ADHD documentation for students requesting accommodations at the postsecondary level

Update on standards and diagnostic concerns

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Abstract

OBJECTIVE To update primary health care providers on the guidelines and standards for documentation of attention deficit hyperactivity disorder (ADHD) at the postsecondary level.

QUALITY OF EVIDENCE We synthesized information from consultations with other experts at postsecondary disability offices and from relevant research in this area (specifically, PsycLIT, PsychINFO, and MEDLINE databases were searched for systematic reviews and meta-analyses from January 1990 to June 2009). Most evidence included was level III.

MAIN MESSAGE Symptoms of ADHD can occur for many reasons, and primary health care providers need to be cautious when making this diagnosis in young adults. Diagnosis alone is not sufficient to guarantee academic accommodations. Documentation of a disability presented to postsecondary-level service providers must address all aspects of the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, criteria for diagnosis of ADHD, and must also clearly demonstrate how recommended academic accommodations were objectively determined.

CONCLUSION Students with ADHD require comprehensive documentation of their disabilities to obtain accommodations at the postsecondary level. Implementing the guidelines proposed here would improve access to appropriate services and supports for young adults with ADHD, reduce the risk of misdiagnosis of other psychological causes, and minimize the opportunity for students to obtain stimulant medications for illicit use.

Résumé

OBJECTIF Renseigner les professionnels des soins de santé primaires sur les directives et les normes à suivre pour documenter un trouble d'hyperactivité avec déficit de l'attention (THADA) au niveau postsecondaire.

QUALITÉ DES DONNÉES Nous avons résumé l'information recueillie à partir de consultations avec d'autres experts de bureaux de services aux étudiants postsecondaires ayant une incapacité et de recherches pertinentes dans ce domaine (plus précisément, une recension des revues systématiques et des méta-analyses de janvier 1990 à juin 2009 dans les bases de données PsycLIT, PsychINFO et MEDLINE). La plupart des données étaient de niveau III.

MESSAGE PRINCIPAL Les symptômes du THADA peuvent se produire pour de nombreuses raisons, et les professionnels des soins de santé primaires doivent être prudents quand ils posent ce diagnostic chez de jeunes adultes. Le diagnostic à lui seul ne suffit pas pour garantir des accommodements sur le plan scolaire. La documentation présentée aux bureaux de services postsecondaires doit répondre à tous les aspects des critères de diagnostic du THADA selon la 4e édition *du Manuel diagnostique et statistique des troubles mentaux*. Elle doit aussi démontrer comment les accommodements scolaires recommandés ont été objectivement établis.

CONCLUSION Pour obtenir des accommodements au niveau postsecondaire, les étudiants ayant un THADA doivent fournir une documentation exhaustive. En suivant les lignes directrices proposées ici, on peut améliorer l'accès aux services et au soutien appropriés par les jeunes adultes ayant un THADA, réduire le risque de mal diagnostiquer un problème dû à d'autres causes psychologiques et minimiser la possibilité que les étudiants obtiennent des stimulants pour un usage illicite.

Attention deficit hyperactivity disorder (ADHD) is a commonly diagnosed childhood behavioural disorder. The core symptoms include inappropriate levels of attention, concentration, activity, and distractibility.[1] It is estimated that between 3% and 10% of children are affected by this disorder, but that less than half of these individuals will go on to demonstrate clinically significant symptoms of ADHD in adulthood.[2] Despite the fact that ADHD symptoms become less debilitating with age, research estimates that about 20% of the disabled college student population is diagnosed with ADHD,[3] and postsecondary institutions have witnessed a dramatic increase in the number of students presenting to disability services offices (DSOs) with a diagnosis of ADHD from their family physicians.[4] This might reflect the fact that family physicians are now increasingly faced with adult patients coming to their offices with questions about the diagnosis and treatment of ADHD. However, in such instances there are no accompanying test data to objectively demonstrate that the students are substantially impaired in performing academic tasks, or that medications fail to effectively alleviate academic impairments. This causes difficulties for DSO staff charged with providing academic accommodations to these students, as it is not clear in which areas and to what extent ADHD is affecting learning. Indeed, there is no single typical accommodation profile for those diagnosed with ADHD, and so DSO staff cannot use a diagnosis alone to determine appropriate accommodations. Further, accommodations must mitigate an impairment but not provide an unfair advantage to the individual relative

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to others at the postsecondary level. The following is a review of the challenges facing clinicians, physicians, and disability service providers when determining which, if any, accommodations should be provided to students diagnosed with ADHD at the postsecondary level.

Quality of evidence

We synthesized information from consultations with other experts at postsecondary DSOs and from relevant research in this area. Specifically, PsycLIT, PsychINFO, and MEDLINE databases were searched for systematic reviews and meta-analyses from January 1990 to June 2009, using key words including *ADHD, hyperactivity, adults, accommodation, diagnosis,* and *post-secondary education.* Most evidence included was level III.

Diagnostic criteria and challenges

Confirmation of symptoms. In order to be diagnosed with ADHD, the student must first demonstrate at least 6 of 9 symptoms of inattention or 6 of 9 symptoms of hyperactivity and impulsivity, as outlined in the *Diagnostic and Statistical Manual of Mental Disorders,* 4th edition, *(DSM-IV)*.[5] However, some research has suggested that in the adult population this criterion is overly restrictive and relies on child-centric symptoms.[6] At minimum, in addition to confirming that the patient met the diagnostic criteria in childhood, the adult student must currently demonstrate at least 5 symptoms in 1 of the aforementioned areas.[7] The presence of these symptoms alone, however, is not sufficient for diagnosis, as research has shown that a large proportion of students[8] and adults[9] report experiencing at least 5 ADHD symptoms on a regular basis. While clinicians or medical doctors employ self-report scales to measure the frequency and severity of symptoms, this alone is not sufficient for a diagnosis.[2]

Impairment. The second criterion necessary for adult diagnosis of ADHD is that these symptoms must substantially impair the person's ability to function in more than 1 main life area (ie, not just in school). Symptoms must also be shown to occur more frequently than is typical for others of the same age.[10] Distinguishing between normal and abnormal behaviour is extremely difficult when evaluating adolescents and young adults (eg, differentiating between developmentally normal and abnormal levels of procrastination, disorganization, distractibility, and academic underachievement, and school problems secondary to poor attendance or low self-esteem).[11] It is therefore important that the evaluator conduct a comprehensive assessment to determine whether the intensity and frequency of reported symptoms is abnormal relative to the peer group in question, and whether these behavioural problems substantially impair the person in performing *main* life functions.

Furthermore, there has been much recent controversy about the "average-person standard" as a benchmark for determining the presence of cognitive disabilities in postsecondary education.[12,13] This requires that an individual be substantially impaired "relative to the average person" in the population, as opposed to being impaired relative to other above-average abilities possessed by the individual himself or herself (eg, above-average intelligence but only average reading skills), or relative to those with whom the individual is being compared educationally (eg, performing less well than other medical students as opposed to all individuals in the population).[12,13] In other words, the question is whether documentation must demonstrate the existence of attention impairments relative to the average person in the general population, to a person's own general intellectual ability, or to peers at the same educational level. This becomes an issue insofar as DSOs at the postsecondary level are mandated to provide accommodations to those who have impairments that interfere substantially with their ability to perform main life functions.[7-9]

In Canada, no guidelines currently exist to assist professionals in determining at what point an impairment becomes disabling to an individual and how the term *impairment* should be used. In the United States, courts have ruled in support of both the average-person standard and the educational-peer standard for high-stakes postsecondary testing.[14,15] Currently, most DSOs in Canada will provide some services for students based on comparisons with educational-appropriate peers or intrapersonal comparisons, but they prefer documentation that meets the average-person standard. If documentation does not meet this standard, fewer services will typically be provided.

Long-standing nature of symptoms. As noted above, the third criterion for diagnosis is that the disorder has been long-standing, such that the student also met diagnostic criteria in childhood. Currently, *DSM-IV* criteria require that the symptoms be present before age 7, but other researchers have suggested that inattentive symptoms might not be evident until later in childhood.[7,16] At the very least, there must be evidence to clearly demonstrate that the symptoms existed before age 12, that they have been long-standing (ie, that they have been present consistently and chronically), and that they caused impairments in childhood functioning.

Exclusion clause. The final criterion for diagnosis, and one that is often overlooked, is that other causes for the reported symptoms must be objectively ruled out.[5,17-19] Many psychiatric disorders include inattention as a common symptom, and so inattentiveness, in and of itself, is nonspecific. Inattention and concentration problems are very common in the general student population,[8] and also in those who have suffered from abuse or post-traumatic stress disorder.[20] Additionally, many other psychiatric disorders tend to co-occur with ADHD, and it

is often the effects of these secondary disorders, rather than ADHD itself, that require more substantial academic accommodation and other supports. Frequently, ADHD is comorbid with mood disorders, anxiety disorders, learning disabilities, and substance abuse disorders. The rate of comorbidity ranges between 20% and 50% and typically increases in adulthood, making diagnosis of ADHD even more difficult.[21,22] In all cases, the diagnostician must determine which disorder is the primary cause of impairment. It is therefore critical to perform a comprehensive assessment to ensure that symptoms of inattention are in fact due to ADHD rather than another disorder. Physicians who are unfamiliar with making mental health diagnoses should consult with a psychiatrist or psychologist who is trained in diagnosing such disorders to assist with differential diagnosis.

Recency of documentation. Although not listed among the *DSM-IV* criteria, postsecondary DSOs require that disability documentation reflect the current functioning of the student. The symptoms of ADHD change and frequently become less debilitating as the person ages.[23,24] Therefore, it is also necessary for students who come with a diagnosis from childhood to demonstrate that the symptoms continue to cause impairments that disable them in their current academic and other life functions.[10] Consequently, documentation to demonstrate the need for academic accommodations and supports must be no more than 5 years old if conducted before the age of 18. This recent information should more accurately reflect the student's current level of functioning and the current effects of the impairments on academic achievement. After age 18, research has not clearly demonstrated that any substantial neurological changes in cognitive or information processing occur, and therefore testing conducted after age 18 likely remain valid.[25-28]

Symptom exaggeration or feigning. An issue causing growing concern in the postsecondary sector is the possibility that students might feign or exaggerate symptoms of ADHD for personal gain. Recent research[29-35] suggests that students might be motivated to feign ADHD in order to receive academic accommodations or other types of secondary gain such as tax benefits, access to government-funded programs and services, or even having their student loan repayments waived. Furthermore, students might be motivated to receive extra time on high-stakes testing, with the belief that this will improve their scores and give them a competitive edge over fellow students when applying to graduate school or other specialized programs.[36]

Another reason that students might be motivated to feign symptoms of ADHD is to access stimulant medication for illicit purposes,[29,31,37] as stimulants can be ground up and inhaled or injected to produce a cocaine-like high. Recent studies show how easy it is to fake symptoms of ADHD, especially when filling out self-report checklists,[32,38,39] a concern for physicians who rely exclusively on self-reports when making this diagnosis. Family physicians must therefore be aware that some students might be motivated to obtain a diagnosis of ADHD for reasons of secondary gain, and should educate themselves about ways to identify such exaggeration when it occurs. Physicians might wish to consider including multiple symptom validity measures when assessing for ADHD, as these might help identify those individuals exaggerating or feigning symptoms of this disorder.[40]

What is needed by postsecondary disability service providers?

Attention deficit hyperactivity disorder is not necessarily a disability; rather, it is a disorder or syndrome.[41] Hence, meeting the criteria for a *disorder* does not necessarily imply a *disability* in the legal sense, and as such might not qualify a student for accommodations at the postsecondary level. Additionally, the manner in which a student demonstrates symptoms of ADHD and the circumstances under which the symptoms occur often differ among individuals,[2] so there is no typical accommodation profile to deal with this condition. Furthermore, family physicians should know that simply diagnosing a student with ADHD does not, in and of itself, mean the student will receive academic accommodation. It simply confirms the presence of a disorder, which might or might not be disabling.

Owing to the inconsistencies in ADHD documentation provided by students requesting accommodations at the postsecondary level, the Consortium on ADHD Documentation collaborated with various respected professionals in order to develop *Guidelines for Documentation of Attention-Deficit/Hyperactivity Disorder in Adolescents and Adults*.[42] These guidelines outline components to be included within ADHD documentation to allow service providers to be certain that accommodations are warranted based upon the level of impairment. Since their development, the consortium's guidelines are being used by a growing number of institutions and national testing agencies in the United States.[43]

Canadian disability service providers can only provide academic accommodations to students at the postsecondary level if presented with documentation supporting a formal diagnosis of a disability.[44] As noted above, in order to advocate for academic accommodations, this documentation should reflect the current level of functioning of the student and verify the extent to which the disorder currently impairs academic and other main life functions. This normally requires the administration of objective tests, along with corroborating reports from multiple sources (eg, parents, teachers, significant others). If another disability is responsible for the academic impairment in question, it is important that accommodations be specifically designed to address the most pertinent causes

for the observed difficulties. Documentation should also note the degree to which symptoms are causing impairment, so that suitable accommodations can be provided (eg, how much extra time is required). Finally, if stimulant medication is already being taken, it is important to document how academic functioning is still impaired while taking this medication.

Who can diagnose?

Family physicians are able to diagnose adult ADHD using all of the criteria outlined in the *DSM-IV*.[5] However, as noted above, a diagnosis alone is not sufficient to identify what accommodations would be reasonable or equitable for a student at the postsecondary level. Disability services offices require evidence that identifies the actual level of impairment experienced secondary to a diagnosed disability. Family physicians typically do not administer any objective, standardized tests of function to document the degree to which ADHD is impairing academic achievement, or evaluate the extent to which medication has improved attention or schoolwork. Many physicians use response to medication as a means of supporting ADHD diagnosis; however, stimulant medication has been shown to improve working memory and attention in healthy subjects as well as impaired individuals.[45] Hence, even with a medical diagnosis of ADHD from a family physician, the DSO still does not know how the condition affects the student at school, which accommodations to provide (if any), or the types of technology that might help to address any cognitive impairments caused by ADHD. Ideally, accommodations should be tailored to the needs of the individual student.[46] This can only be accomplished if sufficient documentation is provided to indicate specific areas of functioning that are being affected, along with the causes of impairment. Faraone et al[47] found that primary care physicians were more likely than psychiatrists to seek outside consultation before making a diagnosis of ADHD in adults; however, only 15% of these individuals made referrals to other professionals for testing.

Registered psychological service providers (practitioners with doctoral or master's degrees, depending on provincial guidelines) have specific tests to evaluate how the disorder is impairing academic functioning relative to what would be expected based on intelligence; if previously prescribed medication improves ability to process information and pay attention (using standardized tests); whether other psychological conditions or disorders might better explain the reported symptoms; if symptom exaggeration or feigning is occurring; and if academic accommodations are warranted on the basis of obtained test scores. Psychometric testing of this sort is typically necessary to allow students with ADHD full access to disability services. Many students arrive at university or college with only brief physicians' notes as documentation of ADHD. With such minimal documentation, disability service providers are able to justify only limited, interim services.

Recommendations

Family physicians can now access Web-based support and information to aid in diagnosis and treatment of adult ADHD (eg, Canadian Attention Deficit Hyperactivity Disorder Resource Alliance guidelines,[48] ADHD consortium resources[42]). It is important for primary health care providers to be aware of the pitfalls in diagnosis of adult ADHD and to recognize that diagnosis alone does not guarantee accommodations at the postsecondary level. Owing to variation in the way that ADHD can affect students' performance, reports from qualified specialists are required to provide definitive information on which to base accommodations. Based on the complexity of ADHD diagnosis, as well as the types of information that disability service providers require in order to implement appropriate accommodations for students diagnosed with ADHD, it is advised that physicians refer students who wish to receive accommodations to psychological service providers within their communities. In Ontario, provincially funded assessment centres, such as the Regional Assessment and Resource Centre and the Northern Ontario Assessment and Resource Centre, are available to assist such students by providing comprehensive assessments that include neuropsychological tests to help identify specific cognitive processes responsible for reported impairments. Furthermore, the fee for such assessments is geared to income, assuring that all students can obtain appropriate investigation of their symptoms. In other provinces, staff at the DSOs will be able to advise students about the best ways to access appropriate assessment services in the community and whether bursaries or other subsidies are available to offset the cost of such testing. By providing evidence for the cognitive underpinnings of specific impairments, disability documentation will properly inform service providers about which accommodations are reasonable and necessary, and will help determine to what degree these accommodations should be implemented.

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Both authors contributed to the literature search and to preparing the article.

Competing interests
None declared

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References
1. West J, Taylor M, Houghton S, Hudyma S. A comparison of teachers' and parents' knowledge and beliefs about attention-deficit/hyperactivity disorder (ADHD). *Sch Psychol Int* 2005;26(2):192-208.
2. McCann BS, Roy-Byrne P. Screening and diagnostic utility of self-report attention deficit hyperactivity disorder scales in adults. *Compr Psychiatry* 2004;45(3):175-83.
3. DuPaul GJ, Schaughency EA, Weyandt LL, Tripp G, Kiesner J, Ota K, et al. Self-report of attention-deficit/hyperactivity disorder symptoms in university students: cross-gender and cross-national prevalence. *J Learn Disabil* 2001;34(4):370-9.

4. Allsopp DH, Minskoff EH, Bolt L. Individualized course-specific strategy instruction for college students with learning disabilities and ADHD: lessons learned from a model demonstration project. *Learn Disabil Res Pract* 2005;20(2):103-18.
5. American Psychiatric Association. *Diagnostic and statistical manual of mental disorders*. 4th ed. Washington, DC: American Psychiatric Association; 1994.
6. Wender P. Attention deficit hyperactivity disorder in adults: a wide view of a widespread condition. *Psychiatr Ann* 1997;27(8):556-62.
7. Barkley RA. A critique of current diagnostic criteria for attention deficit hyperactivity disorder: clinical and research implications. *J Dev Behav Pediatr* 1990;11(6):343-52.
8. Harrison AG. An investigation of reported symptoms of ADHD in a university population. *ADHD Rep* 2004;12(6):8-11.
9. Gordon M, Antshel K, Faraone S, Barkley RA, Lewandowski L, Hudziak J, et al. Symptom versus impairment: the case for respecting DSM-IV's criterion D. *J Atten Disord* 2006;9(3):465-75.
10. Barkley RA. Issues in the diagnosis of attention-deficit/hyperactivity disorder in children. *Brain Dev* 2003;25(2):77-83.
11. ADHD Consortium. Appendix B: the consortium guidelines for documentation of attention-deficit/hyperactivity disorder in adolescents and adults. In: Gordon M, Keiser S, editors. *Accommodations in higher education under the Americans with Disabilities Act (ADA): a no-nonsense guide for clinicians, educators, administrators, and lawyers*. New York, NY: Guilford Press; 2000. p. 222-30.
12. Mather N, Gregg N, Simon JA. The curse of high stakes tests and high abilities: reactions to Wong v. Regents of the University of California. *Learn Disabil* 2005;13(4):139-44.
13. Brinckerhoff LC, Banerjee M. Misconceptions regarding accommodations on high-stakes tests: recommendations for preparing disability documentation for test takers with learning disabilities. *Learn Disabil Res Pract* 2007;22(4):246-55.
14. Giovingo LK, Proctor BE, Prevatt F. Use of grade-based norms versus age-based norms in psychoeducational assessment for a college population. *J Learn Disabil* 2005;38(1):79-85.
15. Barksdale-Ladd MA, Thomas KF. What's at stake in high-stakes testing: teachers and parents speak out. *J Teach Educ* 2000;51(5):384-97.
16. Faraone SV, Biederman J, Spencer T, Mick E, Murray K, Petty C, et al. Diagnosing adult attention deficit hyperactivity disorder: are late onset and subthreshold diagnoses valid? *Am J Psychiatry* 2006;163(10):1720-9.
17. Nahlik JE, Searight HR. Diagnosis and treatment of attention deficit hyperactivity disorder. *Primary Care Reports* 1996;2:65.
18. Searight HR, Burke JM, Rottnek F. Adult ADHD: evaluation and treatment in family medicine. *Am Fam Physician* 2000;62(9):2077-86, 2091-2.
19. Sparks RL, Javorsky J, Philips L. Comparison of the performance of college students classified as ADHD, LD, and LD/ADHD in foreign language courses. *Lang Learn* 2005;55(1):151-77.
20. Harrison AG, Wilson JB. Inattention and dissociation: overlapping constructs? *ADHD Rep* 2005;13(3):9-12.
21. Biederman J. Attention-deficit/hyperactivity disorder: a selective overview. *Biol Psychiatry* 2005;57(11):1215-20. Epub 2004 Dec 18.
22. Fischer AG, Bau CH, Grevet EH, Salgado CA, Victor MM, Kalil KL, et al. The role of comorbid major depressive disorder in the clinical presentation of adult ADHD. *J Psychiatr Res* 2007;41(12):991-6. Epub 2006 Nov 13.
23. Brook U, Boaz M. Attention deficit and hyperactivity disorder/learning disabilities (ADHD/LD): parental characterization and perception. *Patient Educ Couns* 2005;57(1):96-100.
24. Wender EH. Attention-deficit hyperactivity disorders in adolescence. *J Dev Behav Pediatr* 1995;16(3):192-5.
25. Bunge SA, Wright SB. Neurodevelopmental changes in working memory and cognitive control. *Curr Opin Neurobiol* 2007;17(2):243-50. Epub 2007 Feb 23.
26. Crone EA, Wendelken C, van Leijenhorst L, Honomichl RD, Christoff K, Bunge SA. Neurocognitive development of relational reasoning. *Dev Sci* 2009;12(1):55-66.
27. Crone EA, Wendelken C, Donohue S, van Leijenhorst L, Bunge SA. Neurocognitive development of the ability to manipulate information in working memory. *Proc Natl Acad Sci U S A* 2006;103(24):9315-20. Epub 2006 May 31.
28. Bunge SA, Dudukovic NM, Thomason ME, Vaidya CJ, Gabrieli JD. Immature frontal lobe contributions to cognitive control in children: evidence from fMRI. *Neuron* 2002;33(2):301-11.
29. Conti RP. Malingered ADHD in adolescents diagnosed with conduct disorder: a brief note. *Psychol Rep* 2004;94(3 Pt 1):987-8.
30. Frazier TW, Frazier AR, Busch RM, Kerwood MA, Demaree HA. Detection of simulated ADHD and reading disorder using symptom validity measures. *Arch Clin Neuropsychol* 2008;23(5):501-9. Epub 2008 Jun 4.
31. Harrison AG. Adults faking ADHD: you must be kidding! *ADHD Rep* 2006;14(4):1-7.
32. Harrison AG, Edwards MJ, Parker KC. Identifying students faking ADHD: preliminary findings and strategies for detection. *Arch Clin Neuropsychol* 2007;22(5):577-88. Epub 2007 May 15.
33. Osmon DC, Plambeck E, Klein L, Mano Q. The word reading test of effort in adult learning disability. *Clin Neuropsychol* 2006;20(2):315-24.
34. Suhr J, Hammers D, Dobbins-Buckland K, Zimak E, Hughes C. The relationship of malingering test failure to self-reported symptoms and neuropsychological findings in adults referred for ADHD evaluation. *Arch Clin Neuropsychol* 2008;23(5):521-30. Epub 2008 Jun 17.
35. Sullivan BK, May K, Galbally L. Symptom exaggeration by college adults in ADHD and learning disorder assessments. *Appl Neuropsychol* 2007;14(3):189-207.
36. Mullis C. Faking it: using learning disabilities to boost SAT scores. *Psychol Today* 2003;36(1):24.
37. Svetlov SI, Kobeissy FH, Gold MS. Performance enhancing, non-prescription use of Ritalin: a comparison with amphetamines and cocaine. *J Addict Dis* 2007;26(4):1-6.
38. Jachimowicz G, Geiselman RE. Comparison of ease of falsification of attention deficit hyperactivity disorder diagnosis using standard behavioural rating scales. *Cogn Sci Online* 2004;2(1):6-20.
39. Quinn CA. Detection of malingering in assessment of adult ADHD. *Arch Clin Neuropsychol* 2003;18(4):379-95.
40. Nelson NW, Boone K, Dueck A, Wagener L, Lu P, Grills C. Relationships between eight measures of suspect effort. *Clin Neuropsychol* 2003;17(2):263-72.

EDITOR'S KEY POINTS

- Despite the fact that attention deficit hyperactivity disorder (ADHD) symptoms become less debilitating with age, research estimates that about 20% of disabled college students are diagnosed with ADHD, and postsecondary institutions have witnessed a dramatic increase in the number of students presenting to disability services offices with a diagnosis of ADHD from their family physicians.
- This article reviews the challenges facing clinicians, physicians, and disability services staff when determining which, if any, accommodations should be provided at the postsecondary level to students diagnosed with ADHD.
- It is important for primary health care providers to be aware of the pitfalls in diagnosis of adult ADHD, and to recognize that diagnosis alone does not guarantee accommodations at the postsecondary level.

POINTS DE REPÈRE DU RÉDACTEUR

- En dépit du fait que le trouble d'hyperactivité avec déficit de l'attention (THADA) devient moins incapacitant avec l'âge, les recherches donnent à croire qu'environ 20 % des étudiants de niveau collégial ayant une incapacité ont reçu un diagnostic de THADA, et les établissements postsecondaires ont vu une hausse dramatique des étudiants qui se présentent aux bureaux des services aux personnes ayant une incapacité avec un diagnostic du THADA posé par leur médecin de famille.
- Dans cet article, on présente les défis que rencontrent les cliniciens, les médecins et le personnel des services aux personnes déficientes quand ils doivent déterminer les accommodements à accorder ou refuser aux étudiants du niveau postsecondaire ayant un diagnostic du THADA.
- Il importe que les professionnels des soins de santé primaires connaissent les pièges que pose un diagnostic du THADA chez l'adulte et reconnaissent qu'un diagnostic à lui seul ne garantit pas l'octroi d'accommodements au niveau postsecondaire.

41. Ingram S, Hechtman L, Morgenstern G. Outcome issues in ADHD: adolescent and adult long-term outcome. *Ment Retard Dev Disabil Res Rev* 1999;5(3):243-50.
42. McGuire JM, Brinckerhoff LC. Independent consortium issues new ADHD documentation guidelines. *ALERT* 1998;22:19-20.
43. Byron J, Parker DR. College students with ADHD: new challenges and directions. In: Brinckerhoff LC, McGuire JM, Shaw SF, editors. *Postsecondary education and transition for students with learning disabilities*. 2nd ed. Austin, TX: PRO-ED; 2002. p. 335-87.
44. *Ontario human rights code*. R.S.O. Chapter H 19. Toronto, ON: Government of Ontario; 1990.
45. Mehta MA, Owen AM, Sahakian BJ, Mavaddat N, Pickard JD, Robbins TW. Methylphenidate enhances working memory by modulating discrete frontal and parietal lobe regions in the human brain. *J Neurosci* 2000;20(RC65):1-6.
46. Ranseen JD. Lawyers with ADHD: the special test accommodation controversy. *Prof Psychol Res Pr* 1998;29(5):450-9.
47. Faraone SV, Spencer TJ, Montano CB, Biederman J. Attention-deficit/hyperactivity disorder in adults: a survey of current practice in psychiatry and primary care. *Arch Intern Med* 2004;164(11):1221-6.
48. Canadian Attention Deficit Hyperactivity Disorder Resource Alliance. *Canadian ADHD practice guidelines, CADDRA 2008*. Toronto, ON: Canadian Attention Deficit Hyperactivity Disorder Resource Alliance; 2008. Available from: **www.caddra.ca/cms4/index.php?option=com_content&view=article&id=26&Itemid=70&lang=en**. Accessed 2009 May 23.