ADHD case conferences: GPs, parents and schools working together

Since 1996, the Mid North Coast Division of General Practice has developed a framework to implement school-based case conferencing focusing on attention deficit (hyperactivity) disorder.[1] (For simplicity, in this article 'ADHD' will refer to the disorder with or without hyperactivity.)

The project has resulted in enthusiastic uptake of the new case conferencing (MBS enhanced primary care) item numbers.[2] Both the diagnosis of ADHD and the case conference process have been demystified for the participating GPs. Increasing numbers of GPs are involved in new schools as the project expands. Case conference involvement has been highly valued by both GPs and parents.

What we hoped to achieve

The case conference model aimed initially to provide education and support for parents and teachers involved in the management of children with a confirmed ADHD diagnosis.[3] An additional aim was to involve GPs in multidisciplinary management with parents and other professionals.

What we did

Each term, parents of ADHD children in participating schools met with the class teacher, the child's GP, speech therapist, psychologist, project officer and school principal.

During the second year of the project, funding allowed for attendance of GP observers with support from the designated GP. The aim of this initiative was to provide GPs with an opportunity to view the benefits of a multidisciplinary case conference.

At the start of the project in 1996, GPs within the Division were surveyed to assess their understanding of the complex medical issues associated with the diagnosis and the appropriate referral pathways.

After participation in the project, GP observers were surveyed to assess their views of the value of the case conference process.

What we found

GPs' responses

The initial surveys were posted to 106 GPs within the Division (with a 49% return rate).

Overall responses to prevalence and aetiology of ADHD were appropriate. However, understanding of the ADHD diagnosis by the GPs was variable. Fifty per cent of respondents were unaware of the Diagnostic and Statistical Manual of Mental Disorders (DSM IV) or the criteria for ADHD (Table 1). Importantly, a large number of GPs reported that parents consulted them about academic (89%) or behavioural concerns (94%) – areas that GPs may not feel qualified to explore. While 73% of the GPs stated they would like teacher contact, only 15% had initiated this contact.

Over 30 GPs took advantage of case conference observation. Nineteen GP observers (64% response) completed an evaluation survey (Table 2). The survey used a scale of 1 to 5: a score of 1 indicated 'not at all/no value'; a score of 5 indicated 'great deal/very high value'.

GP observation at the case conferences was found to improve the GPs' understanding of identification, multimodal management, educational impact and importance of early intervention of ADHD. As a result of their participation in the ADHD case conferences, 100% of the GPs stated that they would recommend case conferencing to a colleague.

In 'From the Divisions' we continue to present the relationship between GPs and the Divisions of General Practice, plus ways in which the Divisions' programs offer solutions to dilemmas facing general practice. We invite you to participate in this venture by sending us your contributions. This article describes a co-operative approach to managing children with attention deficit (hyperactivity) disorder.

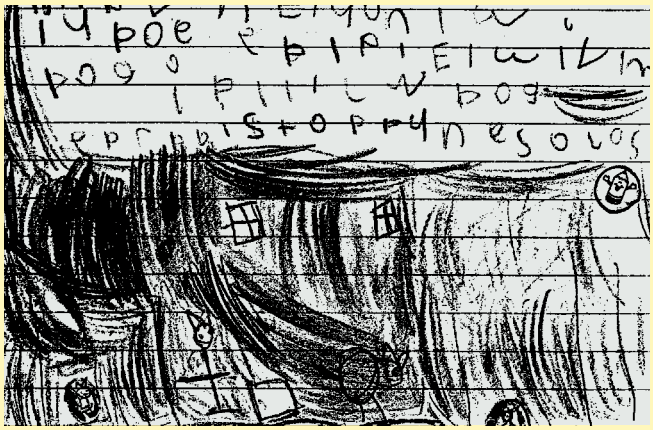

Figure 1. This is a work sample at the beginning of 1999 from Amy, aged 6, who was diagnosed with ADHD. Her mother had resisted medication for Amy because of pressure from family and sensational media reports. When, through participation in the ADHD project, the mother understood some of the potential learning implications associated with ADHD, she elected to trial her daughter on medication for one month with monitoring from both home and school.

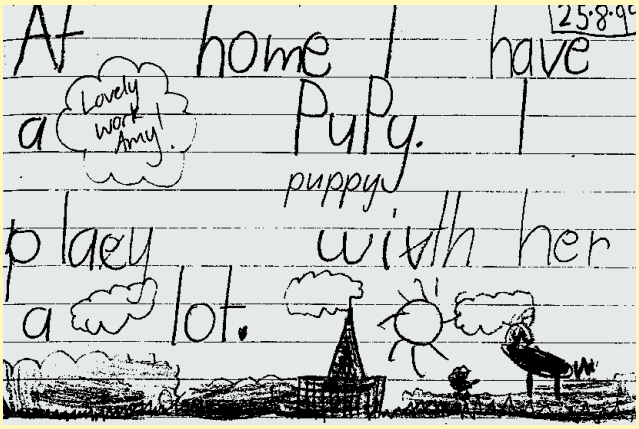

Figure 2. This work sample from Amy was at the start of Term 3 in 1999. Reports from home and school indicated significant improvements in behaviour and performance. Amy continues on her medication (methylphenidate [Ritalin]) while waiting to access the other project recommendations in the public sector (i.e. speech and occupational therapy assessments).

Parents' responses

Thirty-nine parents surveyed at the start of the project reported that prior to diagnosis they had explored for their child: behaviour modification, diet, speech and occupational therapy, counselling, remedial educational support and alternative therapies.

The parents reported that their child's behaviour, social skills and learning difficulties were of greatest concern to them. They believed that the effect of the ADHD diagnosis on the family was considerable, with increased conflict, financial and marital problems, and social isolation of the child and family.

The parents were asked what source of support they had in gaining time out, or help in a crisis. After family (30%), the GP (12%) was next frequently nominated as first contact in a crisis. However, the majority of parents (41%) reported that they had no support.

When surveyed at the end of the 12-month pilot, all of the parents stated they would like the project to continue.

What this means to general practice

The GPs' involvement in case conferences was rewarding for both GP and patient. Involvement in the case conferences and project led to increased GP understanding of ADHD and its comorbidities.

The survey results relating to DSM IV criteria had suggested that some GPs may not be identifying children who are developmentally 'out of step' with their peers. To identify these children, GPs need to be sure of the criteria for

Table 1. Some findings from the initial GP survey

Question	Yes	No	Uncertain/ other
Do parents ever consult you about a child's poor school performance?	89%	11%	0%
Do parents ever consult you about a child's behaviour?	94%	3%	3%
Have you had any contact with the child's teacher?	15%	73%	12%
Would you welcome contact with the child's teacher?	73%	7%	20%
The Diagnostic & Statistical Manual of Mental Disorders (DSM IV) lists the basic criteria used by a specialist to diagnose ADHD. Are you familiar with the DSM IV?	49%	50%	1%

Table 2. GP observers' evaluation of the case conferences*

Question	1 Not at all/ no value	2 Somewhat/ of some value	3 Considerably/ of considerable value	4 Very much/ high value	5 Great deal/ very high value
How useful was your participation in the ADHD case conference to you as a GP?		1	2	10	6
Has your attendance at the ADHD case conference contributed:					
• to your understanding of ADHD?		1	6	9	3
• to your understanding/knowledge of the educational impact of ADHD?			4	9	6
• to your awareness of the importance of an early diagnosis of ADHD?		2	4	9	4
• to your understanding of the importance of active management?			3	11	5
• to you feeling more able to identify and manage children/families with ADHD?		5	7	3	4
Has the case conference participation challenged your attitudes of ADHD?		4	5	5	5
How would you rate the value of input from other health professionals at the case conference?			4	9	6

* The entries in this table are the numbers of GPs giving each answer (or score) to each question.

diagnosis, and to refer the children to the appropriate paediatrician or psychiatrist for screening and diagnosis.

GPs reported that after participation they had greater understanding of referral pathways to allied health and education services. For example, behavioural and social skill issues may be associated with language processing problems in a child with ADHD – the child may misread a situation or not fully understand instructions. Speech therapists have a major role in assisting children with specific learning and/or language difficulties.

Case conferencing has facilitated GP contact with other health and education professionals as members of a multidisciplinary reference team. The educational benefits for GPs of contact with the other professionals were rated highly by the GPs surveyed. Increased understanding of educational protocol and assessments has resulted in increased contact between GPs, class teachers and school counsellors or psychologists.

The success of GP observers has resulted in their requested involvement in new schools. This has increased GP contact with teachers, health professionals and parents. Now that the project is well established, some schools are adopting this model for other medical issues where GP contributions are valued.

References

1. Foster P, Foster J. Case conferencing – effective management of ADHD. Aust Fam Physician 1999; 28: 647-648.
2. Medical Benefits Schedule. Item numbers 720, 724, 726, 740, 742, 744, 759, 762. Canberra: Health Insurance Commission, 1999.
3. Stimulant Subcommittee. Criteria for the diagnosis and management of attention deficit hyperactivity disorder in children and adolescents. Sydney: NSW Dept of Health, 1999 (TG 181/4).

Acknowledgements

The author would like to thank the GPs on the mid north coast for their collaborative spirit, and the Mid North Coast Division of General Practice for ongoing funding support of the ADHD project.

Jude Foster RN
Case Conference Facilitator, Partnership Potentials in Health and Education, and Project Officer for the ADHD project, Mid North Coast Division of General Practice
PO Box 83
Nambucca Heads NSW 2448
Telephone: 0412 101 395
Fax: (02) 6568 1935
Email: jfoster@mncdgp.org.au