A Process for Developing Community Consensus Regarding the Diagnosis and Management of Attention-Deficit/Hyperactivity Disorder

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Pediatrics 2005;115;97-104
DOI: 10.1542/peds.2004-0953

A Process for Developing Community Consensus Regarding the Diagnosis and Management of Attention-Deficit/Hyperactivity Disorder

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ABSTRACT. There remain large discrepancies between pediatricians' practice patterns and the American Academy of Pediatrics (AAP) guidelines for the assessment and treatment of children with attention-deficit/hyperactivity disorder (ADHD). Several studies raise additional concerns about access to ADHD treatment for girls, blacks, and poorer individuals. Barriers may occur at multiple levels, including identification and referral by school personnel, parents' help-seeking behavior, diagnosis by the medical provider, treatment decisions, and acceptance of treatment. Such findings confirm the importance of establishing appropriate mechanisms to ensure that children of both genders and all socioeconomic, racial, and ethnic groups receive appropriate assessment and treatment. Publication of the AAP ADHD toolkit provides resources to assist with implementing the ADHD guidelines in clinical practice. These resources address a number of the barriers to office implementation, including unfamiliarity with *Diagnostic and Statistical Manual of Mental Disorders* criteria, difficulty identifying comorbidities, and inadequate knowledge of effective coding practices. Also crucial to the success of improved processes within clinical practice is community collaboration in care, particularly collaboration with the educational system. Such collaboration addresses other barriers to good care, such as pressures from parents and schools to prescribe stimulants, cultural biases that may prevent schools from assessing children for ADHD or may prevent families from seeking health care, and inconsistencies in recognition and referral among schools in the same system. Collaboration may also create efficiencies in collection of data and school-physician communications, thereby decreasing physicians' non–face-to-face (and thus nonreimbursable) elements of care. This article describes a process used in Guilford County, North Carolina, to develop a consensus among health care providers, educators, and child advocates regarding the assessment and treatment of children with symptoms of ADHD. The outcome, ie, a community protocol followed by school personnel and community physicians for >10 years, ensures communication and collaboration between educators and physicians in the assessment and treatment of children with symptoms of ADHD. This protocol has the potential to increase practice efficiency, improve practice standards for children with ADHD, and enhance identification of children in schools. Perhaps most importantly, the community process through which the protocol was developed and implemented has an educational component that increases the knowledge of school personnel about ADHD and its treatment, increasing the likelihood that referrals will be appropriate and increasing the likelihood that children will benefit from coordination of interventions among school personnel, physicians, and parents. The protocol reflects a consensus of school personnel and community health care providers regarding the following: (1) ideal ADHD assessment and management principles; (2) a common entry point (a team) at schools for children needing assessment because of inattention and classroom behavior problems, whether the problems present first to a medical provider, the behavioral health system, or the school; (3) a protocol followed by the school system, recognizing the schools' resource limitations but meeting the needs of community health care providers for classroom observations, psychoeducational testing, parent and teacher behavior rating scales, and functional assessment; (4) a packet of information about each child who is determined to need medical assessment; (5) a contact person or team at each physician's office to receive the packet from the school and direct it to the appropriate clinician; (6) an assessment process that investigates comorbidities and applies appropriate diagnostic criteria; (7) evidence-based interventions; (8) processes for follow-up monitoring of children after establishment of a treatment plan; (9) roles for central participants (school personnel, physicians, school nurses, and mental health professionals) in assessment, management, and follow-up monitoring of children with attention problems; (10) forms for collecting and exchanging information at every step; (11) processes and key contacts for flow of communication at every step; and (12) a plan for educating school and health care professionals about the new processes. A replication of the community process, initiated in Forsyth County, North Carolina, in 2001, offers insights into the role of the AAP ADHD guidelines in facilitating development of a community consensus protocol. This replication also draws attention to identification and referral barriers at the school level. The following recommendations, drawn from the 2 community processes, describe a role for physicians in the collaborative community care of children with symptoms of ADHD. (1) Achieve consensus with the school system regarding the role of school personnel in collecting data for children with learning and behavior problems; components to consider include (*a*) vision and hearing screening, (*b*) school/academic histories, (*c*) classroom observation by a counselor, (*d*) parent and teacher behavior rating scales (eg, Vanderbilt, Conner, or Achenbach scales), (*e*) consideration of speech/language evaluation, (*f*) screening intelligence testing, (*g*) screening achievement testing, (*h*) full intelligence and achievement testing if discrepancies are apparent in abbreviated

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Accepted for publication Sep 15, 2004.
doi:10.1542/peds.2004-0953
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tests, and (*i*) trials of classroom interventions. (2) Use pediatric office visits to identify children with academic or behavior problems and symptoms of inattention (history or questionnaire). (3) Refer identified children to the contact person at each child's school, requesting information in accordance with community consensus. (4) Designate a contact person to receive school materials for the practice. (5) Review the packet from the school and incorporate school data into the clinical assessment. (6) Reinforce with the parents and the school the need for multimodal intervention, including academic and study strategies for the classroom and home, in-depth psychologic testing of children whose discrepancies between cognitive level and achievement suggest learning or language disabilities and the need for an individualized educational plan (special education), consideration of the "other health impaired" designation as an alternate route to an individualized educational plan or 504 plan (classroom accommodations), behavior-modification techniques for targeted behavior problems, and medication trials, as indicated. (7) Refer the patient to a mental health professional if the assessment suggests coexisting conditions. (8) Use communication forms to share diagnostic and medication information, recommended interventions, and follow-up plans with the school and the family. (9) Receive requested teacher and parent follow-up reports and make adjustments in therapy as indicated by the child's functioning in targeted areas. (10) Maintain communication with the school and the parents, especially at times of transition (eg, beginning and end of the school year, change of schools, times of family stress, times of change in management, adolescence, and entry into college or the workforce). *Pediatrics* 2005; 115:e97–e104. URL: www.pediatrics.org/cgi/doi/10.1542/peds.2004-0953; *attention-deficit/hyperactivity disorder, community consensus.*

ABBREVIATIONS. AAP, American Academy of Pediatrics; ADHD, attention-deficit/hyperactivity disorder; PMHP, public mental health program; CH, Child Health; SAT, Student Assistance Team.

Publication of the American Academy of Pediatrics (AAP) guidelines for assessment[1] and management[2] of attention-deficit/hyperactivity disorder (ADHD) was a welcome contribution to pediatricians' efforts to improve the care and outcomes of 6- to 12-year-old children with attention and behavior problems. As a chronic disorder that affects 4% to 12% of 6- to 12-year-old children[1] and results in very challenging personal, clinical, educational, and societal problems, ADHD is an appropriate focus for the efforts of the AAP and practicing pediatricians.

There remain large discrepancies between pediatricians' practice patterns and the AAP guidelines. As many as 50% of children with ADHD are unidentified and untreated.[3] A study by Zito et al[4] of methylphenidate use patterns among Medicaid-insured youths raised the additional concern of racial disparities in the treatment of ADHD. That study found that black youths were 2.5 times less likely to receive methylphenidate than were white youths. Bussing[5] reported that there are significantly greater barriers to ADHD treatment for girls, blacks, and poorer individuals; these barriers occur at multiple levels, including obtaining evaluations by parents, obtaining the diagnosis by the provider, and obtaining treatment. These studies confirm the importance of establishing appropriate mechanisms to ensure that children of both genders and all socioeconomic, racial, and ethnic groups receive appropriate assessment and treatment.

The AAP ADHD toolkit (available to members at www.aap.org/MOC and to others by telephone order at 800-433-9016, extension 5898) provides resources to assist with implementation of the ADHD guidelines in clinical practice. These resources address a number of the barriers to office implementation, including unfamiliarity with *Diagnostic and Statistical Manual of Mental Disorders* criteria; difficulty identifying comorbidities; and inadequate knowledge of effective coding practices. Also crucial to the success of improved processes within clinical practice is the establishment of community collaboration in care, particularly collaboration with the educational system. Such collaboration is essential for addressing other barriers to good care, such as pressures from parents and schools to prescribe stimulants, cultural biases that may prevent schools from assessing children for ADHD or prevent families from seeking health care, and inconsistencies in recognition and referral among schools in the same system. Collaboration may also create efficiencies in collection of data and school-physician communications, thereby decreasing physicians' non–face-to-face (and thus nonreimbursable) elements of care.

This article describes a community process that has the potential to increase practice efficiency and improve practice standards for children with ADHD. This approach also has the potential to enhance identification of children in schools. Perhaps most importantly, this community process has an educational component that increases knowledge of school personnel regarding ADHD and its treatment, increasing the likelihood that referrals will be appropriate and will not presume diagnosis and treatment and increasing the likelihood that children will benefit from coordination of interventions among school personnel, physicians, and parents.

The process depends, at its core, on the mutual interest of school personnel and community health care providers in improving the care of children with ADHD. Like physicians, school personnel find ADHD both challenging and time-consuming. Teachers and school counselors spend enormous amounts of time addressing concerns regarding children who may have ADHD; however, educators may have little accurate knowledge about ADHD and may, in some cases, share misperceptions common among parents, ie, that ADHD is not a real disorder, that ADHD is real but is a minor problem, or that ADHD is caused by too much sugar, food additives, poor parenting, or a stressful family environment. They may think that ADHD is overdiagnosed and overtreated, they may not know which treatments are effective or ineffective, or they may jump to conclusions that children have ADHD and