



What you should
know about the

AAP Guidelines

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MANY CHILDREN experiencing behavioral or learning difficulties are taken to their primary care physician for evaluation and guidance. Primary care physicians, including pediatricians and family physicians, are typically quite pragmatic in their approach to evaluation and case management for these types of problems. Recognizing this pragmatic orientation, the American Academy of Pediatrics (AAP), working in concert with family physicians, psychiatrists, psychologists and neurologists, developed clinical practice guidelines with clear recommendations for the diagnosis and treatment of attention-deficit/hyperactivity disorder (AD/HD).

AAP formulates its clinical practice guidelines through a rigorous process of identifying all of the relevant literature, assessing the quality of the research on which the reports were based, and making recommendations based on this assessment. The committees that developed these guidelines were carefully constructed and included a mixture of primary care clinicians and sub-specialists. Draft guidelines received extensive peer review prior to final review by the AAP Board of Directors. This process assured that clinical practice guidelines were consistent with the best available knowledge about AD/HD and would produce better outcomes for children and families.

In the case of the clinical practice guidelines for AD/HD, the AAP was privileged to partner with the Agency for Healthcare Research and Quality. This agency provided funding for two designated groups of experts, also known as Evidence-Based Practice Centers, to assess the medical and scientific literature. These reviews formed the basis of the AD/HD clinical practice guidelines. Initial deliberations were further augmented by additional evidence, including the Multimodal Treatment Study (MTA) of AD/HD funded by the National Institute of Mental Health (NIMH). In addition, experts including Peter Jensen, M.D., and

William Pelham, Ph.D., met with the committee and offered their expert opinions about the clinical and research evidence for assessing and treating AD/HD.

Based on this careful process, the AAP committee responsible for writing the AD/HD guidelines, chaired by James Perrin, M.D., and Martin Stein, M.D., developed a series of clear recommendations. In the area of diagnosis, the committee recommended that (1) primary care physicians consider the diagnosis of AD/HD when a child is brought to them for behavioral concerns or school failure, that (2) they use the Diagnostic Statistical Manual–IV criteria for making the diagnosis, that (3) information be obtained from both the teacher and the parent prior to making a diagnosis, and that (4) the child also be assessed for coexisting conditions.

Regarding treatment of the child with a diagnosis of AD/HD, the committee highlighted that AD/HD should be considered a chronic condition. The management of chronic conditions requires many components including (1) close partnership between physicians and families over time, (2) the development of shared goals for management, (3) coordination with community resources, and (4) obtaining appropriate specialty expertise. In terms of specific treatment, the

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AAP guidelines highlight that two evidence-based treatments exist for children with AD/HD—stimulant medication and behavioral therapy.

While the AAP guidelines do not specify which of these treatments should be initiated first, nor do they indicate greater preference for one or the other, the quality of evidence on medication was somewhat stronger. The committee statement indicates that both therapies are helpful for many children and that the treatment approach should be individualized for each child and family depending on the family's goals and ability to implement the treatment plan. Furthermore, failure to achieve desired goals should prompt a reassessment of the diagnosis and exploration of coexisting conditions. The guidelines also recommend that primary care clinicians determine the family's adherence to the recommended treatment plan and establish a follow-up plan to meet with the child and family over time.

To a greater extent than has ever occurred with past AAP guidelines, the AAP, working in collaboration with CHADD and others, has mounted a systematic campaign to promote the use of these guidelines

to improve care and outcomes for youth with AD/HD. The AAP partnered with the National Initiative for Children's Healthcare Quality (NICHQ) to demonstrate that these guidelines could indeed be implemented in real world practices. Through this collaboration, NICHQ and the AAP developed a toolkit that facilitates training and use of guideline recommendations. Experts such as Mark Wolraich, M.D., and Dr. Pelham [already mentioned] provided several of these tools. In addition, the AAP has developed an online educational program that provides feedback on practice performance focused on AD/HD. The AAP has revised its patient education materials, and soon will be publishing a book for families. Furthermore, the AAP is working with many partners, including CHADD, to eliminate the financial and administrative barriers that families face when seeking care for their children with AD/HD.

Published studies indicate that pediatricians treating children with AD/HD in the community typically use stimulant medication. As often highlighted in MTA study reports, community physicians with resources

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that allow less intensive monitoring and who use lower and less frequent doses, achieve somewhat to significantly less optimal results than were achieved in the MTA study. Based on reviews of the literature, the AAP guidelines indicate that there is limited information available on the long-term efficacy of stimulant medication treatment for AD/HD.

Less is known about whether pediatricians also recommend the use of behavioral therapy. Anecdotal information suggests pediatricians are not comfortable discussing more than the most elemental forms of behavioral treatment, and may not clearly understand the differences among various forms of mental health treatment. During the NICHQ learning collaborative, physicians were eager to learn more about behavioral therapy so they could offer their patients something in addition to medication. Primary care physicians will likely need to identify community resources to provide behavioral treatment, or receive appropriate training to provide such treatment.

Practice guidelines, like other recommendations about medical care, need to be updated at regular intervals as new science emerges. All AAP policies need to be affirmed, revised or retired every three

years. The AAP treatment guidelines for AD/HD have not reached the review date. Experts on the committee, however, have continued to monitor the literature on AD/HD and do not believe that new published information merits modification of the existing recommendations.

AD/HD has always elicited great controversy and strong emotional reactions in the media and in medical, educational and lay communities. The purpose of the AAP practice guideline is to replace emotional reactions with science—because that is what we know works best to improve the lives of children with AD/HD and their families. The judicious approach recommended by the AAP—recommending the use of stimulant medication, behavioral therapy, or their combination—is based on science. An evidence-based approach gives the greatest flexibility for clinicians working in partnership with families to develop a treatment plan that best meets the needs of children with AD/HD and their families. ■

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