It Takes a Full-Service Village to Treat Children With ADHD

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In this month's issue of *Pediatrics*, the article titled "Preschool ADHD Diagnosis and Stimulant Use Before and After the 2011 AAP Practice Guideline"[1] makes use of the aggregate of electronic medical records (EMRs) from multiple programs to investigate the effect of guideline recommendations on the practice of pediatricians. It is an innovative process that can provide more rigorous information about moving evidence into practice. It is encouraging for those of us who worked on crafting the revised guidelines to find some evidence about the impact of those recommendations.

However, as the investigators point out, although they were able to find out that in preschool-aged children with attention-deficit/hyperactivity disorder (ADHD), recommended criteria for the use of stimulant medications, specifically methylphenidate, did not result in an increase in its use in this age group, the frequency of behavioral parent training, the first-line recommended treatment,[2] could not be determined. The challenge is that behavioral services for 4- to 5-year-olds with ADHD has frequently consisted of play therapy that is not evidence-based rather than parent training in which the evidence base is stronger.[3]

As with older children, meeting the needs of preschool-aged children with ADHD requires more than the administration of appropriate medications. Complex ADHD cases should not only include input from a child's primary care provider, psychiatrist, neurologist, or developmental-behavioral specialist, but also should incorporate behavioral services, such as parent training (usually provided by psychologists, licensed therapists, or social workers), preschool programs with behavior interventions, and school services and classroom modifications for older children.

Although use of the EMR is beginning to improve communication among physicians in various specialties, it still has a long way to go. Mental health services frequently have a higher level of security, making it more difficult for communication even among physicians. Communication with behavioral therapists is more of a challenge, and communication with school personnel is even more difficult with a different system of personal information protections (Family Educational Rights and Privacy Act). The previous guidelines[2] recommended combined medication and behavior treatment as frequently being required and optimal in most circumstances. Yet combining treatments requires an increase in the need for communication between families and care providers, an increase that is more easily recommended than actually implemented.

We are seeing the beginnings of enhanced communication in EMRs through patient and community portals, but these have yet to be readily available and implemented across the United States. The delivery of care for ADHD has been improved by the ability to more precisely measure behaviors through the use

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of rating scales. These scales should be available electronically so they can be completed and reviewed by the providers and families on an ongoing basis. These systems need to let busy families and providers communicate more easily while being able to protect personal information. It also will be important to develop a reimbursement for the time it takes for providers to use these systems.

In addition, to address the issue that was the focus of this study, examining the implementation of evidence into practice, there needs to be greater standardization of assessment and treatment modalities so that we can better examine the outcomes of changes in treatment. Studies of prevalence and treatments of children with ADHD have indicated wide variations across the country. Clarifying those differences will require the improved ability to examine the various factors responsible for these variations, particularly across the systems of care that go beyond just medication use.

Our record for improving the long-term outcomes of individuals with ADHD is less than optimal.[4,5] ADHD is a chronic illness, and like other chronic illnesses, improvement in long-term care is an important component that can be enhanced by better communication and investigation of factors predicting long-term outcomes.

Improvement of outcomes for children with ADHD will require ongoing coordination that goes beyond the coordination of just the medical providers. It will need a system that includes all key stakeholders. It also requires our ability to monitor the process and outcomes so that we can move toward the goal of assessing evidence and turning it into practice. Therefore, it truly will take a full-service integrated village to optimize ADHD care across the life span.

ABBREVIATIONS

ADHD: attention-deficit/hyperactivity disorder
EMR: electronic medical record

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