Docket ID: ED-2017-OS-0074

Response to Request for Comments under Executive Order 13777
Regarding
Dear Colleague Letter and Resource Guide on Students with ADHD

Comments of Children and Adults with Attention-Deficit Hyperactivity Disorder (CHADD)

CHADD's major comment: We request that the Dear Colleague Letter and Resource Guide on Students with ADHD (ADHD DCL)[1] issued on July 26, 2016, by the Office for Civil Rights of the United States Department of Education (OCR) **be retained as active guidance**.

Summary of our arguments: Claims on behalf of elementary and secondary students with ADHD represent the single most common form of complaint filed with OCR. In fiscal years 2011-2015, one out of every nine complaints that OCR received alleging discrimination on the basis of disability in elementary and secondary schools involved students with ADHD.[2] The ADHD DCL was well-calculated to address efficiently this resource demand on OCR and to curtail this form of discrimination.[3]

As discussed further below, ADHD is the most prevalent mental disorder in children and adolescents in the U.S. ADHD is an extremely impairing disorder, and, especially when inadequately treated, often results in academic failure. Childhood ADHD is associated with "significantly increased risk" of suicide and "the cumulative burden of ADHD through the lifespan is considerable."[4] Nonetheless, most teachers have little understanding of the nature of ADHD and even less understanding of how to provide effectively education services to such children, consistent with the requirements of Section 504 of the Rehabilitation Act of 1973 (Section 504) and the Americans with Disabilities Act (ADA). The ADHD DCL fills this gap by providing clear technical assistance. Without this ADHD DCL, students with ADHD would continue to suffer academic failure and other devastating outcomes and would continue to be among the central participants in the school to prison pipeline.[5]

This ADHD DCL is sound, helpful, well-informed guidance. This reflects the fact that it was not developed in secrecy but rather in collaboration with well-informed private citizens, technical

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[1] *Available at* https://www2.ed.gov/about/offices/list/ocr/letters/colleague-201607-504-adhd.pdf
[2] Office for Civil Rights of the United States Department of Education, *Dear Colleague Letter and Resource Guide on Students with ADHD*, 2 of *Dear Colleague Letter*, July 26, 2016, *available at* https://www2.ed.gov/about/offices/list/ocr/letters/colleague-201607-504-adhd.pdf
[3] *Supra* at 2-3 of *Dear Colleague Letter*.
[4] William J. Barbaresi, *et al*., *Mortality, ADHD, and Psychosocial Adversity in Adults With Childhood ADHD: A Prospective Study*, 131:4 Pediatrics (2013), *available at* http://pediatrics.aappublications.org/content/early/2013/02/26/peds.2012-2354.full.pdf+html
[5] See, *e.g*., Myles Moody, *From Under-Diagnoses to Over-Representation: Black Children, ADHD, and the School-To-Prison Pipeline*, 20:2 J. of African American Studies 152, (June 2016), *abstract available at* https://link.springer.com/article/10.1007/s12111-016-9325-5 ; Behnken, M. P., *Linking early ADHD to adolescent and early adult outcomes among African Americans*, 42:2 Journal of Criminal Justice 95 (March 2014), a*bstract available at* http://dx.doi.org/10.1016/j.jcrimjus.2013.12.005

experts, and other stakeholders. In the year since the DCL has been issued to the public, not one legal, political, or scholarly objection has been raised concerning its content. Nor are we are aware of a single critical article suggesting any grounds to be concerned that the content of the DCL is inconsistent with the underlying authority of OCR to implement the FAPE provisions of Section 504 or to enforce Title II of the ADA. The DCL saves lives, saves money, and reduces the burden placed on society when students with ADHD have poor educational outcomes.

As explained in more detail below, the benefits of the ADHD DCL make clear that it should be retained as active guidance.

About CHADD: *Children and Adults with Attention Deficit/Hyperactivity Disorder (CHADD) is a national non-profit, tax-exempt organization (under section 501(c)(3) of the Internal Revenue Code) providing education, advocacy, and support for individuals with ADHD.* ***CHADD is recognized by the U.S. Centers for Disease Control and Prevention as the national clearing house for ADHD information.***

CHADD has three current priority objectives: (1) serving as a clearinghouse for evidence-based information on ADHD, (2) facilitating face-to-face family support groups through our local chapters, and (3) serving as an advocate for appropriate public policies and public recognition in response to needs faced by families and individuals with ADHD.

CHADD currently has about 12,000 members. Most are children and adults with ADHD and their family members. About 2,000 CHADD members are professionals providing clinical and other services to people with ADHD.

Discussion of our comments:

Prevalence. ADHD is one of the most prevalent mental disorders in children in the United States and often persists into adulthood with associated symptoms and impairments.[6] The Center for Disease Control and Prevention's (CDC's) most recent National Survey of Children's Health (NSCH) reports the prevalence of children and adolescents currently diagnosed with ADHD (by parent report) in the U.S. to be 8.8%, meaning 5.1 million individuals, or 1 in 11, of the age group 4–17 years have a current diagnosis of ADHD.[7]

Etiology. Research shows that ADHD has a strong biological basis, including structural and chemical abnormalities in the brain.[8] "Insights from neuroscience have unequivocally shown that

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[6] *Practice Parameters for the Assessment and Treatment of Children and Adolescents with Attention-Deficit/Hyperactivity Disorder*, 46:7 Journal of the American Academy of Child and Adolescent Psychiatry 894, 895 (2007), *available at* http://www.aacap.org/App_Themes/AACAP/docs/practice_parameters/jaacap_adhd_2007.pdf ; Jalpa A. Doshi., et al., Economic *Impact of Childhood and Adult Attention-Deficit/Hyperactivity Disorder in the United States*, 51:10 Journal of the American Academy of Child and Adolescent Psychiatry 990 (2012),

[7] National Resource Center on ADHD (NRC), a Program of CHADD funded by the CDC, *General Prevalence,* http://chadd.org/Understanding-ADHD/About-ADHD/Data-and-Statistics/General-Prevalence.aspx (Last updated 2017)

[8] National Resource Center on ADHD (NRC), a Program of CHADD funded by the CDC, *The Science of ADHD,* http://www.help4adhd.org/Understanding-ADHD/About-ADHD/The-Science-of-ADHD.aspx (Last updated 2017)

the brains of children with ADHD differ from those of controls."[9] "[F]indings from structural and functional neuroimaging suggest the involvement of **developmentally abnormal brain networks related to cognition, attention, emotion and sensorimotor functions**."[10] Genetics also contribute significantly to ADHD.[11] In 1998, the American Medical Association's Council on Scientific Affairs commented, "Overall, ADHD is one of the best-researched disorders in medicine, and the overall data on its validity are far more compelling than for many medical conditions."[12]

Brain Function Impairment: Impaired Executive Function (EF): "Many of the symptoms classified as ADHD symptoms of inattention are actually symptoms of **executive function impairment**. [Emphasis added.] Executive function refers to a wide range of central control processes in the brain that activate, integrate, and manage other brain functions."[13] The impaired executive functions of students with ADHD can make doing school work quite difficult.[14]

ADHD is a significantly impairing disorder. "[T]here is no debate among competent and well-informed health care professionals that ADHD is a valid neurobiological condition that causes significant impairment in those whom it afflicts."[15] **ADHD, particularly when untreated or inadequately treated, can lead to devastating consequences**; individuals with ADHD are far more likely than unaffected individuals to experience school failure, employment problems, car accidents, depression, failed relationships, teen pregnancies, children born out of wedlock, injuries, conduct disorder, antisocial and criminal behavior, and substance abuse.[16] As mentioned above, a longitudinal, population-based study concludes that childhood ADHD is associated with "significantly increased risk" of suicide and that "the cumulative burden of ADHD through the lifespan is considerable, including mortality, social adversity in the form of criminal behavior, persistence of ADHD into adulthood, and increased rates of other mental health problems."[17]

Co-occurring Disorders. At least two thirds of individuals with ADHD have one or more co-occurring conditions, including but not limited to, learning disabilities, obsessive compulsive

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[9] Samuele Cortese, *The neurobiology and genetics of Attention-Deficit/Hyperactivity Disorder (ADHD): What every clinician should know*, 16 European Journal of Paediatric Neurology, 422, 430 (2012), *abstract available at* http://dx.doi.org/10.1016/j.ejpn.2012.01.009

[10] Samuele Cortese, *Id*., See Abstract.

[11] Samuele Cortese, *Id*., See Abstract.

[12] *Practice Parameters for the Assessment and Treatment of Children and Adolescents with Attention-Deficit/Hyperactivity Disorder*, 46:7 Journal of the American Academy of Child and Adolescent Psychiatry 894, 895 (2007), *available at* http://www.aacap.org/App_Themes/AACAP/docs/practice_parameters/jaacap_adhd_2007.pdf

[13] National Resource Center on ADHD (NRC), a Program of CHADD funded by the CDC, *The Science of ADHD*, http://www.help4adhd.org/Understanding-ADHD/About-ADHD/The-Science-of-ADHD.aspx (Last updated 2017)

[14] See NRC, *id*.

[15] *Practice Parameters for the Assessment and Treatment of Children and Adolescents with Attention-Deficit/Hyperactivity Disorder*, *Supra* at 894.

[16] Russell A. Barkley, *et al*., *International Consensus Statement on ADHD*, 5:2 Clinical Child and Family Psychology Review 89 (2002), *available at http://www.russellbarkley.org/factsheets/Consensus2002.pdf*; *Practice Parameters for the Assessment and Treatment of Children and Adolescents with Attention-Deficit/Hyperactivity Disorder*, *Supra* at 895-896.

[17] William J. Barbaresi, *et al*., *Mortality, ADHD, and Psychosocial Adversity in Adults With Childhood ADHD: A Prospective Study*, 131:4 Pediatrics (2013), *available at* http://pediatrics.aappublications.org/content/early/2013/02/26/peds.2012-2354.full.pdf+html

disorder, anxiety, depression, and tics and Tourette Syndrome.[18] About 50 percent of children with ADHD have a coexisting learning disorder, most commonly dyslexia and dyscalculia, while 5 percent of children without ADHD have learning disorders. An individual with ADHD may have more than one co-occurring disorder. However, the presence of even one co-occurring disorder in an individual also diagnosed with ADHD increases the likelihood that the individual will have academic and other problems.

Treatment and Management of ADHD: The largest longitudinal study to date on the treatment of ADHD, often referred to the as Multimodal Treatment of ADHD Study (MTA Study), found that effective treatment includes medication, various psychotherapies including behavior therapy, education and training, and "a school-based intervention organized and integrated with the school year."[19] Treatment does not cure ADHD; but for a majority of the individuals studied, treatment helped control the symptoms of ADHD.[20]

The ADHD DCL was developed with assistance from well-informed experts: This ADHD DCL is sound, helpful, well-informed guidance. This reflects the fact that it was not developed in secrecy but rather in collaboration with well-informed private citizens, technical experts, and other stakeholders, including CHADD. Through its Public Policy Committee, CHADD maintained ongoing and active discussion with OCR from November 2013 through July 2016. Based on the results of a survey that we conducted with our membership, we shared the concerns of our members about the implementation of Section 504 of the Rehabilitation Act of 1973 and the effects on their children. In response to iterative requests from OCR, we provided scientific research findings and other knowledge about ADHD. CHADD has strived to serve as a resource to OCR and the Department, sharing insights and ideas about how to improve the implementation of Section 504 to benefit students with ADHD and their peers, learning together in the classroom.

Conclusion: As discussed, the ADHD DCL itself acknowledges the **resource demand on OCR** before school districts had the clear technical assistance provided in the ADHD DCL. Before issuance of the ADHD DCL, one out of every nine complaints that OCR received alleged discrimination on the basis of disability in elementary and secondary schools involving students with ADHD. As also discussed, research clearly demonstrates that untreated, or inadequately treated, ADHD can have **costly societal consequences**, including but not limited to, increased rates of suicide and school failure. The ADHD DCL provides clear technical assistance that helps teachers understand the nature of ADHD and how effectively to provide education services to such children, consistent with the requirements of Section 504 and the ADA. This DCL has the potential to make teachers' work easier, to reduce the number of complaints filed with OCR,

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[18] Thomas E. Brown, Ph.D, *AD/HDand Co-occurring Conditions, Comorbid—or co-occurring—disorders, Types of comorbidity*, Attention! 10, 10-11 (February 2009), *available at* http://www.chadd.org/Membership/Attention-Magazine/Attention-Magazine-Article.aspx?id=262; National Resource Center on ADHD (NRC), *ADHD and Coexisting Disorders*, *available at* http://www.chadd.org/Understanding-ADHD/About-ADHD/Coexisting-Conditions.aspx (Last updated 2017); *see also*, Patrick Brown, M.D., *ADHD and the DSM-5: Update on Revisions to Diagnostic Criteria*, 12:10 Consultant for Pediatricians. 453 (2013); *available at* http://www.pediatricsconsultant360.com/article/adhd-and-dsm-5-update-revisions-diagnostic-criteria

[19] The MTA Cooperative Group, *A 14-Month Randomized Clinical Trial of Treatment Strategies for Attention-Deficit/Hyperactivity Disorder*, 56:12 Journal of the American Medical Association (1999), *available at* http://archpsyc.jamanetwork.com/article.aspx?articleid=205525

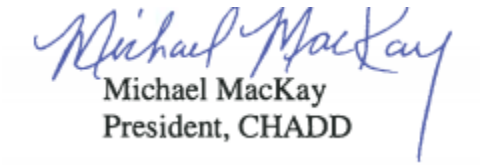
[20] *Id.*

and to reduce the societal costs of students with ADHD experiencing academic failure. Again we emphasize that this DCL saves lives, saves money, and reduces the burden placed on society when students with ADHD have poor educational outcomes.

The U.S. Department of Education cannot afford to rescind the clear technical guidance provided to school districts in the ADHD DCL.

CHADD appreciates the opportunity to provide the U.S. Department of Education with our comments on the ADHD DCL. We commend OCR for issuing this strong document that does not exceed any legal bounds and can provide great benefit to OCR and students with ADHD. We urge the U.S. Department of Education to retain the Dear Colleague Letter and Resource Guide on Students with ADHD as active guidance.

Respectfully submitted,



Michael MacKay
President, CHADD