at the time of the incident? I’d like that answered before we discuss sanctions.”
- **If pushed:** “Punishing a distress signal escalates it — that is 13.1’s trajectory. I’m asking for the SEND and safeguarding review the behaviour policy sits inside.”
- **For the record:** Everything in writing; request the governors’ review; contact SENDIASS; submit the timeline log. Exclusions have appeal routes, and paper wins them.

Online: holding a comment thread

The rules of the medium first, because they decide everything. You are never writing for the commenter; you are writing for the silent readers scrolling past, and receipts beat emojis with that audience every time. Children are never a topic — yours or anyone’s. And never use someone’s pain as a weapon, even provoked: the moment you ask an opponent what happened to make them this way, you have handed them the screenshot that beats your whole argument. Three levels each: the short reply, the version with receipts, and when to stop.

The laughing emojis arrive — reactions, no argument.

- **Short:** “That’s a reaction, not a rebuttal. Pick any claim in the post and I’ll put the citation under it.”
- **With receipts:** Post one fact with its source — the 1978 NIMH schoolboys is the best opener — and add: “There are 180 more where that came from.”
- **Then:** One invitation is the limit. Whatever laughs after that gets silence — the silent readers saw who brought sources.

“Correlation doesn’t equal causation.”

- **Short:** “Agreed — which is why the book leans on a natural experiment: nothing about a child’s brain changes at a school cut-off date, yet the youngest in class are diagnosed about a third more, on teacher ratings only.”
- **With receipts:** “Now apply the rule consistently: heritability is a correlation, drug response proves nothing, and fifty years produced no causal biomarker. Your principle demolishes the deficit model first.”
- **Then:** Link the section, invite them to pick one claim, and stop after the second exchange.

“It’s genetic — four generations of my family have it.”

- **Short:** “Genes and households travel down a family line together — four generations of one label is equally consistent with four generations of one house.”
- **With receipts:** “Twin studies measure how strongly a checklist score runs in families, not what causes the score — and antenatal stress alone predicts ADHD-type symptoms years later. The transmission chain masquerades as a pedigree.”
- **Then:** Never analyse their family specifically — keep it structural, or you hand them a grievance and lose the room.

“I’ve read the DSM — it doesn’t say that.”

- **Short:** “Correct — the DSM doesn’t say anything causes ADHD. It’s descriptive, there’s no test, and its own criterion E demands ruling out better explanations. That is my whole point.”

- **With receipts:** “The trauma category was formally proposed — Developmental Trauma Disorder, 2005 — and declined. ICD-11 has since added complex PTSD. The manuals are moving; the DSM is behind.”
- **Then:** If they go off to re-read the DSM to fight you, the silent readers already scored it. Leave it there.

“This is dangerous misinformation — reported.”

- **Short:** “Every claim carries a citation. Name one that’s wrong and I’ll correct it publicly.”
- **With receipts:** “The book tells nobody to stop medication — the opposite is printed on the copyright page. It demands a documented history before prescribing. Report a page number, not a feeling.”
- **Then:** “Report away — the references stay up.” And let them.

A parent posts, angrily, that medication saved their child.

- **Short:** “I believe you, and I’m glad. Nothing in the book takes that away — it asks that every child get the question yours also deserved first.”
- **With receipts:** “The drug helps every brain — which is exactly why helping can’t confirm the label. Two things can be true at once: it helped, and nobody looked.”
- **Then:** No family gets judged in your comments — say so and move on. Warmth to parents costs the argument nothing and wins the readers everything.

The personal attacks start on you.

- **Short:** “Address the argument and I’ll answer all day. Address me and you get this sentence.”
- **The discipline:** Never return fire, and never weaponise pain — asking an opponent what happened to make them this way uses trauma as an insult, in a thread about taking trauma seriously. If you’ve said it, withdraw it; the withdrawal reads stronger than the jab ever did.
- **Then:** Report, mute, done. The audience keeps the receipts; you keep the register.

Someone attacks a child — yours or anyone’s.

- **The only reply:** “A child is not a topic. The comment is reported, and this is the last reply you’ll get.”
- **The rule:** Never defend the child’s qualities — listing them accepts the premise that a child is up for review. Refuse the premise instead.
- **Then:** Report it (attacks on minors breach platform rules), delete it if the post is yours, mute — and say nothing further about the child, because every added detail extends their exposure.

“Show me ONE study.”

- **Short:** Post one — Rapoport 1978 — with the sentence: “Amphetamine improved attention in ordinary schoolboys; response proves nothing.”
- **With receipts:** Keep a ready block of five: the 1978 NIMH study; MTA benefit gone by 36 months, absent at 8 years; Cochrane’s 185 trials, every one high risk of bias; Moffitt’s ~90% of adult cases without childhood onset; Baldwin’s gap between documented and remembered maltreatment. Paste, cite, done.
- **Then:** Two servings maximum — endless ‘one more study’ is sport, not enquiry. Link the sources listed under each section and go.

A survivor writes: “This was me.”

- **Short:** “I believe you, and I’m sorry it was. Thank you for saying it here — that takes more than the arguing does.”
- **The care:** Never ask for their story publicly, never deploy their comment as ammunition without asking them privately first, and offer Section 27’s routes by message if they want them.
- **Then:** Protect their comment — if anyone piles onto it, that is where your moderation goes first.

“What are your qualifications?”

- **Short:** “The references are the qualifications — courts, Cochrane, four-decade cohorts, the DSM’s own history. Check any of them without trusting me at all.”
- **With receipts:** “That’s what 180 citations are for: nothing in the book runs on my authority. It asks you to read Moffitt, Storebø, Williams, Teicher — people with every qualification you could ask for.”
- **Then:** Credentials-talk past two rounds is deflection. Return to the claim on the table, or leave the thread to the readers.

Someone writes: “This sounds like my son. What do I do?”

- **Short:** “Three questions to start tonight: when did it change? Where, and with whom, is he calm? What do his old school reports say, year by year?”
- **The pointer:** Send them the action kit and the routes (Sections 26 and 27) — the log, the doctor questions, the sentence for the file.
- **The boundary:** “I’m not a clinician — take this list to the GP and have them write the answers down.” Help travels further with its limits stated.

Said out loud: the plain-spoken set

The responses above are polished for the page. These are how it actually sounds — kitchen, school gate, phone. Shorter, rougher, no studies mid-sentence. Use whichever fits your mouth.

“A bit of medicine won’t hurt if it helps him at school.”

- **Easy version:** “Maybe. But nobody’s checked why he’s struggling yet. You wouldn’t take painkillers every day without asking where the pain’s coming from.”
- **If they push:** “It’s the speed family of drugs. I’m not giving a nine-year-old that every day on a guess.”
- **Last word:** “We’re getting him properly checked first. That’s it really.”

“All kids are like that. He’ll grow out of it.”

- **Easy version:** “Some kids, yeah. But he wasn’t like this two years ago. That’s the bit that bothers me.”
- **If they push:** “You grow out of things you grew into. You don’t grow out of something that started overnight.”
- **Last word:** “I’d rather look and find nothing than not look.”

“You’re overthinking it. You read too much online.”

- **Easy version:** “I’m reading his old school reports, not Facebook. Year 3 he was fine. Year 4 he wasn’t. Something changed and I want to know what.”
- **If they push:** “If I’m wrong, the checks come back clear and I’ll drop it. If I’m right and I did nothing — I couldn’t live with that.”
- **Last word:** “Someone’s got to overthink it. That’s the job.”

“So you think everyone with ADHD was abused?”

- **Easy version:** “No. I think nobody ever checks, and that’s the problem. Big difference.”
- **If they push:** “Could be sleep, could be his ears, could be he’s the youngest in the class, could be something happened. Right now they check none of it — they count ticks on a form.”
- **Last word:** “I’m not against the label. I’m against skipping the looking.”

“The doctor knows best.”

- **Easy version:** “The doctor had ten minutes and a form. I’ve had nine years with him. We’re both useful.”
- **If they push:** “A good doctor doesn’t mind questions. If they mind, that tells me something too.”

- **Last word:** “I’m not fighting the doctor. I’m giving them the full picture.”

“Half his class is on it. It’s normal now.”

- **Easy version:** “And that’s supposed to make me feel better? Half a class on stimulants isn’t normal, it’s a fashion.”
- **If they push:** “The youngest kids in every class get diagnosed about a third more. That’s not a brain thing, that’s a birthday thing. Look it up.”
- **Last word:** “Everyone doing it is how we got here.”

“He’s fine at mine. Must be something you’re doing.”

- **Easy version:** “That’s actually really useful — he’s calm at yours. So it’s not his brain, is it? His brain comes on the visit.”
- **If they push:** “I’m not having a go. If he’s fine there and not somewhere else, the question is what’s different — not who’s to blame.”
- **Last word:** “Help me work out what’s different at yours. That helps him more than anything.”

“Are you saying I did something to him?”

- **Easy version:** “No. I’m saying I want everything checked so nobody can ever say we didn’t. That protects you too.”
- **If they push:** “If nothing happened, the checks show nothing, and it’s in writing forever. Refusing to look is the only thing that looks bad.”
- **Last word:** “I’m not accusing you. I’m refusing to skip a step on our kid.”

“What if we wait and he falls behind?”

- **Easy version:** “The checks aren’t waiting — they’re doing. Hearing test is a week. Blood test is a week. Reading his old reports is tonight.”
- **If they push:** “The tablets will still be there in two months. His cause won’t find itself.”
- **Last word:** “We’re not choosing slow. We’re choosing in order.”

The blame ping-pong: “it only happens at school” — “well, it doesn’t happen here.”

- **Easy version:** “Good — that’s not an argument, that’s a clue. If it only happens in one place, that place has the answer.”
- **If they push:** “Kids don’t carry a disorder that clocks in at nine and clocks off at three. Whatever it is lives in that building — a lesson, a corridor, a kid, a teacher. Let’s find it.”
- **Last word:** “Can we get it written down exactly when and where it kicks off? Patterns don’t lie.”

And the one for yourself, on the days you’ve got nothing left.

- **Say this:** “One thing this week. Not the whole war — one phone call, one letter, one page of the log.”
- **And this:** “Him at forty. That’s who the bookwork is for.”
- **And this:** “I don’t have to win every room. Paper wins rooms while I sleep.”

Online drive-bys: “did ChatGPT write this?” — “ok, whatever.”

- **Easy version:** “The references wrote it. There are 190 of them. Pick one.”
- **If they push:** “Argue with Cochrane, not with me.”
- **Last word:** Drive-bys get one reply, then nothing. They weren’t reading anyway — the silent ones were.

“Stop gatekeeping my ADHD.”

- **Easy version:** “Keep your label if it helps you — honestly. My argument’s with a system that never checks kids, not with you.”
- **If they push:** “You can have your diagnosis and still agree kids deserve a proper look first. Those two things aren’t enemies.”
- **Last word:** Never fight an individual about their own identity — you lose even when you win. The system is the opponent, every time.

“You can’t say that — it’s ableist.”

- **Easy version:** “Ableist would be saying struggling kids don’t need help. I’m saying they need more help — a whole search, not a form.”
- **If they push:** “The book says wounded kids are being told they’re faulty. That’s the ableism I’m against.”
- **Last word:** One round on the word, then leave it. The readers already got the point, and word-fights bury it.

A vocabulary for the child: the words that keep the question open

Words decide what gets asked next. Each pair below swaps a word that closes the enquiry for one that leaves it open — use them in meetings, in emails, in the notes you keep, and out loud in front of the child.

- **“Symptom” → “reaction”:** a symptom belongs to a disorder; a reaction has a cause, and causes get looked for
- **“Disorder” → “response”:** a response is what a body does to something; the something is the question
- **“Naughty” → “frightened” or “dysregulated”:** naughty ends the conversation; frightened starts the right one (13.4)
- **“Attention-seeking” → “connection-seeking”:** the first is an accusation; the second is a need, and needs get met
- **“Non-compliant” → “not safe enough to comply”:** compliance is what a body offers when it is not braced (Section 5)
- **“Meltdown” → “overwhelm”:** a meltdown is the child’s fault; overwhelm has an amount, and amounts can be reduced
- **“Manipulative” → “strategic”:** a child who works the adults has learned that adults need working; ask what taught them
- **“Challenging behaviour” → “communication”:** behaviour is the language a child uses when words did not work (Section 6)
- **“Hyperactive” → “hypervigilant, until shown otherwise”:** the same movements, a different reading, and the reading decides the assessment (Section 2)
- **“Comorbid” → “the same history, filed twice”:** until a single history has been ruled out, the stack is one question, not several (13.7)
- **“Responded to medication” → “showed the drug’s effect”:** everyone shows the drug’s effect; nobody’s diagnosis is confirmed by it (12.2)
- **“Unmasked” → “surfaced”:** something surfaced at the transition; the word unmasked has already decided what (Section 4)
- **“What’s wrong with you?” → “What happened to you?”:** the whole book, in the only two questions a child ever gets asked

For GPs: one page

You have ten minutes and a repeat-prescription template. This page is the version of the book that fits in them. Three questions, one duty, one line to record — and the reassurance that nothing on it conflicts with the guideline you already work under; it only asks you to keep the part of it that time has quietly removed.

- **Before any stimulant:** the cardiac screen you already do, and beside it the adversity history you do not — named domains, more than one informant, documented either way (Sections 12.30, 18)
- **The cheap differential:** sleep including snoring, hearing, vision, ferritin, thyroid, reading, language, birth month within the school year (13.6, 13.14)
- **Onset:** a dated change is a presumption against ADHD until the window before it has been searched (Section 4)
- **Response proves nothing:** stimulants sharpen attention in every patient you have; do not write 'responded, confirming diagnosis' (12.2)
- **At every review:** what has changed for this child since the last one; the sleep; the growth; the child's own account (12.24, 12.27)
- **The sentence for the notes:** what happened to this child was actively looked for, by these means, with this result
- **When you are declining shared care:** say what the family should do instead — a discharged child on a repeat prescription is nobody's patient (15.12)

For social workers: one page

You are the professional most likely to already hold the answer to this book's question, and the least likely to be asked for it. This page is for the child on your caseload who has an ADHD label, or is about to get one: what to check in the file, what to say to the clinic, and what the label will do to the child's case if nobody joins the two records together.

- **The label is not a finding:** a child 'known to have ADHD' is a child whose distress has been filed; read the file for what happened, not for the diagnosis (15.1)
- **Children in care:** the care record already contains the history; every prescription should be reviewed against it (Section 5)
- **Contact and handover:** the ninety minutes either side are evidence; ask for the log, not the label (15.9, Section 16)
- **The toxic trio:** domestic abuse, parental mental illness, substance misuse — where any is present, the child's 'ADHD' is a hypothesis about exposure first (Section 5)
- **Medication in your caseload:** a rising dose, an added antipsychotic, or a new label is a re-assessment trigger, not a treatment update (12.26, 12.27, 13.7)
- **The safe adult:** name one, in writing, for every child on your list who does not have one (Section 22)

For grandparents: one page

You hold the archive: the parent's childhood, the house they grew up in, the year things changed, the photographs. This page is how to put that in the room without starting a war in the family — what to write down, what to offer, and the one sentence to say to a clinic that has never heard from you.

- **You hold the timeline:** write down when the child changed and what changed around them that year — nobody else remembers it as well (Section 4)
- **You hold a second setting:** if the child is calm at yours, say so, and describe what is different (Section 16)
- **You hold the parents' childhoods:** what happened to your own children is part of your grandchild's history — gently, and to the assessor, not the kitchen (Section 5)
- **Do not investigate:** if something is said to you, write down the exact words and the date, and pass them on; do not question the child (Section 6, 26)
- **Do not take sides on the tablets:** the medication conversation belongs with the prescriber; your job is the history and the safe place (12.24)
- **Your test:** 'Was anyone ever asked what happened to this child?' If the answer is no, you are the person who asks.

The log: what an entry looks like

Section 16 asks for a log and never shows one, so here is a week of it. The rule is three things per entry — when, what, who was there — and no adjectives. “Disruptive” is a rating. “Threw his pencil case when the supply teacher shouted” is a record.

- Mon 7.45am — refused breakfast, said stomach hurt. Dad on nights, Mum only. Ate at 4pm.
- Mon 3.20pm — came out of school tearful, wouldn't say why. Fine within 20 min at Gran's.
- Tue 6.10pm — explosion over homework (dose 7.30am). Calm by 7. Same as last Tuesday.
- Wed — no incidents. Note: Mr K off sick, Mrs A took the class.
- Thu 8.50pm — wouldn't sleep with door shut. Third time this week. Started after half-term.
- Fri 3.15pm — stepdad collected. Silent in car per stepdad. Loud and silly at Gran's an hour later.
- Sat — no tablet. Ate three meals. Played out. One argument with sister, ordinary.

Read that week back and it is already an assessment. The stomach ache tracks school; the tears track one classroom; the explosion tracks the dose; the door tracks a date; the silence tracks a person; the Saturday shows the child underneath. Nobody rated anything. The pattern rated itself.

Asking the child: safe questions, by age

The rule from Section 6 is absolute — open questions, no leading, no pressing, and anything alarming taken to the routes in Section 27 rather than pursued at the kitchen table. Within that rule, here are questions a parent or teacher can safely ask, and the age they work at.

- Under 6 — through play and drawing rather than questions: “Draw your house. Who lives there? Who is the happiest one? Who is the crossiest?” Watch what the child avoids drawing.
- 6 to 9 — “What is the best bit of your day? What is the worst bit? If you had a magic wand, what would you change about home / school? Who do you go to when you feel sad?”
- 9 to 12 — “Is there anywhere you don't like going, or anyone you don't like being with? You don't have to say why. Has anything happened that you've never told anyone? You can tell me, or someone else, whenever you want.”
- Teenagers — “When did things start feeling hard — was there a year, a term? Is there anything you've always thought you couldn't say at home? If you could tell the doctor one thing they never asked, what would it be?”
- At every age — believe the answer, thank the child for it, do not react with alarm in front of them, and never promise to keep it secret: say instead that you will help, and that you will tell them what happens next.

For clinicians: the note that protects the child — and you

One paragraph in the record, written before any prescription, satisfies every duty this book has described and every guideline you already work under. It also protects the clinician, because it is the paragraph a coroner, a court or a complaints panel will look for first. A version that fits any template:

- Developmental history taken from [mother / father / carer], separately, on [date]; school reports reviewed from [year] to [year]; behaviour change first documented [term / year].
- Adversity screen completed ([instrument]) with [child alone / parents]; domains asked: household violence, separation and loss, abuse of any kind, bullying, medical events, bereavement, care history. Result: [nil disclosed / disclosed: ...]. Action: [none required / safeguarding referral made to ... on ...].
- Physical screen: hearing, vision, sleep history including snoring, ferritin, thyroid, language — [results]. Setting pattern: [same across settings / different: ...].
- Child's own account sought on [date]: [summary in child's words]. Child's view of medication: [...].
- Decision: [support in school / review in ... weeks / medication trial with consent script completed]. Review date: [...].

Five lines. They take longer to type than the prescription. A file that contains them cannot be accused of not asking, and a child whose file contains them has been seen — which is the entire demand of this book, reduced to the size of a clinic note.

The one-page timeline: how to lay it out

Take a sheet of paper sideways. Draw a line across it. Mark the years from birth to now. Above the line, write the child's world: moves, separations, new adults in the house, illnesses, deaths, school changes, the year a particular teacher took the class, anything the family would call an event. Below the line, write the child: what each year's school report said in three words, when wetting returned, when sleep broke, when the anger began, when the first prescription started and every dose change since. Then look for the place where the two lines touch. That sheet, which takes an evening, is the assessment this book has argued for. It is also admissible in every room the child will ever be discussed in, because it records what happened rather than what a form concluded.

What to bring to the appointment

- The timeline, as above, with a copy to leave behind
- The school reports in date order, with the year the comments turned flagged
- The log of Section 16 — two weeks minimum, dated, specific, noting who was present
- The dose and side-effect history if the child is already medicated (12.4, 12.31)
- The growth chart, the sleep history and any hearing, vision or blood results (13.6, 13.8)
- The four questions from Section 17, written down, with space to write the answers
- A second adult, if you can — to listen, to take notes, and to be the person who was not expecting anything (12.29)

If the school will not listen: the ladder

In order, and in writing at every step, keeping copies. The class teacher. The SENCO, in a meeting you request by email so that the request is dated. The head teacher. The chair of governors, whose address is on the school website. The local authority's SEN team and, if the child has or needs an EHC plan, IPSEA's advice line (Section 27). And, for a complaint the school has failed to resolve, the Department for Education's school-complaints route. Most disputes end at the second rung, because a dated written request for a meeting about a child's welfare is a document a school does not want on a file it did not answer.

If the clinic will not listen: the ladder

Ask, in writing, for the assessment to be repeated with the developmental history and adversity screen recorded, citing the guideline by name. If refused, PALS at the trust. If unresolved, the trust's formal complaints process, which must reply within a set time. If still unresolved, the Parliamentary and Health Service Ombudsman for NHS services, or the Care Quality Commission for private clinics, which regulates them. And for any clinician who has prescribed a controlled drug to a child without a documented history, the question of whether that meets the professional standard is one the General Medical Council exists to answer. None of these steps is dramatic. All of them are letters. A pathway that runs on unrecorded omissions is unusually vulnerable to a parent who writes things down.

The adult's own kit: re-opening your file

Half the people reading this are not parents of a child with the label. They are the child, grown up. This kit is for you, and it runs the same method on your own life. Nobody is going to do this for you — the pathway does not re-open files — so here is how you do it yourself.

- Get your records. A subject access request to your GP surgery gets your lifetime medical notes, including childhood referrals and prescriptions; your old school or the local authority may still hold reports and, if you were in care or known to social services, your care file. Free, in writing, one month.
- Read them in date order, looking for first appearances: the year the word restless or disruptive or anxious first turns up, the first prescription, the dose changes. Then write beside each year what you know was happening in your life — and what you do not know.

- Ask the archive keepers. A parent, a grandparent, an older sibling, an aunt: what was I like at six? What was going on at home that year? Was there anything nobody talked about? Ask one at a time, not at Christmas, and accept that the person you most need to ask may be the person least able to answer.
- Run the checks of 13.6 and 13.8 on yourself: sleep, snoring, iron, thyroid, drink, the phone at midnight. Half of adult inattention has a boring cause that nobody has looked for either.
- Decide what you want. Some people want the label reassessed; some want to keep it and add the history; some want neither and only wanted to know. All three are allowed. If you want reassessment, take the timeline and the questions of Section 17 into the room and ask for the history to be taken properly this time.
- And if the file turns up something you had not remembered, or something you had: Section 27, NAPAC, before anything else. Finding it is not the same as being ready for it. You are allowed to stop and get help.

Five questions for a private or online clinic, before you pay

Right to Choose sends thousands of people to private assessment now, and the BBC filmed what some of those assessments look like. Ask these five before the appointment, in writing, and keep the answers.

- How long is the assessment, and is it in person or by video? A full assessment with a developmental history takes hours, not forty-five minutes.
- Who takes the developmental history, and from whom? For a child, both parents and the school; for an adult, someone who knew you as a child. If the answer is “the questionnaire covers that,” you have your answer.
- Is adversity or trauma screened, with what instrument, and will the result be recorded? A clinic that does not know what you mean has not read the guideline.
- Will my GP accept shared care afterwards? Many now refuse for private assessments, and a prescription nobody will continue is a prescription you will be paying for privately, indefinitely.
- What happens if the assessment finds I do not have it? A good clinic can answer that. A clinic whose business depends on the answer being yes usually cannot.

When parents disagree about medication

It happens constantly and almost nobody knows the rules. In England and Wales, everyone with parental responsibility — usually both parents, married or not, if both are on the birth certificate — has an equal say in a child’s medical treatment. For something as significant as starting a controlled drug, a clinician should seek the agreement of both, and should not proceed on one parent’s signature over the other’s known objection; if parents cannot agree, either can ask the family court to decide, and the court decides on the child’s welfare, not on who shouts loudest. Two things follow. A parent who objects should say so in writing to the prescriber, calmly, with the reasons — the timeline, the questions of Section 17 not yet asked — because a written objection changes what a clinic can do. And a parent who is being told “the other one has agreed, so it is happening” should know that is not how the law reads, and can say so. This is general information, not legal advice; the Children’s Legal Centre in Section 27 gives the specific kind for free.

A letter to prescribers

You did not build this pathway, and this book is not aimed at you. It is aimed at the twenty minutes you are given to do a job that needs two hours, and at the one step in that job that costs almost nothing and is mandated nowhere. You already take a cardiac history before you prescribe, because the drug can kill and the guideline says so. I am asking you to take one more history for the same reason: because a child medicated instead of asked can be harmed for a decade, and because the question — what has happened to this child — is the one criterion E of the diagnosis you are making already requires you to satisfy. I know the referral arrived pre-labelled, the parents arrived relieved, and the waiting list behind them is measured in years. I know that the child in front of you may well have exactly what the referral says. All I ask is that the file record that you looked, by what means, and what you found — either way — before the first prescription. If that sentence is already in your notes, this book was written about someone else. If it is not, it was written for you.

A letter to the teacher who referred, and now doubts it

You saw a child struggling and you did what the system gave you to do. Nothing in this book says you were wrong to notice; it says the form you were handed could not carry what you noticed. If you are reading this with a name in your head — a child you referred, who is now quieter, and who you are no longer sure about — there are three things you can still do. Write down, with dates, what you actually saw in the months before the referral: when it started, in which lessons, after which weekends, around which adults. Ask the child's other teachers whether they see the same child. And say, in the review the school will be asked to attend, the sentence that no one in that room may otherwise say: "We never established what changed for him that year, and I think we should." That sentence is not an admission. It is the only thing that can turn a referral into an assessment.

Getting the records: the subject access request

Everything this book asks you to reconstruct, the system already holds — and you have a legal right to it. A subject access request under UK data-protection law gets you your child's complete records: GP notes, CAMHS files, school records, social-care files. It is free, needs no solicitor, and must be answered within one month. Send a short email to each organisation separately — "I am making a subject access request for the complete records of [child's name, date of birth]. I am their parent with parental responsibility; ID enclosed" — and keep the timeline of Section 16 beside you as you read. You are looking for the year the comments turned, the referral's actual wording, what the rating scales scored, whether the Section 18 sentence appears anywhere — and anything about your family the file asserts that nobody ever asked you about. You can require factual errors to be corrected; disagreements you can have noted on the record.

Recording appointments

You may record your own medical appointments for your personal use — it is your consultation and your data, and no permission is legally required, though saying "I'd like to record this so I don't misremember — is that OK?" keeps the room warm and changes behaviour all by itself. A recording settles every later argument about what was said, captures the moment you asked the Section 26 questions and what came back, and — where a clinician knows the tape is running — has a way of making the history get taken. School meetings differ: ask first, and if refused, take minutes and email them back "to confirm my understanding" — which makes your note the record.

Reading the file

Files talk in codes and shorthand. Things to know: diagnoses live as codes (ADHD is F90); "no concerns" usually means "not asked"; "known to social care" is a flag to read the social-care file, not a conclusion; and reports copied between agencies repeat each other — one unexamined sentence written in Year 2 can appear, re-quoted, in every document for a decade, wearing more authority each time (15.1). Trace every assertion about your child to its first appearance and see what it was based on. Very often the entire edifice stands on a single rating scale and a ten-minute observation — which is worth knowing before any tribunal, review or court.

The data gap: the box that does not exist

Here is the whole scandal in a database field: the NHS record has codes for the diagnosis, the drug, the dose, the review — and no mandatory field, anywhere, recording whether anyone screened for trauma before prescribing. What is not recorded is not counted; what is not counted does not exist; and that is why nobody can even tell you what proportion of medicated children were ever asked. The fix costs one line of data entry: a required field — adversity history taken: yes/no; by whom; outcome — before a first prescription can be issued. Ask your MP why it does not exist. Ask the taskforce (15.13). It is the cheapest reform in this book, and the most revealing: a system confident in its answer would already be counting.

One sentence should exist in every child's file before any prescription is written: what happened to this child was actively looked for, by these means, with this result. If it is not there, ask why not.

If It Was You

This page is for one reader, and if it is you, you already know. You have read three hundred pages asking what happened to the child, and somewhere in them you recognised the house. The drinking was yours. The shouting was yours. The hand, the silence, the thing you did or the thing you let happen — yours. You have got this far, which most people in your position never do, and this page is going to treat that as the fact it is: you are still reading.

First, what not to do. Do not disappear into shame, because shame is where the child's silence came from and it will keep him there. Do not confess to him as though he were the priest; a child cannot carry a parent's guilt, and handing it to him is one more thing done to him. Do not decide that the damage is done and nothing can change it, because that is the one belief the evidence flatly contradicts: the single most powerful intervention any hurt child can receive is a safe adult, and a parent who becomes one — late, imperfectly, for the rest of the childhood — is the safe adult the research is describing (Section 22). The child does not need you to have been good. He needs you to be different, from now, and to stay different.

What to do instead, in order. Get help for the thing itself before anything else, from people who exist for exactly this and will not turn you away: Respect's phoneline for anyone worried about their own violence or abuse toward a partner or child, and Stop It Now for anyone with thoughts or behaviour toward children they are frightened of — both confidential, both used every day by people who thought they could not ring (Section 27). Then make the house safe, which may mean leaving it, or asking someone to leave it, or letting a service in. Then — only then — the child: not the confession, but the change, and one true sentence when he is old enough to hear it. "What I did was wrong. It was never your fault. I am getting help so it never happens again." Children can survive an enormous amount if one adult finally tells them the truth about it.

And then let the file be true. If your child is on the pathway, the history that this book has begged every clinician to take is a history you can supply. That will cost you, and it will be the most useful thing anyone has done for that child since the referral. A parent who says to a doctor "there was violence in the house and I want that on his record" has done what no rating scale can do. It is not the end of you. It is the beginning of the assessment.

You were probably a child this book is about, once. Nobody asked you either. Breaking the chain is not an apology; it is a decision, made daily, that it stops here. The children of this book did not get that from the adults who hurt them. Yours can. That is not a small thing. It is the whole thing.

To the Parent at the Kitchen Table

You have a child who is struggling, a school that has used the letters, and an appointment coming. Somewhere in you there is a choice, and this page is going to name it, because nobody in the pathway will. You can find out what happened and deal with it. Or you can medicate the child and let the question close. Most parents who take the second road do not think of it as a choice at all; it arrives as the only door anyone opened. This page opens the other one and tells you honestly what is behind it.

Behind the first door there are three hard things, and none of them is the thing you are afraid of. The first is your own past. Section 15.5 has the research: a parent's childhood adversity predicts the child's label, not because parents cause it but because the same house, the same fear, the same silence get handed down until someone stops handing them. Disclosing the family past does not mean confessing to a clinic or blaming your parents. It means putting on the child's timeline the things that were on yours — the drinking, the violence, the loss, the thing nobody mentions — so that whoever assesses him is assessing the actual child and not the one the form describes. If you cannot write it down, you can say it to one safe person first. That is how most parents start.

The second is the hard talk. With your partner, about what the child may have seen and heard in this house, and whether one of you is the person he goes stiff for at the door. With your own parents, who hold the archive and may be the archive. And with the child, alone, calmly, in the words of Section 26 — not what is wrong with you, but what is the worst bit of your day, is there anyone you don't like being with, has anything happened you never told anyone. You may hear nothing. You may hear something you were not ready for. Either way you will have done the one thing the pathway never does, and the child will know, for the rest of his life, that somebody asked.

The third is the boring one, and it is the one that wins: write it down. The reports in date order. Two weeks of what actually happened, when, and who was there. The year the comments turned and what changed that year. Take it into the room instead of the form. A pathway that runs on nothing being recorded cannot argue with a parent who recorded things. This is not fighting the doctor. It is giving the doctor what the guideline says they should already have, and watching whether they use it.

Behind the second door there is a prescription, and this book has spent a chapter on what is in it. Say plainly what the choice is, because you are entitled to make it with your eyes open. The tablets will very likely calm him. The school will be relieved and the file will say responding well. And the thing that happened — if something happened — will still be there, under the calm, untreated, growing, until it comes out at fifteen as the drugs, at twenty as the debt, at thirty as

the marriage, at fifty as the heart. That is not a prediction about your child. It is the average of the studies in Section 13, and averages are made of somebody's children. Medicating is not wrong. Medicating instead of asking is. The silence is the cost, and the silence is charged to him.

So here is what I would do, since you asked, as the child it was done to. I would open the first door before the appointment, not after. I would tell one person the thing about my own childhood that I had never said. I would ask my child the questions on the kitchen sheet and believe the answer. I would write it all down and walk into the room holding it. And if, after all that, the honest picture were still a restless boy with nothing behind him, I would let the clinic help — with the consent conversation, the breaks, the reviews, and the door left open. Because the only thing this book has ever asked of anyone is the thing it is asking of you now. Before the tablet, the question. Before the silence, the truth. He is worth the hard version.

To the One Carrying the Label

Everything else in this book talks about young people like you. This page talks to you — whether you were diagnosed at six or last month, whether the tablets help or you hate them, whether you found this on a parent's table or someone handed it to you.

Start with the only sentence that matters: nothing is wrong with who you are. You have probably been offered two stories about yourself — the naughty one, or the broken-brain one. There is a third story this whole book exists to tell: that some things may have happened, or may still be happening, that your feelings and your body are responding to exactly the way a person is built to respond. Struggling is not malfunction. Sometimes it is the most accurate thing about you.

About the tablets, if you take them. Some people your age say they help; some say "I don't feel like myself". Both are real, both matter, and both belong out loud — to your parents and to the doctor, in your own words, at your own appointment, where you are allowed to speak. One thing said plainly, friend to friend: do not stop them on your own. Not because adults said so — because stopping suddenly makes everything feel worse for a while, and that gets written down as you getting worse. Changes happen with the doctor, and you get a seat in that conversation.

You are also allowed to ask questions nobody expects from you. "What else was checked — my sleep, my hearing, my reading?" And the big one: "Did anyone ever ask what has happened around me?" If the room goes quiet, you have just done the most grown-up thing in it.

And if something has happened to you — at home, at school, online, long ago or still going, however small you have told yourself it was, whoever it involves: it was not your fault, you will not be in trouble for saying it, and saying it is how it stops. Tell an adult you trust. If they do nothing, tell another one. Keep telling until somebody does their job — that is not you causing trouble, that is you giving the adults the chance to be what they are supposed to be. The next section has phone numbers where the person who answers believes young people for a living, for free, in private.

Maybe nothing happened, and school is just loud and boring and hard. Then this book still wants better answers for you than a checklist — you might be the youngest in your year, or tired, or bored because you are quick, or wrestling with reading. Ask for the checks. You deserve the full search, not the fast answer.

Last thing. Whatever the file says, you are not a diagnosis, not the naughty kid, and not a broken brain. You are somebody this entire book was written to get properly seen. The adults are supposed to be on it — and this book is one adult's way of making sure they are.

27. Support Resources and Helplines (United Kingdom)

When trauma-related presentations are identified, or when differential diagnosis between ADHD and trauma raises safeguarding concerns, clinicians and families require timely access to specialist support. The following national UK helplines and services provide free or confidential assistance for children, young people, adults, and those supporting them. Numbers and opening hours should be verified on the organisations' official websites, as details may change.

How to use this page. If a child is in danger now, the first line is 999 and nothing else. If you are a parent who has read this book and recognised something, the NSPCC helpline will talk it through with you without judgement, and will tell you what happens next before anything happens. If you are an adult who has found your own childhood in these pages, NAPAC exists for exactly that, and its call-handlers are used to first calls from people who have never said it out loud. Two honest cautions. Helplines cannot promise what will or will not follow a call — some things, once disclosed, must by law be acted on, and a good service will tell you that at the start rather than the end. And numbers change: every one below was checked when this book went to press, and the organisation's own website is the final word.

Emergency and crisis support

- **999** — Emergency services (police, ambulance, or fire) in situations of immediate danger to life or ongoing risk of serious harm
- **NHS 111** — Non-emergency medical and mental-health advice. In many areas, selecting the mental-health option connects callers to trained professionals 24 hours a day
- **Samaritans** — **116 123** (24 hours, every day). Free, confidential emotional support for anyone in distress
- **Shout** — **Text SHOUT to 85258** (24/7). Free, confidential crisis text support for anyone struggling to cope

Children and young people

- **Childline (NSPCC)** — **0800 1111** (24/7). Free, confidential support for children and young people under 19. Online chat and email also available
- **NSPCC Helpline (for adults concerned about a child)** — **0808 800 5000** (24/7). Advice and support if a child is at risk of abuse or neglect

Sexual abuse and sexual violence

- **24/7 Rape and Sexual Abuse Support Line (England & Wales)** — **0808 500 2222** (24/7). Confidential emotional support for anyone aged 16 or over who has experienced sexual violence or abuse at any time in their life
- **Rape Crisis England & Wales** — Local centres and national support accessible via rapecrisis.org.uk. Links into the 24/7 support line above
- **The Survivors Trust** — **0808 801 0818** (helpline for people aged 16+). Support and signposting for survivors of sexual violence
- **Sexual Assault Referral Centres (SARCs)** — NHS services offering medical, practical and emotional support after sexual assault or abuse. Attendance does not require police involvement. Details available via NHS 111 or local search

Adult survivors of childhood abuse

- **NAPAC (National Association for People Abused in Childhood)** — **0808 801 0331**. Free support line for adult survivors of any form of childhood abuse (physical, sexual, emotional or neglect). Typical opening hours: Monday–Thursday 10:00–21:00, Friday 10:00–18:00 (confirm current times)

Male survivors of sexual abuse

- **National Male Survivor Helpline (Safeline)** — **0808 800 5005**. Free, confidential support for men, boys and those who identify as male or non-binary affected by sexual abuse (childhood or adult). Limited opening hours; online chat options available via safeline.org.uk
- **SurvivorsUK** — Text, WhatsApp and webchat support for men, boys and non-binary people. Details at survivorsuk.org

Suicide prevention and young people's mental health

- PAPYRUS HOPELINE247 — 0800 068 4141 (24/7). Confidential support for anyone under 35 with thoughts of suicide, and for anyone worried about a young person
- YoungMinds Parents Helpline — 0808 802 5544 (weekdays). Advice for parents and carers worried about a child's mental health or behaviour
- The Mix — 0808 808 4994. Free support for under-25s on any issue, including online counselling and crisis messenger
- Mind Infoline — 0300 123 3393. Information on mental-health services, rights and treatment options for adults

Parents dealing with schools, assessments and social services

- IPSEA (Independent Provider of Special Education Advice) — free legal advice on SEN support, EHC plans and exclusions, via ipsea.org.uk booking lines
- SENDIASS — every local authority runs a free, impartial information and advice service for special educational needs; search your council's name plus SENDIASS
- Family Rights Group — 0808 801 0366. Free advice for parents and family members whose children are involved with, or at risk of involvement with, children's social care
- Coram Children's Legal Centre — free legal information for families on education, care and children's rights, at childlawadvice.org.uk
- PALS (Patient Advice and Liaison Service) — every NHS trust has one; the route for concerns about an assessment, a prescription or a service, before a formal complaint

Bereaved children and families

- Winston's Wish — 08088 020 021. Free support for children and young people after the death of someone close, and for the adults around them
- Child Bereavement UK — 0800 02 888 40. Support for families when a child grieves or when a child dies; also advises schools
- Cruse Bereavement Support — 0808 808 1677. Free support for anyone grieving, adults included
- Grief Encounter — 0808 802 0111. Support line for bereaved children and young people

Domestic abuse

- **National Domestic Abuse Helpline — 0808 2000 247 (24/7).** Free, confidential support for women experiencing domestic abuse and those supporting them. Live chat also available
- Men's Advice Line — 0808 801 0327. Confidential support for men experiencing domestic abuse
- Galop — 0800 999 5428. Support for LGBT+ people experiencing abuse or violence
- Women's Aid — live chat and local-service directory at womensaid.org.uk; the Survivor's Handbook explains options step by step
- Respect Phoneline — 0808 802 4040. Confidential support for anyone worried about their own abusive behaviour toward a partner or family member, and for friends and family
- Stop It Now — 0808 1000 900. Confidential helpline for anyone concerned about their own thoughts or behaviour toward children, or about someone else's

Additional victim support

- **Victim Support — 0808 16 89 111 (24/7).** Free, confidential support for anyone affected by crime or traumatic events, including non-recent abuse

Clinical note: these resources complement clinical assessment and intervention. When trauma or safeguarding concerns are identified during differential diagnosis of ADHD-like symptoms, prompt signposting to appropriate

services supports both immediate safety and longer-term recovery. Clinicians should remain aware of local pathways, mandated reporting duties, and the need to verify current contact details.

SOURCES

- GOV.UK guidance on support for victims and survivors of child sexual exploitation and abuse, and sexual violence.
- NSPCC and Childline official resources; Rape Crisis England & Wales; The Survivors Trust; NAPAC; Safeline; Samaritans; NHS 111; Shout; Victim Support; National Domestic Abuse Helpline.

Fifteen books

- **van der Kolk, *The Body Keeps the Score*.** The trauma field's foundational popular text, and the source of the developmental-trauma proposal the manual declined (1.1)
- **Herman, *Trauma and Recovery*.** The phased model of healing and the history of the field's forgetting (15.4, 22)
- **Maté, *Scattered Minds*.** A physician's case that ADHD is a developmental response to early stress — this book's nearest ancestor
- **Perry & Winfrey, *What Happened to You?*** The question, as a title
- **Schwarz, *ADHD Nation*.** The reporter's history of the diagnosis, the marketing, and the men who built it (19, 20)
- **Hinshaw & Scheffler, *The ADHD Explosion*.** The economists' account of why prevalence follows policy (1.4)
- **Timimi, *Naughty Boys*.** A child psychiatrist's argument that the category is a cultural artefact
- **Frances, *Saving Normal*.** The chair of DSM-IV on the epidemics his manual helped make
- **Whitaker, *Anatomy of an Epidemic*.** The long-term outcome evidence for psychiatric drugs, assembled
- **Rasmussen, *On Speed*.** The history of amphetamine, from the first tablet to the last war (12.14)
- **Perry & Szalavitz, *The Boy Who Was Raised as a Dog*.** A child psychiatrist's cases, and the method of asking what happened, in practice (In Their Own Words)
- **Burke Harris, *The Deepest Well*.** A paediatrician on the ACE science, from the clinic that first screened every child for it (13.13)
- **Nakazawa, *Childhood Disrupted*.** How early adversity becomes adult illness, for a general reader (Section 7, 13)
- **Walker, *Complex PTSD: From Surviving to Thriving*.** A therapist-survivor's account of the four responses — fight, flight, freeze, fawn (Section 3)
- **Schaverien, *Boarding School Syndrome*.** The sanctioned separation, and what it does to the adult (Section 5)

Contacting the author

Two things this book has asked readers to send, and where to send them. Accounts — your own or your child's — for possible inclusion in a future edition, handled to the standard set out in *In Their Own Words*: no child identifiable, no accusation against a named person, nothing printed without your written approval, and the right to withdraw at any point before print. And Freedom of Information answers — the replies from NHS trusts to the question in Section 23 about how many ADHD assessments recorded a trauma screen before prescribing — so that the second edition can print the table the first could not. Send either to pipcan@outlook.com. Corrections, with a source, are welcomed at the same address and acknowledged in the next edition (*How This Book Was Written*).