

**AMERICAN ACADEMY OF
CHILD & ADOLESCENT
PSYCHIATRY**

American Academy of Child and Adolescent Psychiatry

Statement for the

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**Protecting Children: The Use of Medication on Our Nation's
Schools**

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Introduction

The American Academy of Child and Adolescent Psychiatry (AACAP) is a medical membership association established by child and adolescent psychiatrists in 1954. With 6,700 members strong, the AACAP is the leading national medical association dedicated to treating and improving the quality of life for the estimated 7 – 12 million American youth under 18 years of age who are affected by emotional, behavioral, developmental and mental disorders. AACAP supports research, continuing medical education and access to quality care. Child and adolescent psychiatrists are physicians fully trained in diagnosing and treating the disorders of childhood and adolescence.

My name is Lance Clawson, M.D. I am a Board Certified Child and Adolescent Psychiatrist practicing in Bethesda, Maryland. Currently in private practice, I have served as the medical director of Child and Adolescent Psychiatry at the University of Maryland School of Medicine, and I am a clinical assistant professor of psychiatry at the Uniformed Services University of the Health Services. I am a member of the American Academy of Child and Adolescent Psychiatry.

The AACAP thanks Chairman Castle for holding this hearing. It is important that this hearing presents the comprehensive information about treatment for children's mental illnesses. This statement represents basic background information rather than the final word on diagnosis and treatment of any one disorder. Hearings such as this help respond to the periodic waves of media attention questioning the prevalence and treatment of certain disorders such as Attention-Deficit-Hyperactivity Disorder (ADHD), which are confusing to the public and understandably perplexing to legislators. Some reports on children's mental illnesses are carefully researched, balanced articles, defining the disorder and its treatment and educating readers, other publications have caused confusion and spread misinformation. This hearing can make legislators and the public better able to judge the validity of information and clarify the misinformation and misperceptions.

The AACAP is concerned about the effect of H.R. 1170, legislation that was attached as an amendment to H.R. 1350, the Individuals with Disabilities Education Act (IDEA) requiring schools to develop policies and procedures prohibiting school personnel from requiring that a child be placed on psychotropic medications as a condition of attending school. AACAP agrees that medications should be used only as part of a treatment plan arrived at after a comprehensive evaluation and diagnosis. Medication assessment and prescribing medication is the exclusive role of a qualified medical professional, not school personnel. The decision to include medication as part of the treatment plan for a child or adolescent with a mental illness should be a decision agreed to by parents and caregivers, in close consultation with a qualified and trusted medical professional.

Schools are a critically important source of information for families about their children and their emotional and mental well being. The importance of open communication between school professionals and families about the health and well being of students, and where indicated, the freedom to recommend a comprehensive medical evaluation, cannot be overstated. The AACAP is concerned about legislation that would restrict school professionals from communicating with families about legitimate mental health related concerns. While H.R.1170 does not explicitly prohibit communication between school

personnel and families about mental health concerns, its enforcement provisions could cause school personnel to be fearful about communicating with families regarding a student's emotional or behavioral well-being.

The more pressing issue, as reported by the Surgeon General in 1999, is the unacceptably high number of children with mental illnesses that are not being diagnosed or treated. The AACAP is concerned that the amendment to H.R. 1350 may create a barrier to treatment for children and adolescents with mental illnesses, many of whom are identified in school settings.

General Status of Children's Mental Health

The Surgeon General's 2000 report on children's mental health estimated that about 12 million American children and adolescents aged 9 to 17 have a diagnosable mental or emotional illness. Of this number, fewer than 20% receive treatment. Barriers to treatment are a lack of affordability, lack of availability of specialists, including child and adolescent psychiatrists, and stigma. The stigma carried by mental illnesses is often worse in children than in adults. Parents often worry that medications will stigmatize their child. The increased recognition of children and adolescents with mental illnesses underscores the importance of research into of children's mental illnesses and the critical need for more effective treatment options, including new medications.

This Congress is also considering whether to make parity for mental illnesses the law, and doing this would advance the timely assessing, diagnosing and treating of children with mental illnesses. We must be sure that this will be done accurately and appropriately.

Attention-deficit/hyperactivity, the Disorder

It is important that this hearing's record contain accurate information about the prevalence, diagnosis and treatment children's mental illnesses, including the use of medications. Research on this disorder is ongoing and extensive, and new findings are a constant, but children and adolescents showing symptoms that raise concerns should have access to timely assessment, appropriate diagnosis and treatment that is safe and effective.

From the AACAP Practice Parameters for the Assessment and Treatment of Children, Adolescents, and Adults With Attention-Deficit/Hyperactivity Disorder

Attention-deficit/hyperactivity disorder is one of the most common psychiatric disorders of childhood and adolescence. Recent clinical experience and research document the continuation of symptoms into adulthood. The literature on ADHD is voluminous, with literature searches revealing hundreds of studies on the disorder. As with all illnesses, mental or physical, research is ongoing with findings integrated into practices as they are made available through training or publication. The AMA's Council on Scientific Affairs 1997 report responded to a request from physicians that the AMA study the increasing number of diagnoses of ADHD and address public concern regarding possible over-prescription of ADHD medications.

ADHD is a condition with onset in childhood, most commonly becoming apparent during the first years of elementary school. ADHD may be associated with a number of co-morbid psychiatric conditions as well as with impaired academic performance and with both patient and family emotional distress.

Epidemiology of ADHD

According to the National Institute of Mental Health (NIMH), Attention Deficit Hyperactivity Disorder, or ADHD, is the most commonly diagnosed psychiatric disorder of childhood. It's estimated to affect approximately 5 percent of school-age children, although published studies have identified a prevalence rate as high as 12% in some populations. It occurs three times more often in boys than in girls.

We also know that ADHD runs in families, and contrary to previous beliefs, it doesn't always go away as you grow up. In fact, the latest research indicates that as many as half of all children with ADHD continue to have problems into adulthood. This is actually one of the reasons there is an increase in the overall use of medication: adults are now being recognized and treated for ADHD.

Understanding and Diagnosing ADHD

The key features of the diagnosis include: inattention, hyperactivity and impulsivity. The symptoms must also be interfering with the child's life at home, in school, at work or with their friends. The diagnostic criteria are specific and well established within the field. They are the product of extensive and numerous research studies conducted at academic centers and clinical facilities throughout the country. (see attached AMA Council on Scientific Affairs (CSA) Report 5-A-97).

ADHD is not an easy diagnosis to make, and it's not a diagnosis that can be made in a 5 or 10 minute office visit. Many other problems, including anxiety disorders, depression and learning disabilities can present with signs and symptoms that look similar to ADHD. There's also a high degree of co-morbidity, meaning that over half the children who have ADHD also have a second significant psychiatric problem.

The diagnosis of ADHD requires a comprehensive assessment by a trained clinician. In addition to direct observation, the evaluation includes a review of the child's developmental, social, academic and medical history. It should also include input from the child's parents and teachers, and a review of the child's records. Schools play a critical role in identifying kids who are having problems, but schools should not make diagnoses or dictate treatment. ADHD is also a condition that should not be taken lightly. Without proper treatment, a child with ADHD may fall behind in schoolwork and have problems at home or with friends. It can also have long-term effects on a child's self-esteem, and lead to other problems in adolescence, including an increased risk of substance abuse, adolescent pregnancy, school failure and trouble with the law.

The treatment of ADHD should be comprehensive, and individualized to the needs of the child and family. Medication, including methylphenidate or Ritalin, can be extremely helpful for many children, but medication alone is rarely the appropriate treatment for complex child psychiatric disorders such as ADHD. Medication, if it is used, should only be used as part of a comprehensive treatment plan, which will usually include individual therapy, family support and counseling, and work with the schools on an individualized education plan (IEP) tailored to help the child succeed academically.

In terms of methylphenidate, there are literally hundreds of studies clearly demonstrating the effectiveness of this medication on many of the target symptoms of ADHD. It is also

generally well tolerated by children, with minimal side effects. Nonetheless, there are concerns that some children may be placed on medication without a comprehensive evaluation, accurate and specific diagnosis or an individualized treatment plan. There are similar concerns about the many children with ADHD and other psychiatric disorders, who would benefit from treatment, including treatment with medication, but who go unrecognized and undiagnosed, and who are not receiving the help that they need.

General Epidemiology and Prevalence of ADHD

Current estimates indicate that 10 percent of boys and 2 percent of girls have ADHD, so general prevalence is estimated at 6 to 9 percent of the school-age population in the United States. ADHD accounts for one third to one half of referrals for mental health services for children. There is a strong male predominance, with an almost 10 to one ratio for diagnosis boys to girls. The reported number of people with ADHD in the United States was over 2 million in 1995, up from 900,000 in 1990. The rapid increase in these numbers and in the prescribing of medications, specifically Ritalin, for the treatment of ADHD, has raised questions about accurate diagnosis and treatment. Medical associations such as the American Academy of Child and Adolescent Psychiatry, the American Psychiatric Association and the American Academy of Pediatrics have developed guidelines for diagnosing and treating ADHD. The AACAP has developed educational materials for parents and educators to help them understand this disorder and judge the accuracy of the diagnosis and the course of the treatment plan. Because child and adolescent psychiatrists are the only medical specialty with specific training in the diagnosing of childhood and adolescent mental illnesses, a special effort has been taken by the AACAP to inform the public and the media about ADHD.

Recent Prevalence Data

Last September, a review article by child and adolescent psychiatrist Peter Jensen, M.D., addressed this issue in detail. Dr. Jensen's article is included in the background materials. Dr. Jensen is currently the Ruane Professor of Child Psychiatry at Columbia University. He was formerly the Associate Director for Child and Adolescent Research at the National Institute of Mental Health. He notes in his article that most studies and media reports have not been based on actual diagnostic data, but have relied instead on HMO or Medicaid medication databases. Dr. Jensen and his colleagues actually performed comparative evaluations of 1,285 children in 4 communities (Atlanta, New Haven, Westchester and San Juan, Puerto Rico) to determine the prevalence of ADHD, as well as the forms of treatment utilized. The results were that 5.1% of children and adolescents between the ages of 9 and 17 met the diagnostic criteria for ADHD; yet only 12.1% of these children were being treated with medication, suggesting that at least in these communities, medication is currently under-prescribed. These authors also found 8 children who were receiving medication who did not meet the full diagnostic criteria for ADHD, although they did have high levels of ADHD symptoms. Dr. Jensen concludes that on the basis of these results, there is no evidence of widespread over-treatment with medication. On the contrary, it appears that, at least in these communities, the majority of children with ADHD are not receiving what we would consider to be appropriate and effective treatment.

Prescribing Practices: Are Children Being Overmedicated?

The issue of prescribing practices also enters into the discussion of diagnosing ADHD or any other mental illness. It is established that there are regional, professional and demographic variations in actual prescribing patterns and practices, which would lead to

making a case for both “under-“ and “over-prescribing,” i.e. appropriate and inappropriate use of medications. Dr. Jensen states that, “...it is essential for clinicians and prescribers to separate fact from fancy concerning actual prescribing practices. Such information should serve not only to define gaps in research knowledge, but also to heighten professionals’ awareness about evolving practice trends, so that more informed discussion could take place in professional and public arenas.” The APA, AACAP and American Academy of Pediatrics have all developed practice parameters and guidelines for treating ADHD. The organizations have also included distribution of the parameters as part of the concerted effort to make updated diagnostic information easily available. One example of reducing geographic differences is the recent purchase of the AACAP’s ADHD practice parameters by the state of North Carolina for distribution to clinicians who work in public health in that state. The results of this exercise are not available yet, but it reveals how serious officials are about the issue of accurate diagnosis and treatment of the children within their jurisdictions.

One disturbing prescribing practice, is that of prescribing presumptively rather than after a thorough assessment. This practice can be adjusted as parameters and guidelines become accessible to physicians who are not trained to treat children with mental illnesses. It will also be assisted by additional training support. In a study released in 2000, a survey of office visits to physicians throughout the United States, found that the proportion of visits by children or adolescents ages 0 to 17 years with a diagnosis of ADHD that also resulted in a prescription of psychostimulant medication had increased significantly between 1989 and 1996.

When looking at prevalence, the prescribing practices must be considered as part of the discussion. Understanding children’s mental illnesses and how to diagnose and treat is not a constant, especially when prescribing medications. The base of research and the data attached to it advance the numbers of children recognized and referred and, thus, the number diagnosed and treated. This is progress. A key part of this progress is to assure the public that the diagnosis is accurate and the treatment effective.

The possibility of misunderstandings about the nature of prescribing practices for children’s mental illnesses reflects the need for ongoing research to assure the public further that these conditions exist and that children and adults do not have to endure the symptoms that keep them from developing naturally. To the extent one believes that such conditions are rare or do not exist in children, any amount of prescribing of psychotropic agents is likely to be viewed as “over-prescribing.” Some research shows that up to 21% of children between the ages of 9 and 17 have diagnosable mental or addictive disorders (Shaffer et al, 1996). Dr. Jensen addresses the issue of “over-prescribing” in his most recent article (Jensen, 2002), “Without awareness of the reality of childhood mental illness and the impact that these conditions exert on children’s development, the myth will persist among many persons that psychotropic medications should not be used at all with children. This “one-size-fits-all” assumption likely does great harm in delaying many parents and professionals in making informed treatment choices. The accusatory question sometimes heard by parents—“Are you drugging your child?”—suggests double standards for the use of psychotropic medications. Although ADHD and other childhood behavioral/emotional disorders can be just as devastating as other life-long ailments, such as asthma and diabetes, psychotropic agents that have been proven effective are often not even considered. However, as when treating asthma or diabetes, delaying effective treatments of childhood behavioral/emotional

disorders also poses significant risks, such as enduring declines in functioning and disturbances in development. In many instances, psychotropic medications constitute an essential tool to assist suffering children and their families.”

Recognition and Diagnosis of ADHD

One of the primary reasons for this hearing is to examine the increase in the numbers of children and adolescents diagnosed with ADHD. One of the first areas to be examined is the accuracy of the diagnosis. The diagnosis of ADHD cannot be made using a simple checklist of symptoms or reacting to initial comments from a parent or a teacher. We are learning from the ongoing research into ADHD how to more accurately diagnose the disorder, but there is no question that the diagnosis is the key to appropriate treatment and effective outcomes. A child or adolescent with ADHD will have one or more of three types of disorders: hyperactivity, inattention (distractibility), and/or impulsivity. Some will have only one of these disorders; some will have two; some will have all three. Critical to the diagnosis is the understanding that ADHD is neurologically-based and, for most individuals, has been present since birth. Thus, the behaviors reflective of the disorder have been present throughout the child or adolescent’s life and are present throughout each day; that is, they are chronic and pervasive.

This concept of chronic and pervasive behavioral patterns is critical to the diagnosis. Such emotional problems as anxiety or depression can result in an individual being restless, inattentive, and irritable (thus impulsive). Certain learning disabilities can result in an individual being inattentive. However, with anxiety, depression, or a learning disability, the hyperactivity, distractibility, and/or impulsivity begins at a certain time or occurs during certain situations. For example, a child is described as hyperactive and inattentive in the fourth grade. It is noted that no previous teacher described the child as such. A more detailed clinical exploration shows that the child’s parents separated during the summer between third and fourth grade.

What are the symptoms of ADHD?

Currently, a child who has ADHD has been diagnosed according to the following criteria:

DSM-IV Diagnostic criteria for Attention-Deficit/ Hyperactivity Disorder

A. Either (1) or (2):

*(1) six (or more) of the following symptoms of **inattention** have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:*

Inattention

(a) often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities

(b) often has difficulty sustaining attention in tasks or play activities

(c) often does not seem to listen when spoken to directly

(d) often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)

(e) often has difficulty organizing tasks and activities

(f) often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or home work)

(g) often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)

(h) is often easily distracted by extraneous stimuli

(i) is often forgetful in daily activities

*(2) six (or more) of the following symptoms of **hyperactivity/impulsivity** have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:*

Hyperactivity

(a) often fidgets with hands or feet or squirms in seat

(b) often leaves seat in classroom or in other situations in which remaining seated is expected

(c) often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)

(d) often has difficulty playing or engaging in leisure activities quietly

(e) is often "on the go" or often acts as if "driven by a motor"

(f) often talks excessively

Impulsivity

(g) often blurts out answers before questions have been completed

(h) often has difficulty awaiting turn

(i) often interrupts or intrudes on others (e.g., butts into conversations or games)

B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years.

C. Some impairment from the symptoms is present in two or more settings (e.g., at school [or work] and at home).

D. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.

E. The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

Longitudinal studies show that between fifty and seventy percent of children will continue to have ADHD as adults. Even for those who improve at puberty, the residual emotional, social, and family problems might persist into adolescence and adulthood if not addressed. It is now understood that in about fifty percent of individuals, ADHD is inherited. Thus, there is a high likelihood that one or both parents also have ADHD or had ADHD as a child. Perhaps some of these studies suggesting parents of children with ADHD have a higher probability of emotional and work difficulties is explained by their unrecognized ADHD.

Another set of research findings suggest that girls with ADHD are more likely to be missed than boys. These findings are especially true for girls who are only inattentive. Boys, when struggling and frustrated, are more likely to act out and misbehave; thus, boys are more likely to be evaluated. Girls, under the same conditions, are more likely to become passive and withdrawn; thus, they are missed.

The Outcome of ADHD

If a child or adolescent with ADHD is not identified and treated, he or she is at great risk for developing serious emotional or behavioral problems. Being unable to attend to learning, there is the risk of academic underachievement and failure, and friendships may suffer. The child experiences more failure than success and is criticized by teachers and family who do not recognize a health problem. These problems increase during adolescence. Some

outcomes studies on these unrecognized individuals suggest a higher risk of school drop out, substance abuse, delinquency, or other serious problems. In November 2000, the Coalition for Juvenile Justice estimated in their annual report that 50 – 75% of teenagers in the juvenile justice system nationwide have a diagnosable mental disorder and these numbers appear to be growing. Thus, it is critical that children with mental illnesses, including ADHD, be identified and diagnosed early. With the proper treatment, the outcome is much more likely to be positive.

Treatment of ADHD

The treatment of ADHD must involve several models of help, including individual and family therapy, cognitive and behavioral therapy, parent education, the use of appropriate behavioral management programs, modification to the child's educational plan, and the use of appropriate medications. Such a multimodal approach is needed because children and adolescents with ADHD frequently have multiple areas of difficulty. As with learning disabilities, the total person must be understood in his or her total environment. Educators, family members and others around a child with ADHD have to understand what is causing the distractibility, loss of concentration, frustration and depression linked to this disorder. Cognitive therapy can help build self-esteem, reduce negative thoughts and improve problem-solving skills. Parents can learn management skills such as issuing instructions one step at a time rather than issuing multiple requests at once. Educational modifications, which all students with ADHD are entitled to under the Individuals With Disabilities Education Act (IDEA) can address the symptoms of ADHD along with any coexisting learning disabilities.

Evaluation by a child and adolescent psychiatrist or psychiatrist specializing in children's disorders is appropriate for any child or adolescent with emotional and/or behavioral problems. Most children and adolescents with serious emotional and behavioral problems need a comprehensive psychiatric evaluation. Unfortunately, access to comprehensive psychiatric evaluations has declined during this age of managed care. Incentives to diagnose quickly and provide a treatment plan based on a rushed evaluation contribute to the statistics that show an ever increasing prevalence rate and more use of stimulant medications.

Comprehensive psychiatric evaluations usually require several hours over one or more office visits for the child and parents. With the parents' permission, other significant people (such as the family physician, school personnel or other relatives) may be contacted for additional information. The comprehensive evaluation frequently includes the following:

- Description of present problems and symptoms
- Information about health, illness and treatment (both physical and psychiatric), including current medications
- Parent and family health and psychiatric histories
- Information about the child's development
- Information about school and friends
- Information about family relationships
- Psychiatric interview of the child or adolescent

- If needed, laboratory studies such as blood tests, EKG, x-rays, or special assessments (for example, psychological, educational, speech and language evaluation)

The child and adolescent psychiatrist then develops a formulation. The formulation describes the child's problems and explains them in terms that the parents and child can understand. Biological, psychological and social parts of the problem are combined in the formulation with the developmental needs, history and strengths of the child or adolescent.

Time is made available to answer the parents' and child's questions. Parents are often worried about how they will be viewed during the evaluation. Child and adolescent psychiatrists are there to support families and to be a partner, not to judge or blame. They listen to concerns, and help the child or adolescent and his/her family define the goals of the evaluation. Parents should always ask for explanations of words or terms they do not understand, and ask questions about the side effects of the medication, how the medication works, and how long it will be before improvement is noted.

When a treatable problem is identified, recommendations are provided and a specific treatment plan is developed. Child and adolescent psychiatrists are specifically trained and skilled in conducting comprehensive psychiatric evaluations with children, adolescents and families.

Prescription of Medications as Part of the Treatment Process

Prescribing psychoactive medications for children and adolescents requires the judgment of a physician, such as a child and adolescent psychiatrist, or psychiatrist, with training and qualifications in the use of these medications in this age group. Certainly any consideration of such medication in a child or infant below the age of five should be very carefully evaluated by a clinician with special training and experience.

Most medications prescribed for children under age 12 do not as yet have specific approval by the Federal Drug Administration (FDA); such approval requires research demonstrating safety and efficacy. Such research, so far, lags behind the clinical use of these medications. To date, no study has been completed to determine the optimal range of effective doses for preschoolers with ADHD. To address this knowledge gap, two years ago the NIMH began PATS, the Preschoolers with ADHD Treatment Study, currently being conducted across six sites around the country. Other efforts to address the deficiency in pediatric drug research include the development of Research Units of Pediatric Psychopharmacology (RUPP), the Food and Drug Administration's (FDA) pediatric studies program, recently reauthorized under the Best Pharmaceuticals for Children Act (P.L. 107-109), and the 1997 Pediatric Rule requiring studies of medications prescribed for children and adolescents. The combination of the FDA program and the Pediatric Rule has seen a dramatic increase in the number of pediatric clinical trials, from just eleven between 1990 and 1997, to over 400 since 1998. Long-term studies are needed to adequately determine the safety and efficacy of psychoactive medications. In making decisions to prescribe such medications the physician - specifically the child and adolescent psychiatrist - should consider data from studies in adults in treating the target disorder and/or symptomatology, any clinical or anecdotal reports of use in child and adolescent patients, studies conducted outside the United States and the experience of colleagues.

It is important to balance the increasing market pressures for efficiency in psychiatric treatment with the need for sufficient time to thoughtfully, correctly, and adequately, assess

the need for, and the response to medication treatment. Monitoring on-going use of psychoactive medications requires sufficient time to assess clinical response, side effects and to answer questions of the child and family. The use of brief medication visits (e.g. 15-minute medication checks) is unacceptable as a substitute for ongoing individualized treatment. The role of psychosocial interventions, including psychotherapy, must be evaluated, and such interventions must be included in the treatment plan.

Research clearly demonstrates that medication can be an effective part of treatment for ADHD. A National Institutes of Mental Health (NIMH) study found that a combination of therapy (specifically behavior modification and social skill building) and medication were the most effective modes of treatment for children with ADHD aged 7 to 9. A child should have had a complete physical examination within the last year before a stimulant is prescribed. This baseline of the physical condition will be used for comparison when the medication is taken over time. Most children should take ADHD medication for a minimum of nine to twelve months. There are medications other than Ritalin prescribed for ADHD, but it has been the first choice for effective treatment. (Koplewicz) Newer medications, such as Strattera, are not stimulants, and are not classified as Schedule II. Ritalin is also the focus of media attention because of the increase in the number of prescriptions written over the last five years. Oversight of this increase should involve an examination of who is prescribing the medication, what diagnostic method was used to establish the disorder, and what does the treatment plan involve other than the medication.

Methylphenidate (Ritalin)

There are more than 200 studies showing that the stimulant Ritalin (generic name: methylphenidate) works effectively for children with ADHD. Stimulants have been used in the treatment of ADHD for more than 90 years. Adults feel more focused and alert after a cup of coffee in the morning. This is basically how Ritalin, and newer stimulants such as Adderall and Concerta, work for children with ADHD. Ritalin and other stimulants increase the alertness of the brain and nervous system, stimulating it to produce more dopamine and norepinephrine. The medication increases the child's attention and reduces excess fidgetiness and hyperactivity, allowing him to focus on his work. Children with ADHD who take Ritalin make fewer errors on a variety of tasks than untreated children do. They are less impulsive and more attentive, both in the classroom and in social situations. (Koplewicz)

Treatment Providers

Currently, treatment for children and adolescents with ADHD can be provided by primary care physicians or by specialists, including child and adolescent psychiatrists, psychiatrists, neurologists, and pediatricians. Other mental health providers who can treat ADHD but do not prescribe medications are psychologists, social workers, and school psychologists.

Different medical specialists see substantially different sectors of the ADHD population. Neurologists tend to see children with ADHD who have seizures and mental retardation. Psychiatrists treat ADHD with personality disorders and concomitant psychiatric illnesses, and child and adolescent psychiatrists are trained to treat specific child and adolescent characteristics and levels of severity. Pediatricians typically treat children with ADHD who have less severe characteristics.

One of the barriers to treatment for children and adolescents with mental illnesses, including

ADHD, is the lack of available specialists trained in the diagnosis and treatment of these disorders. In particular, there is a critical national shortage of child and adolescent psychiatrists. There are about 7,000 child and adolescent psychiatrists nationally while the prevalence rate for children and adolescents with mental illnesses is between 15 and 20 million. Data on this professional shortage comes from several sources including the Council on Graduate Medical Education (COGME), a committee of the Department of Health and Human Services and the Bureau of Health Professions. The COGME report concluded that by 1990, the nation should have over 33,000 child and adolescent psychiatrists. The Bureau of Health Professions projected that between 1995 and 2020, the use of child and adolescent psychiatrists will increase by 100%, with general psychiatry's increase at 19%.

An increase in the numbers of all children's mental health professionals can help reduce one of the barriers to treatment for the families of children with ADHD. The AACAP recommends congressional action in this effort, including passage of the Child Healthcare Crisis Relief Act, H.R. 1359, bipartisan legislation sponsored by Reps. Kennedy (D-RI) and Ros-Lehtinen (R-FL), which would encourage individuals to enter all children's mental health professions through the creation of education incentives.

A Final Word: Are We Over Diagnosing ADHD?

About ten to fifteen years ago a concerted effort was made to educate professionals, parents, and teachers about ADHD. There was concern that too many children in adolescence were missed. A national parent organization, Children and Adults with Attention Deficit Disorder (CHADD), was formed along with other regional organizations. Literature became available to parents and teachers explaining ADHD. Books for the public were written and published. The topic of ADHD became popular in both the print and electronic media. As a result, more children and adolescents have been diagnosed with ADHD. With the increased awareness that the disorder can continue into adulthood, more adults have been diagnosed. The general opinion is that more cases are being diagnosed because parents and teachers are recognizing the behaviors and referring to physicians and because more physicians are correctly making the diagnosis.

RECOMMENDATIONS

The American Academy of Child and Adolescent Psychiatry and the American Psychiatric Association submit the following recommendations for the committee's consideration:

- In order to assure accurate diagnosis and treatment, policies should be approved that support access to clinicians with appropriate training and expertise, and allow sufficient time for a comprehensive assessment.
- To provide access to nondiscriminatory insurance coverage, support is needed for comprehensive parity legislation at both the state and federal level (H.R. 953) so there are fewer barriers to keep children from getting the kind of comprehensive evaluations and individualized treatment they need. The strong support for parity recently voiced by President Bush is appreciated.
- Support is recommended for all efforts to sustain and expand training programs for all child mental health professionals, including programs for child and adolescent psychiatrists (H.R. 1359).

- Opposition to legislation that recognizes only disruptive behavior and offers punitive resolutions rather than recognizing the reasons for the behavior and offering help through federal health and education services.
- To assure safety in prescribing by all physicians, federal support is needed 1) for the increased emphasis of the FDA and the NIMH on research on the appropriate use of medication in the psychiatric treatment of children and adolescents, and 2) for expanded clinical trials and longitudinal studies for all medications prescribed for children (S. 650).
- And finally, support and appreciation should be given to the efforts of the current administration, through the New Freedom Commission on Mental Health, to focus increased attention on the diagnosis and treatment of all psychiatric conditions, including those that affect children and adolescents.

SUMMARY

The prevalence rate for children and adolescents with mental disorders is estimated between 12 and 20 percent – the wide difference of opinion is indicative of the difficulties in measuring numbers across uneven access to treatment and quality of care. Conservatively, there are 15 million American youngsters needing treatment and services at any one time. Only about 20% of these children ever receive any treatment or find their way into a service system that can meet their needs. This rate has not changed significantly for over a decade, yet the question is still raised as to whether there may be too many diagnoses of ADHD and too many prescriptions for stimulants. It is appropriate to look into an issue that receives this much attention, but it is also appropriate to remember that concerns about overdiagnosis can be addressed with better education about the disorder, better training for the providers of treatment, more research into the diagnosis and treatment, and a comprehensive service delivery system. No one -- not children, adolescents or adults -- can be assured an early identification, accurate diagnosis and appropriate treatment until the skills, resources, and governmental support are available. Too many families have to deal with mental illnesses without support, diagnosis, treatment or resources to buy medications. The issue of paramount importance to this debate is the lack of access to affordable treatment for mental illnesses for children, adolescents and their families.

In summary, child psychiatric disorders, including ADHD, are very real and diagnosable illnesses, and they affect thousands of children and adolescents. The good news is that they are also highly treatable. While it is not currently possible to cure all children, with comprehensive, individualized intervention, there can be a significant reduction in the extent to which this disorder interferes with their lives. The key for parents and teachers is to identify kids with problems as early as possible, and make sure they get accurate and effective treatment.

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Attachments:

- 1) AACAP Facts for Families No. 21 *Psychiatric Medication for Children and Adolescents Part I – How Medications Are Used*. 11/99
- 2) AACAP Facts for Families No. 29. *Psychiatric Medication For Children and Adolescents Part II: Types of Medications*.
- 3) AACAP Facts for Families No. 51 *Psychiatric Medication for Children and Adolescents Part III: Questions To Ask*. 3/01.
- 4) AACAP Facts for Families No. 6 *Children Who Can't Pay Attention*. 5/99.
- 5) AACAP Facts for Families No. 52 *Comprehensive Psychiatric Evaluation*. 11/95.
- 6) Report of the Council on Scientific Affairs, Diagnosis and Treatment of Attention Deficit Hyperactivity Disorder in School-Age Children. American Medical Association. CSA Report 5-A-97. 1997.