

List of Appendices

1. Appendix A: Membership of Guideline Development Groups
2. Appendix B: Dualities and Conflicts of Interest
3. Appendix C: Process Report
4. Appendix E: Systematic Review Research Questions
5. Appendix F: Data-Extraction and Critical Appraisal Tables
6. Appendix G: NHMRC Evidence Statement Form
7. Appendix H: Assessment Scales and Questions
8. Appendix I: Australian ADHD Support and Education Groups

DRAFT

APPENDIX A: MEMBERSHIP OF GUIDELINE DEVELOPMENT GROUPS

<p>Reference Group</p> <p>Chair Professor David Forbes</p> <p>Paediatrics Dr Patrick Concannon, NSW Dr Daryl Efron, Vic Dr Brad Jongeling, WA Dr John Wray, WA</p> <p>Adult Psychiatry Dr Mark Kneebone, NSW Dr Julian Trollor, NSW</p> <p>Child & Adolescent Psychiatry Dr Peter Jenkins, Vic Professor Michael Sawyer, SA</p> <p>Psychology Professor Vicki Anderson, Vic Professor David Hay, WA</p> <p>General Practice Associate Professor Geoff Mitchell, Qld Dr Kim Pedlow, WA</p> <p>Education Professor Loretta Giorcelli, NSW Dr Michelle Pearce, WA</p> <p>Consumer Advocates Ms Geraldine Moore, Vic Ms Joy Toll, NSW</p> <p>Juvenile Justice Representative Dr John Brennan, NSW</p> <p>ADHD in the Family Representative Ms Megan McDougall, WA</p>	<p>Management Group Professor David Forbes (Chair) Dr Daryl Efron Mr Gary Disher Dr Melissa Hill Mr Colin Borg (<i>from July 2008</i>)</p> <p>Scientific writer Dr Angela Kirsner</p> <p>Guidelines Assessment Register Consultant Dr Janet Salisbury</p> <p>Project Officer Dr Melissa Hill</p> <p>Literature Review Consultants <i>Centre for Allied Health Evidence Collaborating Centre of the Joanna Briggs Institute University of South Australia Division of Health Sciences</i></p> <p>Ms Leah Jeffries Dr Saravana Kumar Associate Professor Caroline Smith Ms Anthea Worley Professor Karen Grimmer-Somers</p>
--	--

APPENDIX B: DUALITIES AND CONFLICTS OF INTEREST

All individuals involved in the development of the Guidelines on ADHD, including those on the Reference Group and the Project Management Group, as well as external contractors and writers, completed a disclosure statement in relation to any real or perceived conflicts and dualities of interest related to their participation in the revision of the Guidelines on ADHD. This is in accordance with the Royal Australasian College of Physicians' policy on the ethical relationships between physicians and the pharmaceutical industry.

The full disclosure forms are included below (2007 – section B1 and 2008 – section B2). In addition, all agendas prepared for meetings throughout the review process included the College's standard declaration statement that requires the Chair of the group to seek any further update to the standard declaration (section B3).

Additional information on the College's dualities and conflicts of interest policies can be found in "Guidelines for Ethical Relationships between Physicians and Industry" available at <http://www.racp.edu.au/page/policy-and-advocacy/ethics>.

Management of potential or real dualities or conflicts of interest included:

- No member of the Reference Group wrote the resulting guidelines. All writing was undertaken by an independent scientific writer and the project research officer. Reference Group members provided expert opinion which was then prepared as guidelines for their subsequent review.
- During meetings, where a member felt their duality or conflict of interest arose, the member excluded themselves from the discussions.

The Chair of the Reference Group is an independent chair who had no pecuniary or non-pecuniary interest in ADHD and was someone outside the clinical area of expertise.

Most members of the ADHD Reference Group had at least one duality of interest, possibly owing to the fact that they are all experts in this clinical area. It is understood that while members of the Reference Group may have had dualities of interest, these are herein disclosed in a manner that is clear and available to the public.

In October 2008 the NHMRC introduced a draft policy for declarations of interests and potential conflicts of interest for guideline developers. The disclosure of interest statements below are presented in accordance with the draft NHMRC policy.

Dualities and conflicts of interest summary

Reference Group Chair Professor David Forbes, WA

In relation to ADHD: I have a clinical and administrative role in the Child & Adolescent Health Service, Department of Health, WA Government. My role is not involved in service delivery to children with ADHD. I have no previous or current professional or personal pecuniary interest in any companies or other organisations involved in the development, manufacture or marketing and distribution and education of drugs and medicinal preparations.

Members of the Reference Group

In relation to ADHD: No members of the review team declared any personal pecuniary interest in any companies or other organisations involved in the development, manufacture or marketing and distribution and education of drugs and medicinal preparations.

As health and other professionals working in this clinical area, the following dualities or conflicts were declared:

Dr Patrick Concannon, NSW

As a health professional in this clinical area, I:

- am employed as Senior Staff Specialist at Royal North Shore Hospital;
- work part-time in private developmental paediatrics;
- have attended two Advisory Board meetings (Novartis Pharmaceuticals (2006) and Janssen-Cilag (2007)). The sitting fee was directed to a local charity;
- have lectured at a Janssen-Cilag sponsored clinical meeting. The fee was directed to a local charity;
- have been sponsored (Eli Lilly) to attend the 1999 annual conference of the American Academy of Child & Adolescent Psychiatry;
- participated as a principal investigator in international Metadate CD (Celltech) Study. The funds received were paid into a Royal North Shore Hospital Child & Family research fund and my involvement was approved by the RNSH ethics committee;
- have acted as a Medical Consultant to the NSW Board of Studies (1988 to present);
- am currently Chair of the NSW Health Department's Stimulant Committee; and
- was a member of the NSW ADHD Review (2007).

Dr Daryl Efron, Vic

As a health professional in this clinical area, I:

- am a senior Paediatrician at the Royal Children's Hospital (Vic) Centre for Community Child Health;
- The Centre for Community Child Health applied for and received educational grants for ADHD research from Novartis, Eli Lilly and Janssen-Cilag in 2004-2006. These funds have been used in accordance with the Hospital's ethical guidelines, to support research into various aspects of ADHD;
- have been an honorary (unpaid) member of ADHD advisory boards for Novartis and Eli Lilly in 2003-2004;

- am one of four Chief Investigators in a NHMRC-funded, multi-centre research study into the cognitive and behavioural effects of a medication (atomoxetine) for ADHD; and
- am a member of the ADHD Coalition of Victoria – a voluntary, multidisciplinary advocacy group for ADHD in Victoria.

Dr Brad Jongeling, WA

As a health professional in this clinical area, I:

- am employed by the Western Australian Child and Adolescent Community Health Service as a senior paediatrician providing assessment to children with developmental disability, including ADHD;
- work in private paediatric practice assessing children with general and developmental paediatric issues including assessment of ADHD;
- have participated as a site (Joondalup CDC/State CDC) principal investigator in the international Metadate CD (Celltech) Study – concluded in 2005. This medication is not prescribed in Australia. Funds received from this study were paid into a Princess Margaret Hospital (PMH) research account and were used according to PMH ethical guidelines – principally for the employment of a research nurse. My involvement was approved by PMH ethics committee;
- am a member of the WA Health Department Implementation Committee (clinical guidelines subcommittees) on ADHD following a WA Parliamentary Inquiry into ADHD; and
- have until recently been the Chair RACP, Paediatric & Child Health Division – WA and have arranged local conferences which some pharmaceutical companies have sponsored.

Dr John Wray, WA

As a health professional in this clinical area, I:

- am employed by the Western Australian Child and Adolescent Community Health Service as a senior paediatrician providing assessment to children with developmental disability, including ADHD;
- am a member of the WA Health Department Implementation Committee and the Clinical Subcommittee of the WA Parliamentary Inquiry into ADHD;
- am the Western Australian representative of the Child Development and Behaviour Special Interest Group, of the Paediatrics & Child Health Division of the RACP;
- have received several competitive grants – no pharmaceutical research grants – to undertake research in the area of autism. One research project collaborates with an independent company that produces digestive enzymes for children with autism;
- have been a paid member of a global research team in a pharmaceutical company (Eli-Lilly) sponsored research program examining the long-term efficacy of atomoxetine in children with ADHD (2001 to 2008, now completed);
- have appeared before the Australian Pharmaceutical Benefits Advisory Committee in support of inclusion of risperidone on PBS for children with autism;
- attended two international conferences (American Academy of Child and Adolescent Psychiatry) sponsored by Eli-Lilly in 2001 and 2002 (airfare, accommodation and travel paid directly by pharmaceutical company, with approval from employer); and
- infrequently, deliver professional development lectures at meetings that have been partially or fully sponsored by pharmaceutical companies. I have never received payment for these lectures.

Dr Mark Kneebone, NSW

As a health professional in this clinical area, I:

- am a general psychiatrist in full-time private practice in NSW;
- have an interest in complementary treatment approaches with an evidence base;
- attended medical psychiatric meetings in November 2007 and March 2008 that were sponsored by Wyeth;
- attended three ADHD case presentation dinner meetings in 2007, sponsored by Eli-Lilly; and
- enrolled to participate in an Eli-Lilly sponsored clinical trial of strattera in adults with ADHD. No financial reimbursement or inducement was offered or provided to participate.

Dr Julian Trollor, NSW

As a health professional in this clinical area, I:

- am a paid employee of the South Eastern Sydney Illawarra Area Health Service as a Senior Staff Specialist Neuropsychiatrist and the University of New South Wales as a Senior Research Fellow;
- have sought, on behalf of various conference organising committees, sponsorship from numerous drug companies;
- have received personal payments for consultancy and review work for Novartis, Eli-Lilly and Pfizer;
- have reviewed material and provided advice to Janssen-Cilag for which no remuneration was received; and
- have attended many pharmaceutical sponsored education sessions.

Dr Peter Jenkins, Vic

As a health professional in this clinical area, I:

- am a Consultant Child and Adolescent Psychiatrist and Clinical Director of Eastern Health Child & Adolescent Mental Health; and
- am a Fellow of the Royal Australasian and New Zealand College of Psychiatrists, a member of the Faculty of Child and Adolescent Psychiatry of this College and a member of the Executive group of this Faculty.

Associate Professor John Brennan, NSW

As a health professional in this clinical area, I:

- am employed as Director of the Child and Adolescent Mental Health Service at Sydney Children's Hospital (SCH).

Professor Michael Sawyer, SA

As a health professional in this clinical area, I:

- am employed by the Children, Youth and Women's Service of South Australia and the University of Adelaide. I also conduct a range of research activities for the South Australian Departments of Education and Children's Services;
- declined to participate as lead investigator in a 2002–2008 study investigating the relative impact of buprenorphine versus methadone maintenance therapy during pregnancy on children's outcomes. I remain on the study as a co-investigator providing methodological support for a colleague at Flinders

University who subsequently undertook this study, and as a co-supervisor of a PhD student working on the study;

- was a member of the ADHD advisory board for Eli Lilly to advise on the introduction of atomoxetine into Australia; resigned from committee after attending initial meetings because of the desire to avoid conflicts of interest;
- was sponsored (Eli Lilly) to attend the 2002 annual conference of the American Academy of Child & Adolescent Psychiatry;
- am an author of the textbook *Medications for School-age Children* (Brown RT and Sawyer MG. Guilford Press: New York. 1998); and
- am an author of the "Child and adolescent" chapter for *Therapeutic Guidelines. Psychotropic*. Version 6. 2008. Therapeutic Guidelines Limited: Melbourne.

Associate Professor Geoff Mitchell, Qld

As a health professional in this clinical area, I:

- am an Associate Professor of General Practice employed by the University of Queensland;
- currently hold an NHMRC grant to investigate the effects of methylphenidate (MPH) as a treatment for fatigue in palliative care;
- currently hold an NHMRC grant to investigate the effects of methylphenidate (MPH) as a treatment for inattention and higher brain function in children with traumatic brain injury;
- have previously held (1999–2006) funding from AHMAC, RACGP, PHCRED and Queensland Medical Laboratories investigating single patient trials of MPH and dexamphetamine (DEX).

Dr Kim Pedlow, WA

As a health professional in this clinical area, I:

- am a rural generalist medical practitioner with special interest in obstetrics, paediatrics and minor surgery;
- am a member of LADDS in Western Australia;
- was Medical Advisor to the Geraldton Network ADHD Project (1996);
- have published in the *Australian Family Physician* journal on the Geraldton network.

Professor Vicki Anderson, Vic

As a health professional in this clinical area, I:

- am Director of the Psychology Department at Royal Children's Hospital (Vic);
- am Theme Director of Critical Care & Neurosciences at the Murdoch Childrens Research Institute;
- lead a research team, the Australian Centre for Child Neuropsychology Studies, which is currently involved in a clinical trial to test the effects of Omega-3 on attentional behaviours. The research project has been funded by Naturel, a Norwegian company. The trial has been approved by appropriate bodies in Australia, and our ethics approval gives us the right to publish data regardless of whether the trial is positive for the drug or not. I receive no direct, personal benefit from the company. [Trial subsequently cancelled]

Professor David Hay, WA

As an academic and research professional in this clinical area, I:

- am employed as a Professor of Psychology by Curtin University;
- undertake research work on ADHD that is, or has been funded by the US National Institute of Mental Health (NIMH), NHMRC and ARC (International Linkage);
- am a Member of the European Network for Hyperkinetic Disorders;
- am a Member of the NIMH, ADHD Molecular Genetics Network;
- am involved in both the Project Grants Scheme and the Training Awards Committee of the NHMRC;
- receive royalties from the sale of a 2001 book *Attention, Genes and ADHD* (Levy and Hay);
- attended a meeting of the International Collaboration on ADHD and Substance Abuse (ICASA) in Barcelona in September 2008. Curtin University paid for my airfare. My expenses in Barcelona were paid by grants to the Trimbos Institute, which administers ICASA, from Janssen-Cilag, Eli Lilly, UCB Pharma and Shire. This sponsorship was provided under unrestricted conditions. The sponsors had no influence on who participated in ICASA, the topics discussed or any resultant activities, including research;
- was a main speaker at the Janssen-Cilag Sydney meeting "Continuities and Discontinuities of Youth Mental Health" in November 2007. I undertook this with the approval of my employer. The company organised my flight and hotel directly and I received no reimbursement. At the instruction of my University, I refused the honorarium;
- was funded by Shire Pharmaceuticals (who at the time and presently do not operate in Australia) to attend their International Planning Meeting in Amsterdam in 2005; and
- work as a consultant with organisations that may pertain to ADHD including the WA Departments of Health, Education and Training and Community Development. Also the Royal Australian and New Zealand College of Psychiatry (WA Branch). I receive no financial benefit from any of these.

Professor Loretta Giorcelli, NSW

As an academic and consultancy professional in this clinical area, I:

- undertake national and international consultancy work involving consultation to school systems, schools, universities and courts on matters related to the education and inclusion of learners with additional needs. Some of this work involves the examination of empirical evidence regarding best practice for the integration or inclusion of learners with ADHD and comorbid/overlapping conditions;
- have authored a chapter and assisted in the organisation of conferences and seminars about students with ADHD and overlapping conditions. I have also given numerous presentations on the educational implications of students with ADHD since 1996; and
- attended one meeting of Janssen-Cilag in 2005 as an educational adviser. Accommodation expenses for one night were paid. There was no honorarium.

Dr Michelle Pearce, WA

As an educationalist, I:

- have been employed by the NSW Department of Education as a school principal; the Association of Independent Schools in Western Australia as an educational consultant; and the University of Notre Dame and Curtin University as a sessional lecturer;
- offer advice, lectures, articles and professional development that focus on strategies teachers can use to support children with attentional, behavioural and learning difficulties, regardless of whether they have a diagnosis of ADHD or not; and
- have contributed strategies that have been successful with teenagers with ADHD to improve their concentration and organisation, to Novartis Pharmaceuticals Australia. Several of these strategies were published by Novartis in point form in a 2005 pamphlet.

Ms Geraldine Moore, Vic

I am a consumer advocate in this clinical area. I:

- provide my time voluntarily to The ADHD Coalition of Victoria;
- have published a book titled *ADHD Potatoes: A Journey from Darkness into Light*. This book was published by Hybrid Publishers of Melbourne. It told the story of my own family dealing with the challenge of ADHD in the 1990s, and the emergence of the support movement for ADHD in Victoria with which I was associated, throughout that period; and
- launched my book in Melbourne in November 2005. There was a subsidiary launch in Sydney in 2006 attended by about 15 people. The venue was donated by the Children's Hospital and the main speaker donated her services. Travel, accommodation, publicity and communication expenses were paid by myself. The cost of finger food and drinks for the attendees at the Sydney launch (around \$100) was paid by Eli Lilly.

Ms Joy Toll OAM, NSW

I am a consumer advocate in this clinical area and for the past 25 years have provided my time voluntarily to the Learning Difficulties (LD) Coalition of NSW Inc. I:

- am founder (1995) and currently Secretary of ADDults with ADHD (NSW) Inc. and previously founder (1988) and President for 10 years of the Learning Difficulties (LD) Coalition of NSW Inc.;
- was invited as President of the LD Coalition of NSW Inc to attend a 2003 international meeting of ADHD support organisations in Rome, representing parents of children with ADHD. Eli Lilly was a sponsor of this international meeting. Travel and accommodation for the two nights was provided by the conference organisers. I received no financial benefit from attending this meeting – in fact my employer required me to take time off without pay;
- as Secretary of ADDults with ADHD (NSW) Inc., in the absence of other sponsors, approached Eli Lilly to sponsor the cost of printing the organisation's information pamphlet;
- as Secretary of ADDults with ADHD (NSW) Inc., attended two consultation meetings with Janssen-Cilag during the development of a new Australian website: <http://www.livingwithadhd.com.au>. I received no financial reimbursement. The company provided taxi vouchers to cover my travel expenses; and

- as Secretary of ADDults with ADHD (NSW) Inc., since 2003 have attended annual consultation meetings with Eli Lilly who provide taxi vouchers to cover my travel expenses and coffee/sandwiches. I received no financial reimbursement.

Ms Megan McDougall, WA

As a researcher in this area I:

- am employed by Curtin University within the School of Psychology.

Other participants in the review

In relation to ADHD: The following members of the review team declared no personal or pecuniary interest in any companies or other organisations involved in the development, manufacture or marketing and distribution and education of drugs and medicinal preparations.

Dr Angela Kirsner (Scientific Writer)

Dr Janet Salisbury (Guidelines Assessment Register Consultant)

Dr Melissa Hill (RACP Staff Member and Project Officer)

Mr Gary Disher (RACP staff member (until July 2008) and contract Project Officer (post July 2008))

Mr Colin Borg (RACP staff member)

Ms Leah Jeffries (Literature Review Consultant)

Dr Saravana Kumar (Literature Review Consultant)

Associate Professor Caroline Smith (Literature Review Consultant)

Ms Anthea Worley (Literature Review Consultant)

Professor Karen Grimmer-Somers (Literature Review Consultant)

Section B1: RACP 2007 declaration of dualities or conflicts of interests



The Royal Australasian
College of Physicians

DECLARATION OF DUALITIES OR CONFLICTS OF INTERESTS AGREEMENT

Members of the ADHD Guideline Working Group

For the term of the project

The purpose of this declaration is to identify any pecuniary or professional interest of a Working Group Member which is in conflict, has the potential to be in conflict, or might be perceived to be in conflict with their duty as a member of the ADHD Guideline Working Group.

Members must declare any new dualities or conflicts of interest that arise during the course of the project.

This declaration will remain as a permanent record on the published guideline.

1. PECUNIARY INTERESTS

In relation to Attention Deficit Hyperactivity Disorder (ADHD), list the names of any companies or other organisations involved in the development, manufacture or marketing and distribution and education of drugs and medicinal preparations, in which you have a pecuniary interest. In addition, list any organisations with which you are involved that might pertain to ADHD e.g. Department of Education.

List the names of any companies or other organisations that are known by you to be **service providers to the Royal Australasian College of Physicians (RACP)** or with which the RACP has a service/program contract in which you have a pecuniary interest. A pecuniary interest may include any of the following:

- shareholdings;
- holdings in managed funds which have a particular focus in the field of the health and/or pharmaceutical industries;
- indirect or beneficial interests in a company or organisation or in a trust which holds shares or investments in such a company or organisation;
- directorships, board memberships or other offices;
- paid employment or contracting work, including consultancies, commissions, presentations, and advisory work, whether as an individual or on behalf of another organisation or person;
- funding for research or education;
- grants for travel or conference expenses.

2. PROFESSIONAL INTERESTS

In relation to ADHD, list the names of any companies or other organisations involved in the development, manufacture or marketing, evaluation and distribution and education of drugs and medicinal preparations in which you have a professional involvement. In addition, list any organisations with which you are involved that might pertain to ADHD.

List the names of companies or other organisations with which you are involved which are **service providers to the RACP** or with which the RACP has a service/program contractual relationship in which you have a professional involvement. Interests may include involvement in:

- clinical trials;
- research and development;
- directorships or advisory groups;
- consulting;
- investigations or evaluations; and/or
- other committees.

Professor Nip Thompson
President RACP

DRAFT

Section B2: RACP 2008 declaration of dualities or conflicts of interests



The Royal Australasian
College of Physicians

ANNUAL DECLARATION OF INTERESTS AND CONFIDENTIALITY AGREEMENT

Fellows of RACP

For the calendar year 2008

The purpose of this declaration is to discover any pecuniary or non-pecuniary interests of an RACP Board/Council/Committee/Working Group Member which is in conflict, has the potential to be in conflict, or might be perceived to be in conflict with their duty as a member of an RACP Board/Council/Committee/Working Group or member on a panel.

A fresh declaration will be sought from each member annually, but members must also declare any new conflicts of interest that arise during the year when the Chair canvasses this agenda item at each meeting.

These documents will become a record as long as necessary in the Royal Australasian College Physicians Secretariat files. The information will be available to the Chair and the RACP Board/Council/Committee/Working Group or panel members, the Royal Australasian College Physicians Secretariat or delegate acting as Secretariat for the group. All Royal Australasian College of Physicians privacy procedures will be followed to ensure the information is not released to any other party without the express consent of the individual concerned. Records will only be retained whenever a person is an RACP Board/Council/Committee/Working Group or panel member.

1. PECUNIARY INTERESTS

List the names of any companies or other organisations involved in the development, manufacture or marketing and distribution and education around drugs and medicinal preparations, educational products or advisory bodies in relation to the pharmaceutical or alcohol industries or medical education (at undergraduate or postgraduate level) in which you have a pecuniary interest. List the names of any companies or other organisations that are known to you to be service providers to the Royal Australasian College of Physicians or with which the Royal Australasian College of Physicians has, or may develop in the near future, a service/program contract in which you have a pecuniary interest.

A pecuniary interest may include any of the following:

- shareholdings;
- holdings in managed funds which have a particular focus on the field of the health, education and/or pharmaceutical industries;

- indirect or beneficial interests in a company or organisation or in a trust which holds shares or investments in such a company or organisation;
- directorships, board memberships or other offices;
- paid employment or contracting work, including consultancies, commissions, presentations, and advising work, whether as an individual or on behalf of another organisation or person involved in postgraduate medical education;
- funding for research or education;
- grants for travel or conference expenses;
- hospitality of any kind.

2. NON-PECUNIARY INTERESTS

List the names of any companies or other organisations involved in the development, manufacture or marketing and distribution and education around drugs and medicinal preparations, educational programs or products or advisory bodies in relation to the pharmaceutical or alcohol industries or medical education (at undergraduate or postgraduate level) in which you have a non-pecuniary interest. List the names of any companies or other organisations that are known to you as service providers to the Royal Australasian College of Physicians or with which the Royal Australasian College of Physicians has, or may develop in the near future, a service/program contract in which you have a non-pecuniary interest.

Non-pecuniary interests include any interests which may conflict, or give the appearance of being in conflict, with a member's obligations to RACP.

Examples of a non-pecuniary conflict of interest might be, but not limited to the following:

- where a member or his/her immediate family has direct relationships with the pharmaceutical or alcohol industries or an education program or product is being considered;
- where a member or his/her immediate family has strong personal or religious beliefs about a therapeutic implication or education program or product under consideration by the RACP;
- where staff that are on secondment to the RACP on a part-time basis and dualities or conflicts arise in relation to the work for the College and where their primary employer has an interest;
- where Fellows or staff are included on a non-RACP panel or committee where the work of the College is under consideration;
- clinical trials;
- research and development;
- directorships/consultancies or advisory groups;
- investigations or evaluations; and/or
- other committees.

Dr Mel Miller
Chief Executive Officer

8 January 2008

DECLARATION

I, (*name*), acknowledge that my attention has been drawn to the Confidentiality and Declaration of Interest Policy for RACP Board / Council / Committee / Working Groups (*circle applicable*) of the Royal Australasian College of Physicians attached to this form, and I agree to abide by those principles.

Particulars of my pecuniary and non-pecuniary interests and those of my immediate family, of which I am aware, are set out below.

I undertake that I shall advise the Chair of the RACP Board / Council / Committee / Working Group (*circle applicable*) should a situation arise where an interest of mine or an interest of a member of my immediate family of which I am aware, whether pecuniary or otherwise, is in conflict, has the potential to be in conflict, or might be perceived to be in conflict with their duty as a member of the RACP.

I agree to abide by the confidentiality policy of the Royal Australasian College of Physicians.

I declare the following pecuniary and non-pecuniary interests:

Type of interest	Myself	Immediate Family
Pecuniary interests		
Shareholdings	No/Yes*	No/Yes*
Holdings in managed funds which have a particular focus on the field of the health, education and/or pharmaceutical industries	No/Yes*	No/Yes*
Indirect or beneficial interests in a company or organisation or in a trust which holds shares or investments in such a company or organisation	No/Yes*	No/Yes*
Directorships, board memberships or other offices	No/Yes*	No/Yes*
Paid employment or contracting work, including consultancies, commissions, presentations, and advising work, whether as an individual or on behalf of another organisation or person involved in postgraduate medical education	No/Yes*	No/Yes*
Funding for research or education purposes	No/Yes*	No/Yes*
Grants for travel or conference expenses	No/Yes*	No/Yes*
Hospitality of any kind	No/Yes*	No/Yes*
Other	No/Yes*	No/Yes*
Non-pecuniary interests		
Clinical trials	No/Yes*	No/Yes*
Research and development	No/Yes*	No/Yes*
Directorships/Consultancies or advisory groups	No/Yes*	No/Yes*

Section B3: RACP standard declaration statement for agendas

DUALITIES AND CONFLICT OF INTEREST DECLARATION

Any member of a Board/Council/Committee/Working Group of the Royal Australasian College of Physicians (RACP) – in this case the ADHD Reference Group – has a duty to inform the group through the Chair of the Group, of any duality or conflict of interest.

A duality or conflict of interest arises where there is a direct, indirect, pecuniary or non-pecuniary interest that any member of a Group has in any matter before the Group, or likely to be considered by the Group.

A duality or conflict of interest should be declared where any circumstance exists where it may be perceived that a duality or conflict of interest may exist, even if it does not actually exist.

If a member has a duality or conflict of interest in any matter before this Group it will be noted in the minutes, and you may absent yourself for the duration of discussion of that matter, but at any rate must not take part in any discussion, or vote in relation to, that matter.

DRAFT

APPENDIX C: PROCESS REPORT

Section C1: Process overview

The National Health and Medical Research Council (NHMRC) *Guideline on Attention Deficit Hyperactivity Disorder (ADHD)* (NHMRC 1997) was originally developed by an expert working group and endorsed by the NHMRC. On 31 December 2005 the ADHD Guideline was revoked as it was considered out of date. The NHMRC approached the RACP, Paediatrics & Child Health Division, to develop an updated version of the 1997 NHMRC publication. The RACP approached the Department of Health and Ageing (DoHA) for project funding. The contract between the RACP and the DoHA was signed in November 2006. A deed of variation was agreed upon by the DoHA and the RACP in September 2007.

A management group was convened to oversee the redevelopment of the Guidelines. Associate Professor David Forbes, Chair of the RACP Paediatric Policy Committee, was invited to chair the management group. Associate Professor Forbes is an independent chair with no pecuniary or non-pecuniary interest in ADHD. The members of the management group are listed in Appendix A. The terms of reference for the management group are described in section C2.

In late 2006 and early 2007 the RACP assembled a multidisciplinary reference group with expertise from the core professional groups involved with ADHD, including paediatrics, child and adolescent psychiatry, adult psychiatry, psychology, general practice, education and consumer advocates.

The professional associations involved in the management of people with ADHD were approached to nominate representatives for the working group. These associations were the Chapter of Community Child Health of the Royal Australasian College of Physicians, Paediatrics & Child Health Division, the Royal Australian College of General Practitioners (RACGP), The Australian College of Rural and Remote Medicine (ACRRM), the Royal Australian and New Zealand College of Psychiatrists (RANZCP) and the Australian Psychological Society (APS). Each of these professional organisations is represented in the working group by one or more of their members. Consumer groups with a special interest in ADHD were also invited to nominate representatives for the working group. The final multidisciplinary reference group, which is chaired by Associate Professor David Forbes, is listed in Appendix A. Ms Jude Foster, Professor Philip Hazell, Associate Professor Michael McDowell and Ms Michele Toner attended the first meeting of the reference group, but did not participate further as members of the reference group in the development of the Guidelines. The terms of reference for the reference group are described in section C3.

In December 2006 the RACP advertised for a project officer to assist with the redevelopment of the ADHD Guidelines and Dr Melissa Hill was appointed in January 2007. Dr Janet Salisbury was appointed by the NHMRC as the Guidelines Assessment Register (GAR) consultant in February 2007. The management group engaged Dr Angela Kirsner, a professional scientific writer, to write the Guidelines according to NHMRC procedures. The terms of reference for the writing group are described in section C4.

A dissemination plan for the Guidelines was developed and this is described in section C5.

The management of dualities and conflicts of interests for the development of the Guidelines is based on the Royal Australasian College of Physicians 2006 "Guidelines for Ethical Relationships between Physicians and Industry" and complies with current Australian Competition and Consumer Commission (ACCC) processes. In October 2008 the NHMRC introduced a draft policy for declarations of interests

and potential conflicts of interests for guideline developers. The disclosure of interest statements is in accordance with the draft NHMRC policy. The management of dualities and conflicts of interests is described in Appendix B.

The first meeting of the reference group was held in Melbourne on 23 February 2007. The reference group was asked at this meeting to submit their Dualities and Conflicts of Interest declarations to the RACP. At this first meeting the reference group revised the Table of Contents from the 1997 Guideline and discussed the planned content of the updated Guidelines.

The reference group felt that the education section of the 1997 NHMRC Guideline on ADHD needed to be significantly expanded. Input was sought from a number of Australian education groups (section C6). A letter was sent to these groups in April 2007 advising them of the redevelopment of the Guidelines and inviting their input in the form of advice on key educational considerations in ADHD, as well as any policy documents that might assist in the development of the education section of the revised Guidelines.

The standard NHMRC guideline development process, as outlined in the *NHMRC Standards and Procedures for Externally Developed Guidelines (2005)*, includes a public consultation on the draft Guidelines. External consultation is a critical component of guideline development. In May 2007, driven by the perceived large interest in ADHD in Australia, the management group (in consultation with the NHMRC and DoHA) developed a proposal to undertake a two-stage consultation process. The stage 1 consultation document would consist of an outline of the project's scope and the results of the literature review on ADHD management that would be sent out to key stakeholders with an interest in ADHD. The stage 2 consultation document would be on the full draft of the Guidelines and the draft systematic review. The public consultation would be made available to stakeholders and the public.

In May 2007 the management group discussed possible approaches for engaging organisations/individuals to assist with the Systematic Literature Review with representatives from DoHA and the NHMRC. Subsequently, the Centre for Allied Health Evidence (CAHE), a collaborating centre of the Joanna Briggs Institute that conducts evidence-based research consultancy was contracted by the RACP to assist with the literature review over the following periods: July–October 2007 and January–March 2008. The contract with the CAHE was established under the University of South Australia quality assurance program.

The literature review was developed by the project officer and the CAHE, in consultation with the GAR and the reference group. The process report for the systematic review is described in Appendix D.

A stakeholder consultation was conducted between 12 October and 23 November 2007. During this period the stakeholder consultation document, *Redevelopment of the Guidelines on Attention Deficit Hyperactivity Disorder (ADHD) Project Scope and Literature Review*, was available to download from the RACP website, along with a submission form seeking contact and other details and a feedback template to guide written submissions. Invitations to make a submission to the stakeholder consultation were sent to professional colleges, justice departments, representatives of community groups such as Aboriginal and Torres Strait Islanders and people from culturally and linguistically diverse (CALD) backgrounds, ADHD consumer groups, education groups, individuals with clinical and research expertise in ADHD and other interested persons (section C7). Twenty-two submissions were received (section C8). All submissions were formally considered by the reference group in the development of the draft Guidelines on ADHD.

A public consultation on the draft guidelines on ADHD was conducted between 27 June 2008 and 28 July 2008. During this period the *Draft Guidelines on ADHD* and the *Draft Systematic Review* were available to download from the RACP website,

along with a submission form seeking contact and other details and a feedback template to guide written submissions. The public consultation was advertised in *The Australian* on 28 June 2008. Invitations to comment on the *Draft Guidelines on ADHD* were sent to stakeholders, and to all persons who made a submission in the stakeholder consultation. A total of 76 submissions were received (section C9). This included one international expert review co-ordinated by Professor Joseph Sergeant, Chairman of the European ADHD Guidelines Group. All submissions were formally considered by the reference group and the draft document was amended. A document summarising the submissions received and the reference group's response is available from the RACP website.

During the public consultation period an online anonymous survey was also available. The survey was advertised on the mailing lists of the following professional bodies: the Australian Psychological Society (APS), the RACP Paediatrics & Child Health Division, the Royal Australian College of General Practitioners (RACGP) and the Royal Australian and New Zealand College of Psychiatrists (RANZP). The survey asked people whether they agreed or disagreed with each chapter's recommendations and provided a place for comments. A total of 31 people completed all or part of the survey. The responses to the survey were considered by the reference group and the draft document was amended accordingly.

Throughout the course of the project the various guideline development groups have communicated by telephone and email. Three face-to-face meetings have been held in Melbourne at the RACP Victorian State Office. The project grant from the DoHA covers the cost of the systematic review, guideline writing and the co-ordination of the project. Members of the reference group undertook this work in their own time using their own resources.

Section C2: Management Group Terms of Reference

To support the revision of the 1997 NHMRC Guideline on ADHD the management group should:

1. Enable the project to engage with the NHMRC, the Australian government and other key stakeholders.
2. Ensure that contractual agreements are met and kept to time.
3. Act as the reporting link between the College as contractor, the independent guideline writers and the reference group for the revision of the Guidelines.
4. Remain disconnected from decisions on guideline content or the formulation of guideline recommendations.

Section C3: Reference Group Terms of Reference

Within the context of the NHMRC requirements for the disclosure and management of dualities and conflicts of interest, the reference group should:

1. Review and provide advice on the questions for the systematic literature review.
2. Review the guidelines in the process of their development.
3. Review and provide advice on chapter content, including the relevance and use of information for the target audience, to the guideline writing group.
4. Assist the writing group in interpreting the literature and external submissions, leading to the formulation of guidelines and recommendations.
5. Address difficulties or disputes regarding the interpretation of the literature, guideline content and recommendations by consensus of the full reference group.

Section C4: Writing Group Terms of Reference

To support the revision of the 1997 NHMRC Guideline on ADHD the writing group should:

1. Attend discussions of the reference group and its sub-committees, recording the discussion and the conclusions achieved.
2. Utilise the conclusions of the reference group and its sub-committees, to prepare the draft guideline document.
3. Follow the advice on editing chapter content and format as determined by the reference group and its sub-committees.
4. Work in consultation with the GAR to ensure NHMRC methodology is applied properly and consistently and that the requisite records are kept.

Section C5: Guideline dissemination and implementation

Ultimately three documents will be produced for dissemination:

1. One-page bulletin
2. A summary
3. The updated Guidelines and the supporting Systematic Review.

The core strategy for dissemination is as follows;

- The bulletin will be disseminated electronically to relevant professional organisations for use in mailouts, newsletters, meetings and workshops.
- The summary document will be posted to the members of relevant organisations.
- The full Guidelines will be available on the NHMRC website and the RACP website.
- A series of media releases from the RACP in the lead-up to the release of the Guidelines and a major media release when the document becomes available.
- Dissemination by guideline advocates who will promote the Guidelines to their colleagues and within their professional organisations.

Further suggested strategies for implementation of the Guidelines include:

- Consideration of guideline recommendations for future inclusion in education and training curriculum.
- Consideration of the development of specific Continuing Professional Development activities such as conference presentations, lectures and in-service training activities.

Current project funding to undertake the review does not include any component for the implementation of the Guidelines. Organisations seeking to implement all or part of the Guidelines in curriculum, training programs or CPD activities will do so within the resource base available to them.

Section C6: Request for input from key education stakeholders

The following groups and individuals were approached to provide input into the education section of the revised Guidelines.

Independent Schools Bodies

Independent Schools Council of Australia
Australian Independent Schools of the ACT
Australian Independent Schools of NSW
Australian Independent Schools of the NT
Australian Independent Schools of QLD
Australian Independent Schools of SA
Australian Independent Schools of TAS
Australian Independent Schools of VIC
Australian Independent Schools of WA
National Catholic Education Commission

Teachers' Colleges

Australian College of Educators
Western Australian College of Teaching
Queensland College of Teachers

Education Unions

Australian Education Union
Australian Education Union – ACT
Australian Education Union – NT
Australian Education Union – SA
State School Teachers Union of WA
Australian Education Union – TAS
NSW Teachers Federation
Australian Education Union – VIC
Queensland Teachers' Union

National Principals Associations

Australian Primary Principals Association
Australian Catholic Primary Principals Association
Association of Heads of Independent Schools of Australia
Association of Principals of Catholic Schools of Australia
Australian School Principals Association
Post-Secondary Education Disability Network

Federal Government

Julie Bishop, Minister for Education

State & Territory Governments

ACT/NSW

John Della Bosca, Minister for Education

Northern Territory

Paul Henderson, Minister for Employment, Education and Training

Department of Minister for Employment, Education and Training, Margaret Banks, Chief Executive

Queensland

Rod Welford, Minister for Education Training and the Arts
Department of Education Training and the Arts
Rachel Hunter, Director General

South Australia

Jane Lomax-Smith, Minister for Education and Children's Services
Department of Education and Children's Services, Christopher Robinson, Chief Executive

Tasmania

David Bartlett, Minister for Education
Department of Education, John Smyth, Secretary

Victoria

Jacinta Allen, Minister for Skills, Education, Services and Employment
John Lenders, Minister for Education
Department of Education
Peter Dawkins, Department Secretary

Western Australia

Mark McGowan, Minister for Education and Training; South West
Department of Education and Training
Sharyn O'Neill, A/Director General, Central Office

Section C7: Groups and individuals invited to provide feedback in the stakeholder consultation and/or the public consultation

Professional bodies
<p>Australian College of Rural and Remote Medicine (ACCRM) Australian Medical Association (AMA) Australian Psychological Society (APS) New South Wales Clinical Excellence Commission Royal Australian College of General Practitioners (RACGP) Royal Australasian College of Physicians (RACP), Paediatrics & Child Health Division Royal Australian and New Zealand College of Psychiatrists (RANZCP)</p>
ADHD support and education groups
<p>Active Inc. ADD ASSOC. Queensland Inc. (ADDAQ) ADDults with ADHD (NSW) Inc. The ADHD Coalition of Victoria Inc ADHD Tasmania Attention Deficit Hyperactivity Disorder Association of Victoria The Attention Disorders Association of South Australia (ADASA) Canberra & Queanbeyan ADD Support Group Inc. Far North Queensland Support Group Hyperactivity Attention Deficit Association (NSW) Learning Difficulties Coalition (NSW) Learning & Attentional Disorders Society of Western Australia Inc.</p>
Children's welfare groups
<p>Australian Infant, Child, Adolescent and Family Mental Health Association Ltd Child and Family Welfare Association of Australia Inc. Childhood Foundation Australia Child Safety Commissioner Commissioner for Children, Tasmania Commission for Children and Young People and Child Guardian Disability & Community Services & Children & Young People Commissioner, ACT Disability & Community Services & Children & Young People Commissioner New South Wales Commission for Children and Young People</p>
Government Justice Departments
<p>ACT Government Department of Justice and Community Safety Northern Territory Government Department of Justice New South Wales Government Department of Juvenile Justice Queensland Government Department of Justice and the Attorney-General South Australian Government Justice Portfolio Tasmanian Government Department of Justice Victorian Government Department of Youth Services and Youth Justice Western Australian Government Department of Corrective Services</p>

Individuals and groups with an interest in Indigenous health

Australian Government Department of Families, Community Services and Indigenous Affairs
Associate Professor Colleen Haywood, Manager of the Kulunga Research Network
Associate Professor Jacinta Elston, Assistant Dean, Indigenous Health, James Cook University, Townsville
Dr Tracy Westerman, Managing Director, Indigenous Psychological Services
The Secretariat of National Aboriginal and Islander Child Care (SNAICC)

Representatives of people with culturally and linguistically diverse backgrounds

Multicultural Mental Health Australia

Individuals with an interest in ADHD

Ms Joan Breakey, Dietitian, Queensland
Ms Isabelle Brown, Hill and Knowlton
Ms Libby Burns, Special Learning Needs Coordinator, South Australia
Mr Gregg Chapman, Canberra Grammar School
Dr Richard Clark, School of Psychology, Flinders University
Ms Jude Foster, Managing Director, Fostering Partnerships Pty Ltd
Ms Judith Gillies, Regional Disability Liaison Officer, Curtin University of Technology
Dr George Halasz, Burke Road Medical Suites, Melbourne
Professor Philip Hazell, Director, Child and Adolescent Mental Health Services, Sydney South West Area Health Service, Thomas Walker Hospital (Rivendell) Child, Adolescent and Family Mental Health Services
Mr Shane Hill, Member for Geraldton, Western Australia
Ms Glynis Howard, National Medical Services, Manager of Dore Achievement Centres Australia
Dr Paul Hutchins, Honorary Senior Paediatric Consultant, The Children's Hospital Education Research Institute (CHERI); Head, Child Development Unit, The Children's Hospital at Westmead.
Professor David Isaacs, The Children's Hospital at Westmead
Associate Professor Jon Jureidini, Head, Department of Psychological Medicine, Women's and Children's Hospital, Adelaide
Professor Robert Kosky, Department of Psychiatry, The University of Adelaide
Professor Florence Levy, School of Psychiatry, Faculty of Medicine, University of New South Wales
Ms Natalie Mamone, NSW Government Department of Juvenile Justice
Associate Professor Michael McDowell, Child Development Network Mater CSB, Queensland
Ms Sandy Moran, Western Australia
Professor Frank Oberklaid, Director, Centre for Community Child Health, The Royal Children's Hospital, Melbourne
Dr Frank Parsons, Alternative Health Sciences
Dr Sally Poulton, Senior Lecturer Paediatrics, Paediatrics and Child Health, Nepean Clinical School, Nepean Hospital
Dr Brenton Prosser, Research Fellow, University of South Australia
Dr Aldis Putnins, Families SA, Psychological Services

Ms Sue Saltmarsh, Drug Free Attention Difficulties Support
 Professor Robert Spillane, Macquarie Graduate School of Management, Macquarie University
 Dr Lila Stephens, Paediatrician
 Dr Margaret Stevens FRACP, Chief Medical Adviser, Department of Health, Government of Western Australia
 Dr Caroline Stevenson, Clinical Psychologist, New South Wales Institute of Psychiatry
 Dr Greg van Wick, Eli Lilly Australia
 Dr Kenneth Whiting, Chairman of the Professional Advisory Board of the Learning and Attentional Disorders Society of Western Australia
 Mr Martin Whitely, Member for Bassendean, Western Australia
 Ms Shelly Wilkens, Citizens Committee on Human Rights, Western Australia
 Ms Patricia Winter, Assistant Director, Disability and Statewide Programs

Principals' associations

Association of Heads of Independent Schools of Australia
 Association of Principals of Catholic Secondary Schools in Australia
 Australian Catholic Principals' Association
 Australian Primary Principals Association
 Australian Secondary Principals Association

Teachers colleges

Australian College of Educators
 Queensland College of Teachers
 Western Australian College of Teaching

Catholic education commissions

Catholic Education Commission, New South Wales
 Catholic Education Commission, Victoria
 Catholic Education Office, Australian Capital Territory
 Catholic Education Office, Northern Territory
 Catholic Education Office, Western Australia
 Queensland Catholic Education Commission
 South Australian Commission for Catholic Schools
 Tasmanian Catholic Education Commission

State & Territory education departments

ACT Government Department of Education and Training
 Queensland Government Department of Education, Training and the Arts
 Tasmanian Government Department of Education
 Northern Territory Government Department of Employment Education and Training
 Western Australia Government Department of Education and Training
 South Australian Government Department of Education and Children's Services
 New South Wales Government Department of Education and Training
 Victorian Government Department of Education and Training

Education unions
<p>Australian Education Union Australian Education Union – Australian Capital Territory Branch Australian Education Union – Northern Territory Branch Australian Education Union – South Australian Branch Australian Education Union – Tasmanian Branch Australian Education Union – Victorian Branch New South Wales Teachers Federation Queensland Teachers Union State School Teachers Union of Western Australia</p>
Independent schools associations
<p>Independent Schools Council of Australia Association of Independent Schools of South Australia Association of Independent Schools of the Australian Capital Territory Association of Independent Schools of New South Wales Association of Independent Schools of the Northern Territory Association of Independent Schools of Victoria Independent Schools Queensland Association of Independent Schools of Tasmania Association of Independent Schools of Western Australia</p>
Secondary education
<p>Universities Australia Post Secondary Education Disability Network (PSEDN)</p>

Section C8: Individuals and groups who made submissions in the stakeholder consultation

Australian Education Union (Susan Hopgood, Federal Secretary and Pat Byrne, Federal President)

Ms Joan Breakey, Dietitian, Queensland

Ms Gillian Calvert, New South Wales Commission for Children and Young People

Ms Elizabeth Fraser, Commission for Children and Young People and Child Guardian

Dr George Halasz, Burke Road Medical Suites, Melbourne

Professor Philip Hazell, Director, Child and Adolescent Mental Health Services, Sydney South West Area Health Service, Thomas Walker Hospital (Rivendell), Child, Adolescent and Family Mental Health Services

Mr Shane Hill, Member for Geraldton, Western Australia

Associate Professor Jon Jureidini, Head, Department of Psychological Medicine, Women's and Children's Hospital, Adelaide

Ms Natalie Mamone, NSW Government Department of Juvenile Justice

Associate Professor Michael McDowell, Child Development Network Mater CSB, Queensland

Ms Sandy Moran, Western Australia

Dr Frank Parsons, Alternative Health Sciences

Dr Sally Poulton, Senior Lecturer Paediatrics, Paediatrics and Child Health, Nepean Clinical School, Nepean Hospital

Dr Brenton Prosser, Research Fellow, University of South Australia

Ms Sue Saltmarsh, Drug Free Attention Difficulties Support

Dr Lila Stephens, Paediatrician

Dr Margaret Stevens FRACP, Chief Medical Adviser, Department of Health, Government of Western Australia

Ms Michele Toner, Learning & Attentional Disorders Society of Western Australia Inc.

Dr Greg van Wick, Eli Lilly Australia

Dr Kenneth Whiting, Chairman of the Professional Advisory Board of the Learning and Attentional Disorders Society of Western Australia

Mr Martin Whitely, Member for Bassendean, Western Australia

Ms Shelly Wilkens, Citizens Committee on Human Rights, Western Australia

Section C9: Individuals and groups who made submissions in the public consultation

- Dr Lois Achimovich, Consultant Child Psychiatrist in Private Practice, WA
- The ADHD Coalition of Victoria Inc
- ADDults with ADHD (NSW) Inc.
- Association of Independent Schools of New South Wales [Ms Cate Pinnington]
- Association of Independent Schools of South Australia [Mr Gary Le Duff, Executive Director]
- Australasian College of Nutritional and Environmental Medicine [Mr Stephen Penman (CEO) and Dr Gary Deed (President)]
- Australasian Integrative Medicine Association [Dr Katherine Sevar, Executive Board Member]
- Australian Education Union [Angelo Gavrielatos, Federal President]
- Australian Homoeopathic Association [Ms Michelle Hookham]
- Australian Medical Association (AMA) [Dr David Thomas, Chair, Child and Youth Health Committee]
- Ms Steena Barnett, Qld

- Ms Joan Breakey, Dietitian, Qld
- Mr Darryl Burnside, WA
- Canberra & Qbn ADD Support Group
- Mr Harry Crawford, ACT
- Mr Howard Dengate and Ms Sue Dengate, Food Intolerance Network
- Department of Education and Early Childhood Development
- Dietitians Association of Australia
- Ms Sachelle Draper, Western Australia
- Ms Jude Foster, Managing Director, Fostering Partnerships Pty Ltd
- Ms Elizabeth Fraser, Commissioner, Queensland Commission for Children, Young People & Child Guardian
- Mr Bernie Geary, Child Safety Commissioner, Victoria
- Mr James Graham
- Dr Linda J. Graham, Faculty of Education and Social Work, University of Sydney
- Mr Thomas Grimshaw, NSW
- Dr George Halasz, Burke Road Medical Suites, Melbourne
- Ms Joanne Howard, Director, Student Services, ACT Department of Education and Training
- Hyperactivity Attention Deficit Association (NSW) [Julie Appleton, President]
- Professor David Isaacs, Children's Hospital at Westmead
- Mr Wally Johnston, NSW
- Associate Professor Jon Jureidini, Head, Department of Psychological Medicine, Women's and Children's Hospital, Adelaide
- Ms Fay Karpouzis, Macquarie University, Department of Chiropractic
- Dr Michael Kohn, Centre for Research into AdolescentS' Health (CRASH) and The Children's Hospital at Westmead
- Ms Soula Kourakis, SA
- Mr Andrew Macdonald, NSW
- Ms Rochelle Macredie
- NSW Government Department of Juvenile Justice [Ms Natalie Mamone, Chief Psychologist]
- Ms Kelly Marwick, Qld
- Mindd Foundation
- Ms Sandy Moran, WA
- Ms Deborah Moore (Adv Dip Nat)
- Ms Samantha Motion, WA
- Multicultural Mental Health Australia [Dr Antonio Cocchiaro]
- Mr Mark Neilson, WA
- Ms Sue Nilsen, Association of Independent Schools of Victoria
- NSW Department of Education and Training [Brian Smyth-King, Director Disability Programs]
- Henry Osiecki (BSc(Hons) Grad Dip. Nutrition and Dietetics)
- Associate Professor Trevor Parry, WA, RACP Chapter of Community Child Health
- Dr Frank Parsons, Alternative Health Sciences
- Ms Maureen Pearl, Vic
- Dr Sally Poulton, Senior Lecturer Paediatrics, Paediatrics and Child Health, Nepean Clinical School, Nepean Hospital
- Dr Brenton Prosser, Research Fellow, University of South Australia
- Dr Aldis Putnins, Families SA, Psychological Services
- Queensland College of Teachers [Mr John Ryan, Director]

- Queensland Department of Justice and Attorney General [Ms Julie Grantham, Director General]
- Dr David Rodgers, GP, Vic
- Dr Dianne Rogers, Qld
- Mr John Rufus
- Ms Jane Sala-Tenna, WA
- Ms Sue Saltmarsh, Chairperson, Drug Free Attention Difficulties Support
- Ms Marie Schulz, WA
- Ms Terri Scott, WA
- Dr Doug Shelton, Queensland, Chair, RACP Child Development and Behaviour Special Interest Group
- Dr Natalie Sinn, Nutritional Physiology Research Centre, University of South Australia
- Ms Caroline Smith (BA, B Social Work, Grad Cert SW (Uni of Qld), Accredited Mental Health Social Worker)
- Dr Helen Smith, GP
- Speech Pathology Association of Australia [Ms Marie Atherton, Senior Advisor Professional Issues]
- Dr Margaret Stevens FRACP, Chief Medical Adviser, Department of Health, Government of Western Australia
- Stichting Eunethydis Foundation, The Netherlands [Professor Joseph A. Sergeant, Chairman European ADHD Guidelines Group]
- Dr Richard Stuckey, GP, Qld
- Learning & Attentional Disorders Society of Western Australia Inc (LADS) [Ms Michele Toner, President]
- Mr Richard Weller
- Dr Greg van Wick, Eli Lilly
- Dr Kenneth Whiting, Chairman of the Professional Advisory Board of the Learning and Attentional Disorders Society of Western Australia
- Mr Martin Whitely, Member for Bassendean, WA
- Dr Charles Xu, The Chinese Medicine Association of Australia

APPENDIX D: SYSTEMATIC REVIEW PROCESS REPORT

The draft systematic review is presented in a separate document as a supplement to the Guidelines on ADHD. The methods used to conduct the systematic review comply with NHMRC requirements (1-4).

Research questions

A set of clinically relevant research questions were developed based on the PICO criteria (population, intervention, control and outcomes) to be addressed by systematic review. The questions are listed in Appendix E.

Search strategy

The literature review was designed to update the 1997 NHMRC Guideline on ADHD. Consequently, the literature searches were conducted to encompass research published in the period 1997 – March 2008. Research publications meeting the NHMRC designated levels of evidence I–IV were sought. In the first instance a search was conducted to identify any systematic reviews or meta-analyses that were available to address each research question (Level I evidence). If a systematic review or meta-analysis addressing the research question was not identified, the search limits were extended to include Level II evidence. In the absence of Level I or II evidence, Level III and IV evidence was sought. The databases and other sources of literature searched are described in Table D1 and the search strategies for systematic reviews and RCTs are described in Table D2. The searches for each question were conducted by one reviewer. Twenty percent of the searches were independently conducted and checked for agreement by a second reviewer.

Study selection process

A summary of the study selection process is outlined for each question within the literature review. The following is an overview of the method employed:

1. All citations identified for each question or for a designated group of questions were collated into an endnote database and duplicate references were removed.
2. The title and abstract of these citations were screened for relevance. Studies that would clearly not meet the inclusion criteria were excluded at the level of title and abstract.
3. The remaining studies were retrieved for assessment of the full text.
4. The inclusion and exclusion criteria were applied to each retrieved article by two independent reviewers. Articles that did not meet the inclusion criteria following assessment of the full text were excluded and are listed with the reasons for exclusion with each question. Articles that met the inclusion criteria were included for data extraction and critical appraisal.

Inclusion and exclusion criteria

A set of individual inclusion and exclusion criteria were developed for each research question based on study population, intervention, comparator, relevant outcomes, study design, search period and language.

For all questions the identified studies were excluded on the following rationale:

- animal studies
- inadequate outcome data presented
- review articles with no original data
- sample size of fewer than 10 participants
- inability to locate the article

- articles that fell outside the NHMRC designated levels of evidence I–IV.

Data extraction and critical appraisal

Data were extracted into standardised data-extraction / critical appraisal tables (Appendix F). The internal and external validity of all included studies was critically appraised based on the NHMRC critical appraisal checklists (2) and the NHMRC interim levels and grades of evidence (4). In addition, the modified Overview Quality Assessment Questionnaire (OQAQ) (5-7) was used to assess the quality of systematic reviews and meta-analyses. The data-extraction / critical appraisal tables for each included study are available from the RACP on request.

Grading of recommendations

The recommendations made within the revised guidelines have been developed using *NHMRC Additional Levels of Evidence and Grades for Recommendations for Developers of Guidelines: Stage 2 Consultation 2008–2010* (4). Grade A and B recommendations are based on a strong body of evidence that can be trusted to guide clinical practice. Grade C and D recommendations must be applied with care in individual circumstances.

The NHMRC Evidence Statement Form (Appendix G) sets out the basis for rating five key components of the “body of evidence” for each recommendation. These components are:

1. the evidence base, in terms of the number of studies, level of evidence and quality of studies (risk of bias)
2. the consistency of the study results
3. the potential clinical impact of the proposed recommendation
4. the generalisability of the body of evidence to the target population for the guideline
5. the applicability of the body of evidence to the Australian healthcare context.

The evidence statements for each graded recommendation are available from the RACP on request.

Table D1. Search methods and databases

Electronic Databases
The Cochrane Library
Cochrane Database of Systematic Reviews (CDSR)
Cochrane Database of Abstracts of Reviews of Effects (DARE)
The Health Technology Assessment Database (HTA)
Cochrane Central Register of Controlled Trials (CENTRAL)
Cumulative Index to Nursing and Allied Health Literature (CINAHL)
Excerpta Medica Database (EMBASE)
Medline
PsycInfo
Clinical Evidence
Current Controlled Trials metaRegister; http://controlledtrials.com/
The Centre for Reviews and Dissemination (CRD); http://www.york.ac.uk/inst/crd/
Health Technology Assessment International; http://www.htai.org/
Education databases
ERIC
ProQuest Education Journals
Criminology databases
Criminal justice abstracts
Criminology: a SAGE full-text collection
Pearling
The reference lists of all included articles were searched for additional relevant studies
Searches of Topic Specific Internet Sites
Australian Psychological Society; http://www.psychology.org.au
American Psychiatric Association; http://www.psych.org/search.cfm
American Academy of Child and Adolescent Psychiatry; http://www.aacap.org/
European Society for Child and Adolescent Psychiatry; http://www.escap-net.org/
National Institute of Mental Health; http://www.nimh.nih.gov/nimhhome/index.cfm

Table D2. Standardised search strategies (based on the OVID interface for Medline)

Search strategy for systematic reviews and meta-analysis	Search strategy for randomised controlled trials
1. (systematic adj review*).tw.	1. (randomised controlled trial).pt
2. (data adj synthesis).tw.	2. (controlled clinical trial).pt
3. (published adj studies).ab.	3. (randomised controlled trial).tw
4. (data adj extraction).ab.	4. rct.tw
5. meta-analysis/	5. (double blind method).tw
6. meta-analysis.ti.	6. (single blind method).tw
7. guideline.pt.	7. (clinical adj trial).tw
8. practice guideline.pt.	8. or/1-7
9. comment.pt.	
10. letter.pt.	
11. editorial.pt.	
12. animal/	
13. human/	
14. 12 not (12 and 13)	
15. ADHD search terms	
16. other search terms	
17. combined search	
18. 17 not (9 or 10 or 11 or 14)	
19. or/1-8	
20. 18 and 19	

References

1. National Health and Medical Research Council (NHMRC). A guide to the development, implementation and evaluation of clinical practice guidelines. 1998.
2. National Health and Medical Research Council (NHMRC). How to review the evidence: systematic identification and review of the scientific literature. 1999.
3. National Health and Medical Research Council (NHMRC). How to use the evidence: assessment and application of scientific evidence. 2000.
4. National Health and Medical Research Council (NHMRC). NHMRC additional levels of evidence and grades of recommendations for developers of guidelines. Stage 2 Consultation 2008-2010. 2008.
5. Oxman AD, Guyatt GH. Validation of an index of the quality of review articles. *J Clin Epidemiol* 1991; 44:1271-8.
6. Oxman AD, Guyatt GH, Singer J, Goldsmith CH, Hutchison BG, Milner RA, Streiner DL. Agreement among reviewers of review articles. *J Clin Epidemiol* 1991; 44:91-8.
7. Hoving JL, Gross AR, Gasner D, Kay T, Kennedy C, Hondras MA, Haines T, Bouter LM. A critical appraisal of review articles on the effectiveness of conservative treatment for neck pain. *Spine* 2001; 26:196-205.

DRAFT

APPENDIX E: SYSTEMATIC REVIEW RESEARCH QUESTIONS

Assessment and Diagnosis

1. In individuals suspected of having ADHD does the use of measures of impairment, in addition to DSM-IV/ICD-10, further inform diagnosis and assessment?
2. In adolescents and adults with ADHD are retrospective self-reports of symptoms in childhood accurate?
3. In preschoolers, children or adolescents with ADHD is there consensus between parent and teacher reports of ADHD symptoms when assessed with parallel instruments?
4. In individuals with ADHD is there consensus between third party (parent, teacher or family member) and self-reports of ADHD symptoms when assessed with parallel instruments?
5. In preschoolers, children or adolescents with ADHD does the psychiatric status of the parent influence parent reports in the diagnosis and assessment for ADHD?
6. In individuals suspected of having ADHD does the inclusion of neuropsychological assessment measures, in addition to DSM-IV/ICD-10, further inform diagnosis and assessment?
7. In individuals suspected of having ADHD does the inclusion of neurophysiological techniques, in addition to DSM-IV/ICD-10, further inform diagnosis?
8. In individuals suspected of having ADHD does the inclusion of neuroimaging techniques, in addition to DSM-IV/ICD-10, further inform diagnosis?

Management: psychosocial interventions

9. For individuals with ADHD, do psychosocial interventions, compared to no intervention or standard care, affect outcomes?
10. For preschoolers, children and adolescents with ADHD, does behaviour management in the form of parent training, compared to no intervention or standard care, affect outcomes?
11. For individuals with ADHD, what are the moderators and mediators of treatment response with psychosocial interventions?
12. When comorbidities are present in individuals with ADHD, do psychosocial interventions, compared to no intervention or standard care, affect outcomes?

Management: medication

- 13a. For individuals with ADHD, do stimulant pharmacological interventions, compared with placebo, improve outcomes?
- 13b. For individuals with ADHD does the use of stimulant medications for 1 year or more, compared with placebo or standard care, affect outcomes?
- 13c. For individuals with ADHD who are taking stimulant medication, what are the main side effects?
- 14a. For individuals with ADHD, does the use of atomoxetine, compared with placebo, improve outcomes?
- 14b. For individuals with ADHD does the use of atomoxetine for 1 year or more, compared with placebo or standard care, affect outcomes?
- 14c. For individuals with ADHD who are taking atomoxetine, what are the main side effects?

15. For individuals with ADHD, do other pharmacological interventions compared with placebo, affect outcomes?
 - a. clonidine
 - b. modafinil
 - c. selegiline
 - d. guanfacine
 - e. nicotine patch
 - f. bupropion
 - g. risperidone
16. For individuals with ADHD, do any pharmacological interventions confer an advantage over any other pharmacological interventions?
- 17a. When comorbidities are present in individuals with ADHD, do pharmacological interventions, compared to placebo, improve outcomes?
 - a. anxiety
 - b. bipolar disorder
 - c. depression
 - d. disruptive behaviour disorder
 - e. epilepsy
 - f. tic disorders / Tourette syndrome
- 17b. For individuals with ADHD who are taking medication, what is the risk of developing first-onset tics or worsening existing tics?
- 17c. When developmental disabilities are present in individuals with ADHD, do pharmacological interventions, compared to placebo, improve outcomes?
 - a. learning disorders
 - b. developmental or intellectual disabilities
 - c. autism spectrum disorders
18. For preschoolers, children and adolescents with ADHD who are taking medication, what is the risk of impaired growth?
19. For individuals with ADHD who are taking medication, what is the risk of cardiovascular problems?
20. For individuals with ADHD who are taking medication, what is the risk of psychiatric adverse effects?
21. For individuals with ADHD, does the use of pharmacological interventions, compared to no intervention, alter the risk for substance abuse or medication misuse?
22. For individuals with ADHD and substance use disorders, do pharmacological or psychosocial interventions affect outcomes?

Management: medication compared to and combined with other strategies

23. For individuals with ADHD, do psychosocial interventions, compared to pharmacological interventions, affect outcomes?
24. For individuals with ADHD, do psychosocial interventions used alongside pharmacological interventions, compared with pharmacological interventions alone, affect outcomes?

Management in an education setting

- 25.** For children and adolescents with ADHD, do school-based interventions, compared to no intervention or standard care, affect outcomes?
- 26.** For children and adolescents with ADHD, do peer support, tutoring or mentoring, compared to no intervention or standard care, affect outcomes?
- 27.** For adults with ADHD, do University/TAFE-based interventions that address ADHD, compared to no intervention or standard care, affect outcomes?

Management: complementary and alternative strategies

- 28.** For individuals with ADHD, do diet restrictions (artificial colours, artificial flavours and preservatives), compared with no intervention or standard care, affect outcomes?
- 29.** For individuals with ADHD, does diet supplementation with fatty acids, compared with placebo or standard care, affect outcomes?
- 30.** For individuals with ADHD, does chiropractics, compared with no intervention or standard care, affect outcomes?
- 31.** For individuals with ADHD, does behavioural optometry, compared with no intervention or standard care, affect outcomes?
- 32.** For individuals with ADHD, does biofeedback, compared with no intervention or standard care, affect outcomes?
- 33.** For individuals with ADHD, does homeopathy, compared with no intervention or standard care, affect outcomes?
- 34.** For individuals with ADHD, do cerebellar therapies (such as the Dore program), compared with no intervention or standard care, affect outcomes?
- 35.** For individuals with ADHD, does participation in sport or exercise programs, compared with no intervention or standard care, affect outcomes?
- 36.** For individuals with ADHD, do sensory diets / sensory integrative treatments, compared with no intervention, affect outcomes?

ADHD in society

- 37.** For individuals with ADHD, does the use of interventions (pharmacological, psychosocial or other), compared with no intervention, improve driving performance?

APPENDIX F: DATA-EXTRACTION AND CRITICAL APPRAISAL TABLES

Data extraction and critical appraisal form: systematic reviews

Review Question		
STUDY DETAILS		
Reference [1]		
Affiliation/source of funds [2]		
Number of included studies [3]		
Study design [4]		
Location/setting [5]		
Participants [6] [7]		
Population Characteristics:		
Study Group (s)	Comparator group (s)	
Outcome measures [8]		
Outcome/description	Measure used	Relevant to question?
QUALITY ASSESSMENT (INTERNAL VALIDITY)		
Does the study address an appropriate and clearly focused question? [9]		
The Overview Quality Assessment Questionnaire (OQAQ) [10]		
Score as either: Yes or No if the criterion is explicitly met OR Partially or Cannot Tell if the methods were reported incompletely or not at all		
Q1: Were the search methods used to find evidence (primary studies) on the primary question(s) stated?		
Q2: Was the search for evidence reasonably comprehensive?		
Q3: Were the criteria used for deciding which studies to include in the review reported?		
Q4: Was bias in the selection of studies avoided?		
Q5: Were the criteria used for assessing the validity of the included studies reported?		
Q6: Was the validity for each study cited assessed using appropriate criteria (either in selecting studies for inclusion or in analysing the studies that are cited)?		
Q7: Were the methods used to combine the findings for the relevant studies (to reach a conclusion) reported?		
Q8: Were the findings of the relevant studies combined appropriately relative to the primary question the overview addresses?		
Q9: Were the conclusions made by the author(s) supported by the data &/or analysis reported in the overview?		
Score:		
Overall quality assessment: [11]		

RESULTS			
Was Meta-analysis done? [12]			
Results			
Outcome	Study Group Number / Total number	Comparator Group Number / Total number	Statistic Combined measure (CI)
Review results [13] <ul style="list-style-type: none"> • The quality of individual studies is indicated as good (***) , adequate (**) or poor (*) • Association with industry is indicated by I. • Not reported is indicated as NR 			
Outcomes:			
Heterogeneity analysis [14]			
Descriptive results			
EXTERNAL VALIDITY			
Generalisability [15]			
Applicability [16]			
OVERALL CONCLUSION			
Authors comments [17]			
Reviewers comments [18]			

DRAFT

Explanatory notes for data-extraction and critical appraisal: systematic reviews

STUDY DETAILS

Enter the following details as indicated:

[1] Full reference citation details.

[2] Details of how the study was funded or other relevant affiliations of the authors (designed to expose potential conflicts of interest, such as drug company funding for the drug being trialled).

[3] The study type with additional detail where relevant.

[4] As per the NHMRC levels of evidence, provided at page 8 of the NHMRC toolkit publication: *How to Use the Evidence: Assessment and Application of Scientific Evidence*.

[5] Country/setting (e.g. hospital, primary care, hospice).

[6] Provide information about the study groups and comparators in the included studies.

[7] Also provide information on the size of the study groups in the included studies.

[8] List the outcomes studied and the measures used. Indicate which outcomes are relevant to the review inclusion criteria (yes or no).

QUALITY ASSESSMENT (INTERNAL VALIDITY)

[9] Answer yes or no. If yes list the question addressed in the study.

[10] **The Overview Quality Assessment Questionnaire (OQAQ).**

Each question is scored as either: **Yes** or **No** if the criterion is explicitly met OR **Partially** or **Cannot Tell** if the methods were reported incompletely or not at all.

Notes on individual questions:

Q1: Were the search methods used to find evidence (primary studies) on the primary question(s) stated?

- If yes briefly describe the search methods.

Q2: Was the search for evidence reasonably comprehensive?

- Briefly describe any limitations or concerns.

Q3: Were the criteria used for deciding which studies to include in the review reported?

- Briefly describe any limitations or concerns.

Q4: Was bias in the selection of studies avoided?

- If yes describe how.

Q5: Were the criteria used for assessing the validity of the included studies reported?

- If yes describe the method or rating scale used.

Q6: Was the validity for each study cited assessed using appropriate criteria (either in selecting studies for inclusion or in analysing the studies that are cited)?

- Describe any concerns about criteria used.

Q7: Were the methods used to combine the findings for the relevant studies (to reach a conclusion) reported?

- State method (e.g. meta-analysis or narrative).

Q8: Were the findings of the relevant studies combined appropriately relative to the primary question the overview addresses?

- Briefly describe how combined or not and why.

Q9: Were the conclusions made by the author(s) supported by the data &/or analysis reported in the overview?

- Briefly describe any limitations or concerns.

Scoring mechanics for the modified 9-item OQAQ

(CAT for Systematic Reviews & Meta-Analysis)

Criteria Used to Assess the Scientific Quality of Selected Review Articles (1-3).

***Search methods (maximum score = 4)**

Q1. Were the search methods used to find primary studies on the primary question(s) stated?

2 points: Yes; includes description of databases searched, search strategy & years reviewed (described well enough to duplicate)

1 point: Partially; partial description of methods, but not sufficient to duplicate search

0 points: No; no description of search methods

Q2. Was the search for evidence reasonably comprehensive?

2 points: Yes; must include at least one computerised database search as well as a search of unpublished or no indexed literature (for example: manual searches or letters to primary authors)

1 point: Cannot tell; search strategy partially comprehensive (for example: at least one of the strategies in the foregoing section were performed)

0 points: No; search not comprehensive or not described well enough to make a judgement

***Selection methods (maximum score = 4)**

Q3. Were the criteria used for deciding which studies to include in the review reported?

2 points: Yes; inclusion and exclusion criteria clearly defined

1 point: Partially; reference to inclusion and exclusion criteria can be found in the paper but are not defined clearly enough to duplicate

0 points: No; no criteria defined

Q4. Was bias in the selection of articles avoided?

2 points: Yes; key issues influencing selection bias were covered. Two of three of the following bias avoidance strategies were used: two or more assessors independently judged study relevance and selection using predetermined criteria, reviewers were blinded to identifying features of study (i.e. journal title, author(s), funding source), and assessors were blinded to treatment outcome.

1 point: Cannot tell; if only one of the three strategies above were used

0 points: No; selection bias was not avoided or was not discussed

***Validity assessment (maximum score = 4)**

Q5. Were the criteria used for assessing the validity for the studies that were reviewed reported?

2 points: Yes; criteria defined explicitly

1 point: Partially; some discussion or reference to criteria but not sufficiently described to duplicate

0 points: No; validity or methodological quality criteria not used or not described

Q6. Was the validity for each study cited assessed using appropriate criteria (either in selecting studies for inclusion or in analysing the studies that are cited)?

2 points: Yes; the criteria used address the major factors influencing bias (for example: population, intervention, outcomes, follow-up)

1 point: Partially; some discussion of methodological review strategy but not clearly described with predetermined criteria

0 points: No; criteria not used or not described

***Synthesis (maximum score = 6)**

Q7. Were the methods used to combine the findings for the relevant studies (to reach a conclusion) reported?

2 points: Yes; qualitative or quantitative methods are acceptable

1 point: Partially; partial description of methods to combine and tabulate; not sufficient to duplicate

0 points: Methods of combining studies not stated or described

Q8. Were findings of the relevant studies combined appropriately relative to the primary question the review addresses?

2 points: Yes; combining of studies appears acceptable

1 point: Cannot tell; should be marked if in doubt

0 points: No; no attempt was made to combine findings, and no statement was made regarding the inappropriateness of combining findings; should be marked if a summary (general) estimate was given anywhere in the abstract, the discussion, or the summary section of the paper, and the method of deriving the estimate was not described, even if there is a statement regarding the limitations of combining the findings of the studies reviewed.

Q9. Were the conclusions made by author(s) supported by the data or analysis reported in the review?

2 points: Yes; data, not merely citations, were reported that support the main conclusions regarding the primary question(s) that the overview addresses

1 point: Partially

0 points: No; conclusions not supported or unclear

Scoring (maximum score = 18) > Add up the scores from questions 1–9. Maximum quality score is 18 points

[11] Describe in words your assessment of the overall quality of the study. Good (meets all criteria), adequate (meets $\geq 50\%$ of criteria) or poor (meets $< 50\%$ of criteria). Also include any further comments on particular concerns or flaws. Is the study quality good enough that you have confidence in the results?

RESULTS

[12] Indicate if data have been combined in a meta-analysis. If a meta-analysis has been done, insert the results for each dichotomous (yes/no) or continuous outcome measured, including the outcome measure (RR, OR etc.) with 95% CIs and P-value. Add extra columns (by splitting cells) or rows, as required. (Forest plots of the data may also be helpful.)

[13] For outcomes where there is not a meta-analysis, describe the overall findings of the review, including outcome measures with 95% CIs and P-values for key findings.

- When critical appraisal of individual studies has been done indicate individual study quality: good (***), adequate (**) or poor (*).
- For individual studies indicate whether an association with industry has been reported by the authors. (Denoted as “I”)

[14] Insert the results of a heterogeneity analysis (I^2 /Cochran Q) and discuss any heterogeneity issues.

EXTERNAL VALIDITY

Include a brief discussion of the following questions:

[15] Are the subjects in the study similar to those being considered for our review?

[16] Does this study show any relevant side effects that would outweigh health messages related to this risk factor/intervention?

OVERALL CONCLUSION

[17] Add the author’s comments regarding the interpretation or implications of this study.

[18] Add your overall conclusion regarding the interpretation or implications of this study.

Data extraction and critical appraisal form: intervention / risk factor / prognostic indicator studies (delete whichever does not apply)

REVIEW QUESTION		
STUDY DETAILS		
Reference [1]		
Affiliation/source of funds [2]		
Study design [3]		
Level of evidence [4]		
Location/setting [5]		
Study Group [6]	Comparator(s) [7]	
Sample size [8]	Sample size [9]	
Participants		
Descriptions [10]		
Length of follow up: [11]		
Were the interventions / risk factors / prognostic factors adequately described?		
yes	no	not clear
Outcome measures [12]		
Outcome/description	Measure used	Relevant to question?
QUALITY ASSESSMENT (Internal validity)		
Quality assessment – experimental studies (eg. RCTs / pseudorandomised studies)		
Allocation: [13]		
Comparison of study groups: [14]		
Blinding: [15]		
Treatment and measurement bias: [16]		
Follow-up (ITT): [17]		
Overall quality assessment: [18]		

Quality assessment – observational studies (eg. cohort studies / case control studies)		
Has selection bias been minimised: [13]		
Adjustments for confounding: [14]		
Blinding [15]		
Follow-up for final outcomes: [16]		
Measurement bias: [17]		
Overall quality assessment: [18]		
Results [19]		
<i>Dichotomous Data</i>		
Outcome	Intervention Number / Total number	Comparator Number / Total number
<i>Continuous Data</i>		
Outcome	Group A mean & SD (number)	Group B mean & SD (number)
Clinical Importance (1-4): [20]		
Relevance (1-5): [21]		
Any other adverse effects: [22]		
EXTERNAL VALIDITY		
Generalisability [23]		
Applicability [24]		
AUTHORS COMMENTS [25]		
REVIEWERS COMMENTS [26]		

Explanatory notes for data-extraction and critical appraisal: intervention / risk factor / prognostic indicator studies

STUDY DETAILS

Enter the following details into the table as indicated:

- [1] Full reference citation details.
- [2] Details of how the study was funded or other relevant affiliations of the authors (designed to expose potential conflicts of interest, such as drug company funding for the drug being trialled).
- [3] The study type, with additional detail where relevant.
- [4] As per the NHMRC levels of evidence, provided at page 8 of the NHMRC toolkit publication: *How to Use the Evidence: Assessment and Application of Scientific Evidence*.
- [5] Country/setting (e.g. hospital, primary care, hospice).
- [6] The intervention used as a comparison in the study. There may be more than one comparator. Particular reference should be made to any differences from Australian current practice.
- [7] Provide detail on the intervention/treatment, risk factor or prognostic indicator of interest.
- [8] Number of participants enrolled in the intervention/treatment group.
- [9] Number of participants enrolled in the comparison/control group(s).
- [10] Any factors that may confound/influence the results and/or the external validity of the results.
- [11] Length of follow-up of the participants.
- [12] The outcomes studied (list all outcomes in terms of primary and secondary outcomes). Indicate which outcomes are relevant to the review/guidelines inclusion criteria (yes or no).

QUALITY ASSESSMENT (INTERNAL VALIDITY)

Experimental studies (e.g. RCTs / pseudo-randomised studies) (4)

Enter the following details about the study:

- [13] Intervention: What method was used to assign patients to treatment or control groups? Was the allocation list concealed?
Aetiology: Are the subjects representative of the underlying population?
Prognosis: Are the subjects representative of the underlying population and were they enrolled at a uniform time in the disease progression (i.e. inception cohort)?
- [14] The results of the group analysis, noting any clinically or statistically significant differences between the groups at study inception.
- [15] Whether the participants, outcome assessors and (if different) investigators were blinded to the group allocation.
- [16] Indicate whether, aside from the experimental treatment, the groups were treated and measured the same.
- [17] The proportion of participants that were followed up and whether all participants were analysed according to the group to which they were initially allocated, regardless of whether or not they dropped out, fully complied with the treatment, or crossed over and received the other treatment ("intention to treat analysis" – ITT).
- [18] Describe your assessment of the overall quality of the study as either good (meets all criteria), adequate (meets $\geq 50\%$ of criteria) or poor (meets $< 50\%$ of criteria). Also include any further comments on particular concerns or flaws. Is the study quality good enough that you have confidence in the results?

QUALITY ASSESSMENT (INTERNAL VALIDITY)

Observational studies (e.g. cohort studies / case control studies) (4)

Enter the following details about the study:

[13] Has selection bias been minimised? The method used to select patients. Ideally a consecutive or random sample of patients at a similar time point in their disease. Comparable criteria should be used to enrol subjects and controls. For cohort studies, a prospective cohort is best (some cohort studies allocate subjects retrospectively).

[14] Have adequate adjustments been made for residual confounding?

[15] Whether the participants, outcome assessors and (if different) investigators were blinded to any aspect of the study.

[16] The proportion of participants that were followed up.

[17] Measurement or misclassification bias. Outcomes should preferably be measure blind to the prognostic factors being considered.

[18] Describe your assessment of the overall quality of the study as either good (meets all criteria), adequate (meets $\geq 50\%$ of criteria) or poor (meets $< 50\%$ of criteria). Also include any further comments on particular concerns or flaws. Is the study quality good enough that you have confidence in the results?

RESULTS [19]

Allowing one row for each relevant outcome, enter the following data from the results of the trial:

- The outcome relevant for this entry in the database. (Note: more than one table may be required if there are several outcomes relevant to different clinical questions/guidelines.)
- For binary outcomes, show numbers of patients with the outcome. For continuous outcomes, show means \pm standard deviations; or medians and interquartile ranges.
- For binary outcomes, show numbers of patients with the outcome. For continuous outcomes, show means \pm standard deviations; or medians and interquartile ranges. Add number of columns as needed (e.g. 3-arm trials).
- Absolute and relative measures of effect and measure of variability, e.g. risk differences (absolute risk reduction or absolute risk increase), mean differences, relative risk, odds ratio.
- A measure of benefit, when the treatment increases the probability of a good event. The number needed to treat to benefit (NNT) = the number of participants who must receive the treatment to create one additional improved outcome in comparison with the control treatment; calculated as $1/\text{absolute benefit increase}$, rounded up to the next highest whole number.
- A measure of harm, when the treatment increases the risk of specified adverse outcomes of a condition or reduces the probability of a good event. The number needed to treat to harm (NNH) = the number of patients who, if they receive the treatment, would lead to one additional person being harmed compared with patients who receive the control treatment; calculated as $1/\text{absolute risk increase}$, rounded up to the next highest whole number.
- 95% confidence interval (CI) for all measures, if available, otherwise use P-value (be explicit on what comparison the P-value relates to).

[20] Insert the words corresponding to the appropriate rating from the scale provided at page 23 of the NHMRC toolkit publication: *How to Use the Evidence: Assessment and Application of Scientific Evidence*.

Classifying the size of the effect (4)

Ranking	Clinical Importance of Benefit
1	A clinically important benefit for the full range of plausible estimates. The confidence limit closest to the measure of no effect (the “null”) rules out a clinically unimportant effect of the intervention.
2	The point estimate of effect is clinically important BUT the confidence interval includes clinically unimportant effects.
3	The confidence interval does not include any clinically important effects.
4	The range of estimates defined by the confidence interval includes clinically important effects BUT the range of estimates defined by the confidence interval is also compatible with no effect, or a harmful effect.

[21] Insert the words corresponding to the appropriate rating from the scale provided at page 28 of the NHMRC toolkit publication: *How to Use the Evidence: Assessment and Application of Scientific Evidence*.

Classifying the relevance of the evidence (4)

Ranking	Relevance of the evidence
1	Evidence of an effect on patient-relevant clinical outcomes, including benefits and harms, and quality of life and survival.
2	Evidence of an effect on a surrogate outcome that has been shown to be predictive of patient-relevant outcomes for the same intervention.
3	Evidence of an effect on proven surrogate outcomes but for a different intervention.
4	Evidence of an effect on proven surrogate outcomes but for a different intervention and population.
5	Evidence confined to unproven surrogate outcomes.

[22] Information on any adverse events mentioned in the study.

EXTERNAL VALIDITY

Include a brief discussion of the following questions:

[23] Are the patients in the study so different from those being considered for the guideline that the results may not be applicable to them?

[24] Will the potential benefits outweigh any potential harms of treatment in the guideline population?

[25] Add the author’s comments regarding the interpretation or implications of this study.

[26] Add your overall comments regarding the interpretation or implications of this study.

Data extraction and critical appraisal form: diagnostic studies

Review Question		
STUDY DETAILS		Paper no.
Reference [1]		
Affiliation/source of funds [2]		
Study design [3]	Level of evidence [4]	Location/setting [5]
Index test [6]	Disease of interest [8]	
Reference test [7]	Sample size [9]	
Population characteristics [10]		
Other details (eg length of follow-up) [11]		
Results [12]		
Sensitivity		
Specificity		
Positive predictive value (PPV)		
Negative predictive value (NPV)		
INTERNAL VALIDITY (How well was the study done?)		
Recruitment		
Has selection bias been minimised? (consecutive sample is best) [13]		
Maintenance (follow up)		
Has verification bias been minimised? (by obtaining the endpoint of the reference standard for all subjects). If not, what per cent of subjects were verified? [14]		
Measurement		
Is the reference standard valid?		
Are the test and reference standards measured independently (ie blind to each other) in the same patients? (and/or were the reference standard endpoints objective?)		
Are the tests measured independently of other clinical and test information?		
If index tests are being compared, have they been assessed independently (blind to each other) in the same patients? [15]		

Confounding: If the reference standard is a later event that the test aims to predict, is any intervention decision blind to the test result? [16]	
Overall quality [17]:	
EXTERNAL VALIDITY	
Generalisability [18]	
Applicability [19]	
OVERALL CONCLUSION [20]	

Explanatory notes for data-extraction and critical appraisal: diagnostic studies

STUDY DETAILS

Enter the following details into the table as indicated:

[1] Full reference citation details.

[2] Details of how the study was funded or other relevant affiliations of the authors (designed to expose potential conflicts of interest, such as drug company funding for the drug being trialled).

[3] The study type (e.g. diagnostic cross-sectional study), with additional detail where relevant (include whether the study was with consecutive or non-consecutive patients).

[4] As per the NHMRC revised levels of evidence.

[5] Country/setting (e.g. hospital, primary care, hospice).

[6] State the test(s) being studied (index test).

[7] State the reference test ("gold standard").

[8] Describe the disease being diagnosed.

[9] Number of participants enrolled in the study group.

[10] Describe the population characteristics of the participants (see [13] below).

[11] Describe any other characteristics of the disease, tests or participants that might affect the results, including the length of follow-up of the participants to obtain test results (e.g. if the reference standard is onset of the disease).

[12] The results of the study. Record the sensitivity and specificity of the index test as well as other relevant measures (such as PPV and NPV).

INTERNAL VALIDITY (QUALITY ASSESSMENT)

Enter the following details about the study:

(See also the NHMRC handbook, *How to Review the Evidence* [maroon book], pages 60–64)

[13] Recruitment: Provide information on how the people are recruited for the study. It is ideal if the test is applied to the full spectrum of patients — those with mild, severe, early and late cases of the target disorder. It is also best if the patients are consecutive admissions so that selection bias is minimised (random selection is next best).

[14] Maintenance: To avoid verification bias, the endpoint of the reference standard (i.e. whether the patients are positive or negative for the condition) should be measured for all the participants. In cases where this requires follow-up for a period of time, the follow-up should be long enough to be certain of the outcome.

[15] Measurement: The index test and reference standard should be applied to each patient independently and blindly and independently of other clinical decisions and tests. Those who interpret the results of one test should not be aware of the results of the other test. If the outcome is objective (e.g. onset of a clearly recognisable disease), then blinding is less critical.

If two index tests are being compared, they should ideally be applied independently in the same participants (next best, randomly allocated).

Note: The index test should be well enough described in the paper to be reproduced.

[16] Confounding: If the reference standard measures a later event that the test aims to predict, any intervention decision should be blind to the test result. Otherwise, the test may appear poorly predictive because the treatment is effective in preventing poor outcomes the test aims to predict.

[17] Describe your assessment (in words) of the overall quality of the study. Is the study quality good enough that you have confidence in the results?

EXTERNAL VALIDITY

Include a brief discussion of the following questions:

[18] Are the subjects in the study similar to those being considered for the health messages?

[19] Does this study show any relevant adverse effects that would outweigh health messages related to this diagnostic test?

OVERALL CONCLUSION

[20] Add your overall comments regarding the interpretation or implications of this study.

DRAFT

References

1. Oxman AD, Guyatt GH. Validation of an index of the quality of review articles. *J Clin Epidemiol* 1991; 44:1271-8.
2. Oxman AD, Guyatt GH, Singer J, Goldsmith CH, Hutchison BG, Milner RA, Streiner DL. Agreement among reviewers of review articles. *J Clin Epidemiol* 1991; 44:91-8.
3. Hoving JL, Gross AR, Gasner D, Kay T, Kennedy C, Hondras MA, Haines T, Bouter LM. A critical appraisal of review articles on the effectiveness of conservative treatment for neck pain. *Spine* 2001; 26:196-205.
4. National Health and Medical Research Council (NHMRC). How to use the evidence: assessment and application of scientific evidence. 2000.

DRAFT

APPENDIX G: NHMRC EVIDENCE STATEMENT FORM

NHMRC additional levels of evidence and grades for recommendations for developers of guidelines STAGE 2 CONSULTATION 2008–2010

Key question(s):		Evidence table ref:
1. Evidence base (<i>number of studies, level of evidence and risk of bias in the included studies</i>)		
	A	Several Level I or II studies with low risk of bias
	B	One or two Level II studies with low risk of bias or SR/multiple Level III studies with low risk of bias
	C	Level III studies with low risk of bias or Level I or II studies with moderate risk of bias
	D	Level IV studies or Level I to III studies with high risk of bias
2. Consistency (<i>if only one study was available, rank this component as "not applicable"</i>)		
	A	All studies consistent
	B	Most studies consistent and inconsistency can be explained
	C	Some inconsistency, reflecting genuine uncertainty around question
	D	Evidence is inconsistent
	NA	Not applicable (one study only)
3. Clinical impact (<i>Indicate in the space below if the study results varied according to some <u>unknown</u> factor (not simply study quality or sample size) and thus the clinical impact of the intervention could not be determined</i>)		
	A	Very large
	B	Moderate
	C	Slight
	D	Restricted
4. Generalisability		
	A	Evidence directly generalisable to target population
	B	Evidence directly generalisable to target population with some caveats
	C	Evidence not directly generalisable to the target population but could be sensibly applied
	D	Evidence not directly generalisable to target population and hard to judge whether it is sensible to apply

5. Applicability		
	A	Evidence directly applicable to Australian healthcare context
	B	Evidence applicable to Australian healthcare context with few caveats
	C	Evidence probably applicable to Australian healthcare context with some caveats
	D	Evidence not applicable to Australian healthcare context
Other factors <i>(Indicate here any other factors that you took into account when assessing the evidence base (for example, issues that might cause the group to downgrade or upgrade the recommendation))</i>		
EVIDENCE STATEMENT MATRIX		
<i>Please summarise the development group's synthesis of the evidence relating to the key question, taking all the above factors into account.</i>		
Component	Rating	Description
1. Evidence base		
2. Consistency		
3. Clinical impact		
4. Generalisability		
5. Applicability		
<i>Indicate any dissenting opinions</i>		
RECOMMENDATION <i>What recommendation(s) does the guideline development group draw from this evidence? Use action statements where possible.</i>		GRADE OF RECOMMENDATION

IMPLEMENTATION OF RECOMMENDATION

Please indicate yes or no to the following questions. Where the answer is yes please provide explanatory information about this. This information will be used to develop the implementation plan for the Guidelines.

Will this recommendation result in changes in usual care?	YES
	NO
Are there any resource implications associated with implementing this recommendation?	YES
	NO
Will the implementation of this recommendation require changes in the way care is currently organised?	YES
	NO
Are the guideline development group aware of any barriers to the implementation of this recommendation?	YES
	NO

APPENDIX H: ASSESSMENT SCALES AND QUESTIONS

The SWAN Rating Scale

The SWAN Rating Scale

James M. Swanson, Ph.D.
University of California, Irvine

Child's Name: _____ Gender: _____ Age: _____ Grade: _____

Parent who Completed: _____

Date Completed: _____

Children differ in their abilities to focus attention, control activity, and inhibit impulses. For each item listed below, how does this child compare to other children of the same age? Please select the best rating based on your observations over the past month.

Compared to other children, how does this child do the following:

	far below	below	average	above	far above
1. Give close attention to detail and avoid careless mistakes	_____	_____	_____	_____	_____
2. Sustain attention on tasks or play activities	_____	_____	_____	_____	_____
3. Listen when spoken to directly	_____	_____	_____	_____	_____
4. Follow through on instructions & finish school work/chores	_____	_____	_____	_____	_____
5. Organise tasks and activities	_____	_____	_____	_____	_____
6. Engage in tasks that require sustained mental effort	_____	_____	_____	_____	_____
7. Keep track of things necessary for activities	_____	_____	_____	_____	_____
8. Ignore irrelevant stimuli	_____	_____	_____	_____	_____
9. Remember daily activities	_____	_____	_____	_____	_____
10. Sit still (control movement of hands/ feet or control squirming)	_____	_____	_____	_____	_____
11. Stay seated (when required by class rules/social conventions)	_____	_____	_____	_____	_____
12. Controls motor activity (inhibit inappropriate running/climbing)	_____	_____	_____	_____	_____
13. Play quietly (keep noise level reasonable)	_____	_____	_____	_____	_____
14. Settle down and rest (control constant activity)	_____	_____	_____	_____	_____
15. Controls verbal activity (control excess talking)	_____	_____	_____	_____	_____
16. Reflect on questions (control blurting out answers)	_____	_____	_____	_____	_____
17. Await turn (stand in line and take turns)	_____	_____	_____	_____	_____
18. Enter into conversations & games (control interrupting/intruding)	_____	_____	_____	_____	_____

Note: While the SWAN has a seven-point scale, Rasch modelling of data from over 7,000 Australian children indicates the five point scale is more appropriate

Child Behaviour Questions

PLEASE COMPLETE THIS QUESTIONNAIRE FOR:

_____ (Insert name of child) Date of completion: _____

Listed below are descriptions of children's behaviour or the problems that they sometimes have. Please indicate how applicable you think each item is for this child now or within the time period specified (eg, six months) when compared to other children of the same age.

Circle the 0 if the item does not apply to this child at all. Circle the 1 if the item applies just a little or sometimes. Circle the 2 if the item applies pretty much or often. Circle the 3 if the item applies very much or very often.

Compared to other children of the same age, how applicable are the following items (1 to 26) for this child now or within the past six months? Please circle the appropriate response.

0 = not at all **1** = Just a little/sometimes **2** = Pretty much/often **3** = Very much/Very often

- | | | |
|-----|--|----------------|
| 1) | Is easily distracted by external stimuli (e.g. noise or conversation). | 0 1 2 3 |
| 2) | Has trouble following through on instructions and fails to finish school work, chores or duties. | 0 1 2 3 |
| 3) | Has difficulty keeping attention on work or games. | 0 1 2 3 |
| 4) | Does not seem to listen when spoken to directly. | 0 1 2 3 |
| 5) | Loses things necessary for tasks or activities at home or school (e.g. pencils, toys or tools). | 0 1 2 3 |
| 6) | Has difficulty organising tasks and activities. | 0 1 2 3 |
| 7) | Fails to give close attention to details in schoolwork, work or other activities. | 0 1 2 3 |
| 8) | Is forgetful in daily activities. | 0 1 2 3 |
| 9) | Avoids, dislikes or is reluctant to engage in tasks that require prolonged concentration
(e.g. schoolwork or homework). | 0 1 2 3 |
| 10) | Is "on the go" or acts as if "driven by a motor." | 0 1 2 3 |
| 11) | Leaves seat in classroom or other situations in which remaining seated is expected. | 0 1 2 3 |
| 12) | Has difficulty playing or engaging in leisure activities quietly. | 0 1 2 3 |
| 13) | Runs about or climbs excessively in situations where it is inappropriate. | 0 1 2 3 |
| 14) | Fidgets with hands or feet or squirms in seat. | 0 1 2 3 |

- 15) Often talks excessively. **0 1 2 3**
- 16) Has difficulty awaiting his/her turn. **0 1 2 3**
- 17) Blurts out answers to questions before they have been completed. **0 1 2 3**
- 18) Interrupts or intrudes on others (e.g. butts into conversations or games). **0 1 2 3**
- 19) Argues with you, his/her teacher and/or other adults. **0 1 2 3**
- 20) Loses his/her temper or throws tantrums when he/she does not get his/her own way. **0 1 2 3**
- 21) Actively defies or refuses to comply with adults requests or rules. **0 1 2 3**
- 22) Deliberately annoys people. **0 1 2 3**
- 23) Blames others for his/her own mistakes or misbehaviour. **0 1 2 3**
- 24) Is touchy or easily annoyed by others. **0 1 2 3**
- 25) Is angry and resentful. **0 1 2 3**
- 26) Is spiteful and vindictive. **0 1 2 3**

DRAFT

The SKAMP Rating Scale

Child's Name: _____

Gender: _____ Age: _____ Grade: _____

Teacher who Completed: _____

Date Completed: _____

Children differ in their abilities to focus attention, control activity, and inhibit impulses. For each item listed below, how does this child compare to other children of the same age? Please select the best rating based on your observations over the past month.

Compared to other children, how does this child do the following:

	far below	below	average	above	far above
1. Get started on classroom assignments	_____	_____	_____	_____	_____
2. Stay on task for an entire classroom period	_____	_____	_____	_____	_____
3. Complete work on classroom assignments	_____	_____	_____	_____	_____
4. Perform written work accurately in the classroom	_____	_____	_____	_____	_____
5. Work carefully and neatly on classroom assignments	_____	_____	_____	_____	_____
6. Make transitions to the next topic or classroom period	_____	_____	_____	_____	_____
7. Remain quiet according to classroom rules	_____	_____	_____	_____	_____
8. Stay seated according to classroom rules	_____	_____	_____	_____	_____
9. Comply with the usual requests and directions of the teacher	_____	_____	_____	_____	_____
10. Follow the rules established for the school	_____	_____	_____	_____	_____

Scales for Adult ADHD

Current Behavior Scale (CBS) subscale (1)

Item number and description	
22	Have trouble planning ahead or preparing for upcoming events
27	Can't seem to accomplish goals I set for myself
31	Can't seem to hold in mind things I need to remember to do
44	Easily frustrated
46	Have difficulty motivating myself to stick with my work and get it done
64	Have trouble doing what I tell myself to do
66	Lack self-discipline
70	Have trouble organising my thoughts

Short Adult ADHD Screening Scale adapted from Kessler et al (2)

	Never	Rarely	Sometimes	Often	Very Often
How often do you have trouble wrapping up the fine details of a project, once the challenging parts have been done?	1	2	3	4	5
How often do you have difficulty getting things in order when you have to do a task that requires organization?	1	2	3	4	5
When you have a task that requires a lot of thought, how often do you avoid or delay getting started?	1	2	3	4	5
How often do you have problems remembering appointments or obligations?	1	2	3	4	5
How often do you fidget or squirm with your hands or your feet when you have to sit down for a long time?	1	2	3	4	5
How often do you feel overly active and compelled to do things, like you were driven by a motor?	1	2	3	4	5

General Scale of the Family Assessment

Questions about your family

These items ask you to think about your family **AS A WHOLE**. There are 12 statements about families. Please read each statement carefully and decide how well it describes your own family. Circle the one answer which you think most applies to your family as a whole.

1) Planning family activities is difficult because we misunderstand each other	Strongly Agree	Agree	Disagree	Strongly Disagree
2) In times of crisis we can turn to each other for support	Strongly Agree	Agree	Disagree	Strongly Disagree
3) Individuals (in the family) are accepted for what they are	Strongly Agree	Agree	Disagree	Strongly Disagree
4) We avoid discussing our fears and concerns	Strongly Agree	Agree	Disagree	Strongly Disagree
5) We express feelings to each other	Strongly Agree	Agree	Disagree	Strongly Disagree
6) There are lots of bad feelings in our family	Strongly Agree	Agree	Disagree	Strongly Disagree
7) We feel accepted for what we are	Strongly Agree	Agree	Disagree	Strongly Disagree
8) Making decisions is a problem for our family	Strongly Agree	Agree	Disagree	Strongly Disagree
9) We confide in each other	Strongly Agree	Agree	Disagree	Strongly Disagree
10) We cannot talk to each other about the sadness we feel	Strongly Agree	Agree	Disagree	Strongly Disagree
11) We are able to make decisions about how to solve problems	Strongly Agree	Agree	Disagree	Strongly Disagree
12) We don't get along well together	Strongly Agree	Agree	Disagree	Strongly Disagree

References

1. Biederman J, Petty C, Fried R, Doyle A, Mick E, Aleardi M, Monuteaux M, Seidman L, Spencer T, Faneuil A, Holmes L, Faraone S. Utility of an abbreviated questionnaire to identify individuals with ADHD at risk for functional impairments. *J Psychiatr Res* 2008; 42:304-410.
2. Kessler RC, Adler L, Ames M, Demler O, Faraone S, Hiripi E, Howes MJ, Jin R, Secnik K, Spencer T, Ustun TB, Walters EE. The World Health Organization Adult ADHD Self-Report Scale (ASRS): a short screening scale for use in the general population. *Psychol Med* 2005; 35:245-56.

DRAFT

APPENDIX I: AUSTRALIAN ADHD SUPPORT AND EDUCATION GROUPS

Support groups	
ACT	<p>Canberra & Queanbeyan ADD Support Group Inc. PO Box 717, Mawson, ACT 2607 Ph: 02 6290 1984 / After hours 02 6287 4608 Fax: 02 6286 4475 Email: addact@shout.org.au Web: www.addact.org.au</p>
New South Wales	<p>ADDults with ADHD (NSW) Inc. PO Box 22, Epping, NSW 1710 Ph: 02 9889 5977 / 0416 111 036 Fax: 02 9889 5988 Email: info@add.org.au Web: www.add.org.au</p> <p>Learning Difficulties Coalition (NSW) (Parent support LD/ADHD) PO Box 140, Westmead, NSW 2145 Ph: 02 9806 9960 Email: info@ldc.org.au Web: www.ldc.org.au</p>
Queensland	<p>ADD ASSOC. QUEENSLAND Inc. (ADDAQ)</p> <p>PO Box 1661, Milton, Qld 4064 Ph: 07 3368 3977 Email: addaq_pres@addaq.org.au Web: www.addaq.org.au</p>
Far North Queensland and the Northern Territory	<p>Far North Queensland Attention Deficit Disorder Support Group 4 Laura Court, Deeragun, Qld 4818 Ph: 0747 516 921 Email: Dianne.Rogers@jcu.edu.au</p>
South Australia	<p>The Attention Disorders Association of South Australia (ADASA) 195 Gilles Street, Adelaide, SA 5000 Ph: 08 8232 0685 Fax: 08 8232 0687 Email: admin@adasa.com.au Web: http://adasa.com.au</p>
Tasmania	<p>ADHD Tasmania Email: adhd tas@bigpond.net.au</p>
Western Australia	<p>Learning & Attentional Disorders Society of WA Inc. (LADS). The Niche, 11 Aberdare Road (Cnr) Hospital Ave., Nedlands, WA 6009 Ph: 08 9346 7544 Fax: 08 9346 7545 Email: lads@cns wa.com Web: www.ladswa.com.au</p>

Professional development advice and education about ADHD

Victoria

The ADHD Coalition of Victoria Inc.
Ross House
247 Flinders Lane, Melbourne, Vic 3000
Email: info@adhdcoalitionvic.org.au

DRAFT