SDBP
Society for Developmental & Behavioral Pediatrics

Comparison of AAP and SDBP guidelines

The new clinical practice guideline from the Society for Developmental and Behavioral Pediatrics (SDBP) addresses the management of "complex" ADHD. It is intended to complement the existing practice guidelines from the American Academy of Pediatrics (AAP), which focuses on the treatment of ADHD in the primary care setting. The goal of the SDBP guideline is to facilitate integrated, interprofessional assessment and treatment of children and adolescents with complex ADHD in order to be able to provide the higher level of care that they require.

Table of Key Areas of Added Value

Topic area	AAP	SDBP	Notes
Population	All children ages 4-17 presenting to primary care (usually for the first time) with academic or behavioral problems and symptoms of inattention, hyperactivity, or impulsivity • "Straightforward" ADHD	Children and adolescents with a possible or pre-existing diagnosis of ADHD ***and*** some other condition or factor that complicates diagnosis and management • "Complex" ADHD • i.e. something about the child that calls into question whether their symptoms are truly or exclusively due to ADHD	"Complex" ADHD refers to the following scenarios: • Presentation at an unusually early (< 4 years) or late (> 12 years) age • Having a coexisting condition (medical, psychiatric, or developmental/learning) • Moderate to severe impact of symptoms on daily functioning • Primary care physician being uncertain about the ADHD diagnosis • Inadequate response to treatment
Target user	Primary care pediatricians and other primary care clinicians (PCC)	• Clinicians with (or seeking) additional expertise in childhood ADHD • DBPs and subspecialists in childhood behavioral health	
Assessment	Provides general recommendation that the PCC should include a process to at least *screen* for symptoms of comorbid conditions, including emotional, behavioral, developmental, and physical conditions.	• Recommends that all children being considered for complex ADHD receive a comprehensive diagnostic *assessment*. • Describes the principles and key components that should be included in a comprehensive assessment that would distinguish ADHD and coexisting conditions.	Neither guideline dictates which specific tools or measures should be used.
Co-existing conditions	General recommendation that the PCC should consider coexisting conditions and to	Provides specific, detailed care algorithms for a number of co-existing conditions	Algorithms included in the SDBP guidelines: Autism, tic disorder, substance use disorder, anxiety, depression, disruptive behavior

	treat or refer depending on the level of comfort.		disorders, learning disorders, treatment of preschool children, 3-5 years old.
Psychosocial interventions	Strength of recommendation for evidence-based behavioral and educational interventions changes with age of child with the emphasis shifting to training interventions targeting school functioning in the adolescent population.	Evidence-based behavioral and educational interventions are recommended as foundational treatments for all children with Complex ADHD. Specific types of intervention should match the needs of the child depending on their age, setting, type of co-existing condition and what functions are affected.	
Medications in Preschool-age children	Recommends only methylphenidate in the medication treatment for children ages 4-6 years. Non-stimulant use discussed.	Provides an option for using an alpha-agonist as an alternative to methylphenidate in the preschool population.	• The option for alpha-agonist treatment as an alternative to methylphenidate is based on practice patterns of developmental-behavioral pediatrics and expert clinical consensus. • There is strong evidence supporting the efficacy and tolerability of methylphenidate for the treatment of preschool ADHD • Published evidence documenting the effectiveness and side effect profile for other ADHD medications remains insufficient for this age group.
Functional outcomes	• Promotes the use of a chronic illness care model approach within the medical home. • Assessment of outcomes should include o management of core symptoms o monitoring of academic achievement; peer, parent, or sibling relationships; and risk-taking behaviors and substance use.	• Emphasizes the identification of functional impairments in children and adolescents with complex ADHD • Monitoring of the patient's functional status over time • Implementation of treatments that specifically target functional impairment.	Complex ADHD guidelines focus on lifespan approach as an integral part of management from the onset of evaluation with goals of minimizing long-term or latent adverse effects.
Monitoring	In-person visits should occur: • Within first 30 days of treatment initiation	In-person visits should occur: • Within the first 30 days of treatment initiation	More persistently frequent follow-up is recommended for children with Complex

	• Quarterly for the first year • At least biannually thereafter Rating scales: • ADHD rating scales at each visit • Before any changes in medication and/or dose	• Every 3-4 months thereafter • May be supplemented with remote monitoring (e.g. online rating scales) between visits. Screening for emerging co-existing conditions: • at least annually • when concerns arise Standardized collection of information • E.g. rating scales, questionnaires • obtained at least 2-4 times/year, especially during the school year • from caregivers, school personnel, and from the patient when appropriate (i.e., adolescent patients)	ADHD given the more complicated nature of their presentation and treatment course.

<u>Important Topics in the AAP Guideline Also Emphasized by the SDBP Guideline</u>

Interprofessional	Collaboration between professionals and care providers in each of a child's settings and each of a child's skill areas is crucial to successful treatment of ADHD. Factors that are seemingly limited to the child or family or school can still influence each other indirectly. Common goals and good communication between all stakeholders is crucial to addressing issues that extend across settings.
Collaborative decision-making	It is important for clinicians to be sensitive to the culture and sensibilities of the families they are treating. Exploration of these perspectives allows clinicians to address the families most pressing concerns first and identify topics were education is most needed. Collaborative decision-making also facilitates development of common goals and gives the family a sense of ownership and responsibility for the treatment plan.
Family Functioning	Although ADHD itself is a neurodevelopmental process that is characteristic of the child, the behaviors, consequences, treatments, and outcomes of ADHD are experienced by the family as a whole. Therefore, monitoring of family function and incorporating interventions to address family issues is an integral part of any care plan.
Complementary Alternative (CAM) Therapy	Clinicians should be familiar with the cost, ease of use, and safety of these approaches in order to best guide families. CAM therapies should not take the place of more established and evidence-based therapies.