Incorporating the management of ADHD into your Practice

Can it be done?

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BACKGROUND
Management of children with learning and behavioural disorders has traditionally been the precinct of specialist paediatricians, psychiatrists, psychologists and teaching professionals. Networks and teams have not generally included general practitioners. In Geraldton a professional network of health and educational professionals were of the view that learning disorders including attention deficit hyperactivity disorder (ADHD) frequently went unrecognised or misdiagnosed. In 1996 the National Health and Medical Research Council recommended use of the DSM-IV American Psychiatric Association diagnostic criteria for ADHD. A multimodal model of shared care was considered optimal. In 1999 the US National Institute of Mental Health's Multimodal Treatment of Study of Children with ADHD was released.

OBJECTIVE
To outline the development of a program to educate and support local professionals (doctors, teachers, psychologists, nurses, counsellors) in the management of behavioural disorders in which specific goals were to:

- build capacity for accurate diagnosis and management of children with learning and behavioural disorders
- facilitate via the Midwest Division of General Practice, a network of professionals to assess and manage learning disorders, including ADHD
- create a model of shared care with potential for application elsewhere
- formalise shared care/coprescriber arrangements for stimulant medications between GPs and specialists, including fast-tracking of medication
- develop school networks for early identification, referral and support of ADHD cases.

DISCUSSION
Our creation of a strong professional network enabling a GP case manager role has been very successful. Multiple treatment successes have created much community goodwill toward the Midwest Division of General Practice and my private practice has changed forever with the inclusion of 200 ADHD families. Colleagues considering entering this area need to recognise the potential for disruption to both their practice and their personal lives. A well organised practice with firm boundaries for difficult cases is essential.

Becoming involved
Since 1992 I have been involved in the diagnosis and management of attention deficit hyperactivity disorder (ADHD). As a general practitioner obstetrician in Geraldton and practising old fashioned cradle to grave care, I have had a privileged opportunity to follow families over a 20 year period. It became apparent to me that a significant proportion of children developing behavioural and adjustment problems were not being effectively managed. The overworked services available at the time were GPs, counsellors, psychologists and visiting paediatricians. Formal testing for IQ, specific learning or attentional disabilities was seldom performed. Family behavioural therapy was routinely commenced without he benefit of diagnosis.

Existing Problems
This process resulted in the parents being blamed for much of the child misbehaviour. Many of these children were receiving remedial teaching, repeating academic years and were being suspended or expelled despite not having a formal educational psychometric assessment. Initiation and continuation of behavioural therapy prior to formal assessment is still widespread in school systems around Australia. Many intelligent children with unrecognised learning difficulties such as dyslexia and dysgraphia were lost in the system. Problems with literacy, numeracy, expression and behaviour are common in this group.

Formal assessment of these underperforming children resulted in a high proportion of them being diagnosed with ADHD. Surveys of WA schoolchildren have found a state prevalence of 5% but 11% for rural areas.[i] Our experience confirms this with a higher prevalence in some of the more isolated areas.

The Process
In 1997-1998, via the ADHD project, a program was developed to educate and support local professionals in the management of behavioural disorders. A local network of GPs, schools, psychologists, the local branch of LADS, social agencies and visiting developmental paediatricians was established. A formal shared care programme for medical management was agreed to at a series of coordinated care meetings, the level of skill and interest of GPs determining the extent to which they would become involved in diagnosis and treatment.

Shared care
Coordinated Care Meetings were attended by GPs, psychologists, teachers, school nurses, speech pathologists, occupational therapists, police, and representatives from social agencies, juvenile justice and the prison system, along with a broad range of health and educational professionals. At these meetings, a local schools policy on ADHD was developed.

Establishing a care manager role for local GPs required the visible transference of the 'mantle of authority' by visiting specialists. Developmental paediatricians and a child psychiatrist were invited to visit regularly and are supportive of coprescribing. Without their assistance, the Midwest Shared Care Programme would not have been successful. Our school subcommittee was chaired by a local headmaster and established a school network of ADHD liaison.

- **Professional networks**

The project provided opportunities for extensive networking among health and educational professionals, via the school's subcommittee, workshops, seminars and through liaison with the local LADS branch. Favourable media publicity was received this networking has been spectacularly successful and is expanding beyond the formalities of the project.

- **Making the diagnosis**

Cases are referred from teachers, psychologists, counsellors, remedial teachers, school nurses, child health clinics, day care agencies, support groups (ie LADS), doctors and family members. In addition, self referral often occurs with older cases. It is predicted that in the future, more referrals will come from substance abuse agencies, juvenile justice, police and the prison system.

Our assessments were based on the DSM-IV diagnostic criteria for ADHD (Table 1).[ii] Rating scales were found to be particularly useful. The Barkley Scales (Table 2)[iii] are the most faithful to the DSM-IV, and were used on all cases. Perusal of the comments section in old school reports often revealed a pattern of under-performance. The more detailed Connors, Education Department of WA, and depression rating scales are efficient and reliable ways of gathering more information.

Examination was performed to check for other neurological disorders, defective hearing or sight and to measure height, weight, blood pressure and head circumference.

- **Specialist referral**

The next step is specialist referral for confirmation of suspected cases. If the GP is happy that the diagnostic criteria have been fulfilled, a trial of dexamphetamine or Ritalin may be offered for urgent cases prior to specialist assessment. Australian regulations require the initial prescription for these medications to be made by a paediatrician or psychiatrist, but where access to specialists is limited, fast tracking of these cases works well.

Table 3, Medication

- Dexamphetamine and methylphenidate

These have been shown to be safe, effective and have few side effects in therapy or overdose situations. They should be offered to all ADHD cases.

- SSRIs

Sertraline is now being used in younger patients to treat depression, particularly when associated with the inattentive form of ADHD. Older cases of this type will commonly present with depression. It is best to treat the depression before starting the stimulant.

- Major tranquillisers

Rispendone and olanzapine are finding a place in the treatment of conduct disorders and rage attacks. Documented informed consent is essential if the drug company prescribing guidelines are breached.

- Clonidine

This has a role in treating insomnia hyperactivity and rage attacks particularly in younger …

Early trial of medication

In order to fast track a trial of medication prior to a specialist appointment, details of the case are sent to a specialist accepting of shared care. This includes:

- a letter outlining reasons for the diagnosis, past history, examination and medications
- rating scales and a summary of old school reports
- details of any associated specific learning difficulties (SLDs) or comorbidity.

A prescription is posted to the patient and an application made to the Health Department of WA for GP coprescribing arrangements. Unavailability of an early specialist appointment need not delay commencement of a trial of therapy. The Geraldton Shared Care Programme ahs been well received by patients and professionals. Once the diagnosis is confirmed a multimodal treatment program is commenced.

Case review

Initial review is after a few weeks and then 1-6 monthly, depending on progress. I find it best to plan a review a few weeks into a school term. By that time student, parents and teacher will have had time to assess progress. A telephone reminder for appointments will considerably increase the likelihood of attendance in this chaotic area of medicine.

If in doubt

Difficult cases are best seen by a specialist prior to the commencement of treatment. Cases, which clearly do not fulfil the diagnostic criteria, are counselled accordingly and offered a follow up in 6-12 months or referral for a second opinion by a specialist.

Patient information

Early access to accurate information is important to increase patient and family knowledge of the disorder and its treatment. In particular, suspected cases require early access to information about:

- dexamphetamine/Ritalin – potential benefits and side effects
- monitoring requirements.

This information is best discussed during a counselling session between the GP, patient and family. They are given detailed information in the form of articles and handouts. Our city library

has a comprehensive collection of books, videos and audiocassettes donated by the local branch of LADS.

GP as case manager

General practitioners who become involved in the management of ADHD cases inherit some of the responsibilities previously shouldered by the specialist, such as communication with other professionals.

The multimodal web of shared care includes teachers, psychologists, counsellors, school nurses, speech pathologists, occupational therapists, physiotherapists and GPs. Efficient organisation is necessary to avoid duplication. I find it is both efficient and well accepted to use the referral/feedback letter to specialists as case notes and to send a copy of it to other stakeholders. My policy is to use the parents as the intermediary at all times. The new Coordinated Care Item Numbers for care plans and case conferences are suited to this area. Principal, educational psychologist and teacher are encouraged to contribute to the management of each case. We have found that a network of ADHD School Liaison People is an effective way of supporting families and networking/advocating within the school. When the school is not supportive there needs to be frank discussion of the situation to decide how much information to share.

Why bother?

A large and increasing body of evidence now exists to confirm the validity of ADHD. If the DSM-IV criteria are met, medication will improve significantly the symptoms of inattention, poor concentration, distractibility and hyperactivity in 75% of cases (Table 3). Predominantly inattentive ADHD is more difficult to identify and responds less well to medication. Many cases show spectacular improvement as the before and after Ritalin writing samples show in Appendix 5.

To medicate or not?

Since the 1997 project, results of the US Multimodal Treatment Study of Children with ADHD (MTA) have become available.[iv] The study found that a carefully executed regimen of medication is superior to behavioural medication and nearly as good as a combination of both. As a result of this, Professor Taylor of London's Kings College has called for medication to be offered to all ADHD cases on diagnosis.[v]

Conclusion

Clinicians venturing into this field need to take care. The inclusion of 200 ADHD families have forever changed the nature of my practice – downmarket to be sure and most would agree disruptive to other patients and staff. Raised eyebrows among colleagues and friends are the norm. I became involved when I recognised a large unmet need and now spend 20% of my office time in the management of ADHD.

Our division of general practice facilitated my entry into a specialist area. I am impressed with the results of treatment, feel I am 'making a difference' and the kids need help.

Implications of this discussion for the GP

- The capacity of the local Division of General Practice to improve health outcomes and expand GP involvement in professional networks has been demonstrated.
- Innovative models for rural Australia can be developed and run by the local professionals.