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Attention Deficit Disorder:
Are Schools and Physicians Working Together?

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Abstract

Over the past twenty years, the existence of Attention Deficit Disorder has been documented through hundreds of scientific studies. Schools play a vital role in the early identification of children with ADHD and, in many cases; school personnel coordinate efforts among teachers, parents, physicians, and community resources in the assessment and treatment of children and adolescents with ADHD (Sloan, Jensen & Hoagwood, 1999). In their research, (Satterfield and Cantwell 1981) viewed the classroom teacher as the major determining factor in whether a student with ADHD succeeds or fails in the classroom.

Despite the documented importance of close coordination between physicians and school personnel, in practice the level of communication varies greatly, This paper will examine the personal experiences of well-intentioned teachers, guidance counselors, special educators, psychologists, physicians, school administrators, and parents, and through personal interviews about the quality, quantity, and consistency of their communication present new evidence of the patters of communication and offer recommendations to strengthen these ties.

Research Base

My research is based upon interviews that I conducted with individuals in Vermont, Massachusetts, Virginia, and Pennsylvania. These participants live and work in rural, urban, and suburban communities. The schools chosen represent both private and public settings. I have relied upon the AAP (American Academy of Pediatrics) recommended guidelines for best medical practices for the diagnosis and treatment of students with ADHD. My data is qualitative and my conclusions are based upon patterns of communication that were consistent across settings.

Definition of Attention-Deficit/Hyperactivity Disorder (ADHD)

Attention-Deficit/Hyperactivity Disorder is the most common neurobehavioral disorder of childhood. ADHD is also among the most prevalent chronic health conditions affection school-aged children. The core symptoms of ADHD include inattention, hyperactivity, and impulsivity. Children with ADHD may experience significant functional problems, such as school difficulties, academic underachievement, troublesome interpersonal relationships with family members and peers, and low self-esteem. Individuals with ADHD present in childhood may continue to show symptoms as they enter adolescence and adult life. Pediatricians and other primary care physicians frequently are asked by parents and teachers to evaluate a child for ADHD. Early recognition, assessment, and management of this condition can redirect the educational and psychological development of most children with ADHD.

Prevalence of ADHD

Recorded prevalence rates of ADHD vary substantially across geographic areas. This exacerbated by the varying degree to which practitioners use the DSM-IV criteria to diagnose ADHD. Recent review of prevalence rates in school-aged community samples indicates rates varying from 4% to 12% with males outnumbering females in a ratio of 3 to 1 (Green, Wong & Atkins 1999).

Clinical Practice Guidelines for the Identification of ADHD

The American Academy of Pediatrics in their March 2001 clinical practice guidelines for the assessment and diagnosis of school-aged children with attention-deficit/hyperactivity disorder (ADHD) make the following recommendations for the diagnosis of ADHD:

1. In a child 6 to 12 years old who presents with inattention, hyperactivity, impulsivity, academic underachievement, or behavior problems, primary care physicians should initiate an evaluation for ADHD.
2. The diagnosis of ADHD requires that a child meet *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)* criteria.
3. The assessment of ADHD requires directly obtained from parents or caregivers regarding the core symptoms of ADHD in various settings, the age of onset, duration of symptoms, and degree of functional impairment.
4. The assessment of ADHD requires evidence directly obtained from the classroom teacher (or other school professional) regarding the core symptoms ADHD, duration of symptoms, degree of functional impairment, and association conditions.
5. Evaluation of the child with ADHD should include assessment for associated (coexisting) conditions.
6. Other diagnostic tests are not routinely indicated to establish the diagnosis of ADHD but may be used for the assessment of other coexisting conditions (e.g., learning disabilities and mental retardation)

Presentations of ADHD in Clinical Practices

In most circumstances, concerns from parents, teachers, other professionals, and/or non-parents caregivers bring potential ADHD cases to the attention of physicians. Generally, referrals from schools are for academic underachievement and failure, disruptive classroom behavior, inattentiveness, problems with social relationships, poor self-esteem, or problems with establishing or maintaining social relationships. Teachers identify children with the core symptoms of hyperactivity and impulsivity, because they often disrupt the classroom. Even mild distractibility and motor symptoms, such as fidgetiness, will be apparent to most teachers.

The Diagnosis of ADHD

Children who meet the diagnostic criteria for the behavioral symptoms of ADHD but do not demonstrate functional impairment do not meet the diagnostic criteria for ADHD. The symptoms of ADHD must be apparent in two or more settings (e.g., at home and in school), and the behaviors must adversely affect functioning in school or a social situation. There are no instruments used in primary care practices, which reliably assesses the nature or degree of functional impairment of children with ADHD. The physician can only make clinical judgment about the effect of core and associated symptoms of ADHD with information obtained from the parent and school.

The Role of the Classroom Teacher

The assessment of ADHD requires evidence directly obtained from the classroom teacher (or other school professional) regarding the core symptoms of ADHD, the duration of symptoms, the degrees of functional impairment, and coexisting conditions. Physicians review school based multidisciplinary evaluations, which include assessments from the teacher, or other school based professionals. The evaluation of ADHD must establish whether core behavior symptoms of inattention, hyperactivity, and impulsivity are present in at least two settings.

As children ages 5-12 spend a substantial amount of their waking hours in the school setting. Therefore, a description of their behavioral characteristics in school is highly important to the evaluation. The classroom teacher typically has more information about the child's behavioral than do other professionals at the school. A school counselor or principal is helpful in coordination the teacher's reporting and may be able to provide the required information. These take the form of ADHD specific questionnaires and rating scales. These rating scales have been shown to accurately distinguish between children with and without the diagnosis of ADHD (Green, Wong & Atkins 1999).

If a child routinely spends considerable time in other structured environments such as an after-school care center, additional information about core symptoms can be sought from professionals in those settings.

Frequently there are significant discrepancies between parent and teacher ratings (Lahey, McBurnett & Piacentini 1987). These discrepancies may be in either direction; symptoms may be reported by teachers and no parents and vice versa. These discrepancies may be attributable to differences between the home and school in terms of expectations, levels of structure, behavioral management strategies, and and/or environmental circumstances. This finding does not preclude the diagnosis of ADHD. In these cases, it is prudent to obtain information from other informants such as former teachers, religious leaders, or coaches to corroborate the validity of ratings.

Treatment of School-Aged Children with ADHD

The American Academy of Pediatrics in October of 2001 established guidelines for the treatment of children diagnosed with attention-deficit disorder (ADHD). The guidelines contain the following recommendations for the treatment of a child with ADHD.

1. Primary care physicians should establish a treatment program that recognizes ADHD as a chronic condition.
2. The treating physician, parents, and child, in collaboration with school personnel, should specify appropriate target outcomes to guide management.
3. The physician should recommend stimulant medication and/or behavior therapy as appropriate to improve target outcomes in children with ADHD.
4. When the selected management for child with ADHD has no met target outcomes, physicians should evaluate the original diagnosis, use of all appropriate treatments, adherence to the treatment plan, and presence of coexisting conditions.
5. The physician should periodically provide a systematic follow-up for the child with ADHD. Monitoring should be directed to target outcomes and adverse effects, with information gathered from parents, teachers, and the child.

Primary care physicians cannot work alone in the treatment of school-aged children with ADHD. Ongoing communication with parents, teachers, and other school-based professionals is necessary to monitor the progress and effectiveness of specific interventions (AAP Volume 5 2000).

Recommendation Number 2 is based upon the recognition that the core symptoms of ADHD (i.e. inattention, impulsivity, hyperactivity) can result in multiple areas of dysfunction relating to a child's performance in the home, school, or community. It focuses on treatment as a means to maximize function.

The process of developing target outcomes requires input from parents, children, and teachers as well as other school personnel. They should agree on key target outcomes and desired changes as prerequisites to constructing the treatment plan. The goals should be realistic, attainable, and measurable. The methods of treatment and of monitoring change will vary as a function of the target outcomes.

Behavior Therapy

Most treatment plans include environmental modifications that address a variety of changes in the child's home and school environment, including more structure, closer attention, and limitations on distractions. Training parents and teachers in specific techniques for improving behavior have successfully changed the behavior of children with ADHD (Pelham & Wheeler 1998). Almost all studies indicate positive effects of behavior therapy in addition to medications. In fact, on study (Jadad, Boyle & Cunningham 1999) found that combined treatment (medication with behavior therapy), compared with medication alone, offered improved scores on academic measures, measures of conduct, and some specific ADHD symptoms.

Teachers can provide behavior therapy where ADHD has a significant impact on a child's educational functioning. This can be provided in the context of a Rehabilitation Act (Section 504) plan or an Individual Education Plan (IEP). Otherwise, psychologists and community health therapists can provide it directly or through training of others to implement the therapy.

Recommendation 4 addresses the need to evaluate treatment outcomes through the careful collection of new information from multiple sources, including parents, teachers, and other adults in the child's environment, and the child. If the target symptoms are realistic and there is no response to the treatment plan, the physician should assess the implementation of the treatment plan and determine key problems with, and barriers to, implementation. This should include adherence to medication and behavior therapy. Lack of adherence is not the equivalent of treatment failure; physicians should help families find solutions to adherence problems before considering a plan as failure.

Recommendation 5 directs physicians to establish a plan for periodic monitoring of the effects of treatment. Specifically, information should be gathered on target behaviors, educational output, and medicinal side effects. The plan should also include a system for communication among parent, child, and physician between visits as well as a method for periodic contact with the teacher or other school personnel. Office interviews, telephone conversations, teacher narratives, and periodic behavior report cards and checklist are among the methods used to obtain needed information. As with the diagnosis of ADHD, physicians should have active and direct communications with schools. Requiring office visit every three to six months allows for assessment of learning and behavior. At the refill request, the

family can be asked about the child's functioning in school and interpersonal relationships, as well as updates on communication from the school.

Findings

I interviewed teacher, guidance counselors, principals, special educators, psychologists, physicians, and parents regarding the quality, quantity, and consistency of the communication between physicians and school personnel. The results were remarkably consistent across settings.

School personnel (teachers, special educators, guidance counselors, and administrators) indicated that in those cases where a student was referred to a physician, by a school based assessment team, the AAP guidelines were followed with few exceptions. Teachers and parents completed behavioral checklists and a treatment plan was created either through a 504 Plan or an Individualized Education Plan. These plans include specific target outcomes and have measurable academic and behavioral goals, which are assessed minimally on a semi-annual basis. In those cases where students do not achieve goals, a team of parents and school personnel meet to reevaluate the treatment plan. Should there be a question regarding the effectiveness of medication, physicians are contacted and its place in the treatment plan is reviewed.

School personnel expressed concern with those situations where students were diagnosed with ADHD, but did not present with an adverse impact on learning and thus did not qualify for a 504 or Individualized Education Plan (IEP). In these cases, the American Academy of Pediatrics identification guidelines were followed and less formal treatment plans were created. These plans contain behavioral recommendations but differ from 504 and IEPs because they seldom contain measurable goals and corresponding assessment measures. The responsibility for monitoring these treatment plans is less clear and often falls to the classroom teacher and parent.

Of greatest concern to school personnel are those infrequent cases where a physician does not follow the AAP guidelines and renders a diagnosis of ADHD based upon parent information only. In these circumstances, parents will often choose to keep the diagnosis of ADHD confidential and do not notify the child's school. Time-release pills allow parents to administer the medication at home. This hinders the development of a comprehensive treatment plan, which the AAP recommends as integral to successful intervention.

Of particular concern was the finding that regardless of the setting or circumstances, once a student is identified with ADHD physicians do not initiate contact with schools unless a problem is brought to their attention. Of all those interviewed only one respondent could recall a physician initiating communication with school personnel regarding his patients school progress.

Barriers to Communication

Everyone in my study agreed with the recommendation of the American Academy of Pediatrics for systemic communication between physicians and school. The question is why is this not happening?

In my interviews with physicians, it was clear that they are very busy responding to their most needy patients and families. Each physician agreed with the logic of closely monitoring students who are receiving ADHD medication, but stated that they do not have the time.

The responsibility of monitoring 504 and Individualized Educational Plans falls to Special Educators. These highly qualified teachers and case managers monitor students on plans. As with physicians, they are now held to Medicare guidelines for reimbursement purposes. This serves to minimize time that they can spend on students not on their official caseload.

Teachers' primary responsibility is instruction. They focus their energies on providing for the diverse learning needs of their students. Teachers are called upon to implement treatment plans for students with ADHD. Their observations are often the basis for evaluating these plans. It is unrealistic to add the burden of responsibility for initiating and maintaining communication to their already heavy load.

Recommendations

The need for improved communication between physicians and school personnel is recognized among all those involved. I believe that the key issue is the collection, management, and organization of data on student performance after the initial diagnosis of ADHD.

Dr. Ed Wagner, national program director of Improving Chronic Illness Care has developed a **Chronic Care Model** that focuses on correcting the deficiencies in the current management of chronic disease. These deficiencies are very similar to those faced in the treatment of ADHD

- Rushed practitioners not following established practice guidelines
- Lack of care coordination
- Lack of active follow-up to ensure the best outcomes
- Patients inadequately trained to manage their illness

Dr. Wagner states: Effective chronic illness care is virtually impossible without information systems that track individual patients as well as populations of patients. The first step is to establish a disease registry that outlines recommended care for certain conditions. The system can check on individual's treatment to make sure it conforms to the recommended guidelines, measure outcomes and offer reminders for screenings or check-ups (Bodenheimer, Wagner & Grumbach 2002).

The task of creating such a system is well within the capacity of today's computing professionals. Electronic communications systems can facilitate speedy communication between physicians, teachers, and school personnel. If such a system is to exist, funds must be made available to develop and maintain the database. This can come from insurance companies, patient fees, or the government.

Although many of us in academic settings enjoy the benefits of access to modern computing systems and networks, that is not always that case in both rural and urban settings.

The Health Information Privacy Act (HIPA) can be a significant barrier to communication in those cases where parents wish to keep their child's condition confidential. Without parental permission to share information, participation in such a system is a mute point.

Despite these barriers, Dr. Wagner's Chronic Care Model offers a feasible solution that may someday be within the reach of all physicians.

Another possibly solution would be for physicians to require school performance checklist as a condition for renewal of a prescription. This simple requirement places a burden on the physician's office to create disseminate, collect, and evaluate the checklists in a timely manner.

Finally, as an interim solution until a system similar to D. Wagner's model can be put in place, we should utilize existing school structures. The Individuals with Disabilities Education Act (IDEA) requires all schools to have in place an Educational Support Team (Prereferral Team). These teams help teachers make accommodations and modifications to support student learning. These teams routinely monitor the performance of students with learning differences. With the cooperation of parents in disclosing their child's condition, this team can assist in the development of ADHD treatment plans and provide a system of assessment that can be utilized by physicians.

Conclusion

The diagnosis and treatment of school-aged children with ADHD is a complex process that requires collaboration between physicians, teachers, and parents. Children with ADHD are best served with treatment plans are developed and monitored by school personnel working in conjunction with physicians. Systematic feedback by teachers on academic performance and the achievement of target outcomes is integral to successful intervention.

Children with ADHD on Rehabilitation 504 Plans and those who have Individualized Education Plans (IEP) benefit form carefully monitored treatment plans. Those with ADHD who do not present with an adverse effect on their academic performance are at risk due to this lack of monitoring and resulting lack of communication.

Today's modern computer information systems can provide a means to insure and enhance communication. In those cases where this is not, possible existing School Prereferral Teams can help monitor the success of treatment plans and facilitate communication between school personnel and physicians.

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