

6/5 Ritabin - ^{State} Representative tellana Washington (Pennsylvania)
cm

she is very interested in this issue
maybe foster welfare moms are getting kids diagnosed
& prescribed so they can get SSI

wants to be involved in Conference told her husband
forwarded her info to SG's office but suggested
fax (717) 783-8724 She write a letter to SG as well.

She will fax me her resumption before the NBCSC &
I will fax info on Mrs. Clinton's efforts



Date: _____ June 5, 2000 _____

To: Representative LeAnna Washington

Telephone: _____ Fax: 717-783-8724

From: Heather Howard
Associate Director, Domestic Policy Council
Senior Advisor to the First lady

Telephone: 456-7263 Fax: 456-2878

Subject: _____

Pages: _____7_____ (Including this cover sheet)

Comments:

Representative Washington –

I enjoyed speaking with you about efforts to improve the diagnosis and treatment of children with emotional and behavioral conditions. For your information, I am attaching a background paper describing Mrs. Clinton's efforts, as well as the handout for parents developed by the National Institute of Mental Health.

I hope these are helpful and look forward to hearing more about your efforts.

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TELEPHONE (202) 456-7263 ❖ FACSIMILE 456-2878

51231-1
LEANNA M. WASHINGTON, MEMBER

200TH LEGISLATIVE DISTRICT

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House of Representatives
COMMONWEALTH OF PENNSYLVANIA
HARRISBURG

COMMITTEES

HEALTH AND HUMAN SERVICES
URBAN AFFAIRS, DEMOCRATIC CHAIR —
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CO-CHAIR, PHILADELPHIA DELEGATION
SECRETARY, PA LEGISLATIVE BLACK CAUCUS
SUBSTANCE ABUSE CAUCUS
DEMOCRATIC POLICY COMMITTEE



March 21, 2000

President Bill Clinton
The White House
Washington, D.C. 20500

Re: The Effects of Psychotropic Drugs on our Nation's Children

Dear President Clinton:

I applaud you and the First Lady for your efforts to address the issue of the use of mind-altering, psychotropic drugs on our nation's children. It is unconscionable to think that we have for years been giving them these drugs without actually knowing what long-term effects they may have.

An estimated 6 to 9 million children and adolescents in the United States suffer from serious behavioral or emotional problems. In our schools and classrooms medications are being prescribed at increasingly early ages. As you know, medications are not typically studied in children because of ethical concerns about involving children in clinical trials. While these concerns are legitimate, they have unfortunately created a problem concerning the lack of knowledge about the best treatments for children. I am grateful that you advocate the development of new research approaches for the study of medications on children.

I have been concerned about this issue for quite some time. As an African-American representing a predominately African-American legislative district, I am witness to what I believe is the disproportionate prescribing of these medicines to minority children especially. During my studies of the issue, I have learned that drugs such as Ritalin have

become a convenient, "easy way out" substitute for dealing with the problems that are often unique to poor, urban youth. (Mrs. Clinton alluded this when she recently posed the question, **"Why are we seeing such great variations by community and race."**)

My concern led me to present workshops on the event before other policy makers, including last summer's presentation before the National Organization of Women Legislators Annual Conference in Pasadena, California on the adverse effects of Ritalin use on children. Also, I sponsored a ratified resolution on the matter during the most recent National Black Caucus of State Legislators (NBCSL) Annual Legislative Conference in Baltimore. (A copy of which is enclosed for your review.) I have hosted public hearings on the issue under the auspices of the House Democratic Policy Committee both here in Harrisburg and in Philadelphia as well. I have also appeared on an hour-long television call-in program on the topic that aired statewide on the Pennsylvania Cable Network (PCN).

I was filled with mixed emotions when The Journal of the American Medical Association published its groundbreaking studies on the issue. Though I was pleased that a respected scientific journal had taken steps to bring this issue to the forefront of the national agenda, I was disturbed with some of its findings, including the following:

- From 1991 to 1995, the number of preschoolers on antidepressants increased 200%, and
- the number of children ages 2 to 4 taking stimulants more than doubled.

As you can see this problem is increasing at alarming rates. Chemically treating our children at the rate and manner in which we are now may lead to problems in our society that will require great cost, both emotionally and financially, to correct.

All too often psychotropic drugs are prescribed to children without an attempt to first understand the underlying factors that may be contributing to the condition. Many often over-looked factors such as parental stress or a changing family environment may influence a child's symptoms. I am sure that most behavioral problems may be just as treatable using other methods, such as professional counseling. Also, because it does in fact "take a village to raise a child," family and

community support, patience and love can be as effective as medication in certain instances.

There is much work to be done in dealing with this issue. I am grateful however for the actions that you have taken thus far. You should know that I will continue addressing the matter in the Pennsylvania State Legislature and nationally through such organizations as NBCSL and the National Conference of State Legislatures (NCSL). In fact, it is my goal to introduce legislation in the very near future that would tackle this problem head-on in a manner that I believe will be best for our children.

Accordingly, allow me to offer my support and pledge my willingness to do whatever you deem necessary to assist you in dealing with this issue. I am eager to travel to Washington, D.C. to discuss this matter with you further.

Thank you for your attention. I look forward to hearing from you soon.

Sincerely,



LeAnna M. Washington
State Representative
200th Legislative District

LMW/rlo
enclosures

cc: Mrs. Hillary Rodham Clinton

OFFICE OF DEMOCRATIC LEGISLATIVE INFORMATION
PA House of Representatives --- <http://www.pahouse.com>

G-01 South Office Building
House Box 202229
Harrisburg, PA 17120-2229

FOR IMMEDIATE RELEASE

CONTACT: Jamal Weaver (215) 242-0472

Legislator hosts hearing on Ritalin

HARRISBURG, July 21 - State Rep. Leanna Washington, D-Phila., hosted a Democratic Policy Committee public hearing Tuesday on psychiatric drugs and their effects on children.

Washington said an estimated 5 million children are taking psychiatric drugs.

"We need to find out what, if any, consequences there are and how it affects children."

Washington said it has been suggested that recent incidents of school violence and other occasions of violence are the result of children being medicated by Ritalin and other related drugs.

"Others maintain that placing the blame on the drugs is an overreaction and that the drugs are safe if used properly," Washington said. "The purpose of the hearing was to discover what the experts and those who have experience with the effects of psychiatric drugs on children have to say about the subject."

Those testifying at the hearing included:

- Bruce Wiseman, national president, Citizens Commission on Human Rights;
- Fred Shaw, former Los Angeles County sheriff; and
- Dr. Mary Ann Block, author, "No More Ritalin"

A parent of a child diagnosed with Attention Deficit Disorder also testified at the hearing.

--more--

Washington said another hearing on the subject is scheduled for September with officials from the Department of Public Welfare, school psychologists and educators.

For additional information, contact Washington's office at 215-242-6118.

OFFICE OF DEMOCRATIC LEGISLATIVE INFORMATION
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FOR IMMEDIATE RELEASE

CONTACT: Jamal Weaver (215) 242-0472

Rep to appear on PCN call-in show

HARRISBURG, Sept. 23 -- State Rep. LeAnna Washington, D-Phila., will be the featured guest appearing on a Pennsylvania Cable Network live call-in show on psychiatric drugs and their effects on children.

The one-hour television show will air at 7 p.m. Thursday, Sept. 30.

A panel of experts in the field, including Dr. Bruce Wiseman, national president of Citizens Commission on Human Rights, and Dr. Mary Ann Block, author of "No More Ritalin," will join Washington.

"If you have concerns about the use of Ritalin and other related drugs on children, I encourage you to watch PCN and call in with your questions," Washington said.

Washington recently hosted a House Democratic Policy Committee hearing in Philadelphia on Ritalin and other psychiatric drugs.

--more--

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FOR IMMEDIATE RELEASE

CONTACT: Jamal Weaver (215) 242-0472

NBCSL adopts Washington's resolutions on Ritalin, malt liquor

HARRISBURG, Dec. 7 - At its annual conference in Baltimore, Md., last week, the National Black Caucus of State Legislators (NBCSL) adopted two resolutions sponsored by state Rep. LeAnna Washington, D-Phila.

The first resolution affirmed NBCSL's opposition to downgrading the classification of Ritalin, a Schedule II drug along with opium, morphine and cocaine.

Washington has made it one of her legislative priorities to raise awareness of the use and effects of Ritalin and other psychiatric drugs on children.

Ritalin and similar drugs are prescribed to between 5 million and 6 million children each year - about 10 percent of the school-age population.

"The question of whether these drugs are helping or hurting our children is the subject of great debate," Washington said. "It has been suggested that recent incidents of school violence and other occasions of violence are the result of children being unnecessarily medicated by such drugs."

Washington said there is a push to have Ritalin downgraded from a Schedule II drug.

"There is concern that relaxing controls will give young people easier access to a drug that already is used to get high and frequently is used by young people attempting suicide," Washington said.

--more--

Washington would like the state departments of Health and Education to conduct studies into how children are labeled as having attention deficit disorder and how school districts might benefit.

Washington also wants lawmakers to examine whether or not former welfare mothers are allowing their children to be labeled as ADD in order to receive Social Security benefits.

The second Washington-sponsored resolution urges NBCSL members to focus attention on the disproportionate consumption of malt liquor in urban African-American communities.

Washington said African Americans in urban communities make up almost 75 percent of the malt liquor market.

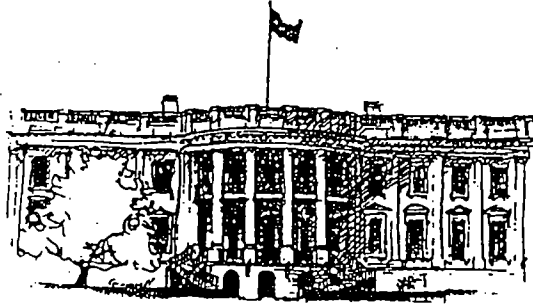
"Malt liquor exceeds the federal government's standard for moderate alcohol consumption," Washington said. "One 40-ounce bottle of a brand popular with young African-American males has roughly the same alcohol content as six 12-ounce cans of beer.

"This jeopardizes the health of those who consume it on a regular basis, among other concerns."

Washington said NBCSL lawmakers have been encouraged to decrease consumption of malt liquor in their respective states. She suggested the need for a study into malt liquor consumption among urban African Americans.

Washington said she was pleased the resolutions were adopted by her NBCSL colleagues but said there is room for more discussion on both issues.

IGH
Math



The White House
Presidential Scheduling

TO:

Karin Kullman

DATE:

5/2

FROM:

Carrie Street
184 OEOB/456-5487

ATTACHED:

☒ Please advise on how to respond	☐ For your information	☐ For your action
☐ As you requested	☐ Please call me regarding the attached	☐ Please prepare response per instructions below
☐ For your approval	☐ For Surrogate Consideration	☐ Please prepare Scheduling Proposal

COMMENTS:

Please advise. Thanks!

ANN - 5/24 —

1 Karin -
Pls. advise
Anna & follow
up w/ this state
legislative trans. - Ann

Again, please advise
regarding who (if anyone)
should meet w/ this state
Rep. Should the First Lady?
Chris Jennings? You?
Melanne? THANKS -
Anna

CC:

The Role for Pills in Preschool

By Harold S. Koplewicz, M.D., Director, New York University Child Study Center (New York Times, March 1, 2000)

The outcry over a recent report showing a dramatic increase in the use of medications like Ritalin for preschoolers reminded me of a patient of mine named Christopher.

In the early 1960's, when I was researching the efficacy of Ritalin in young children, Christopher was 3 1/2. He still slept in a crib to discourage his getting up in the middle of the night and wandering around the house. It didn't work: he often escaped, going to the kitchen and playing with the stove. Babysitters came only once. Nursery schools kept him for just a few days.

We observed Christopher and his mother in our clinic. She kept running after him to catch his attention; he played with 61 toys in one five-minute span. Then we put Christopher on Ritalin. In his mother's words: "He became a different child. He will sit and let me read a book to him. I can take him to a puppet show. We now can enjoy each other."

Christopher is now 20, a high school graduate who describes himself as well adjusted and happy. He also still takes Ritalin twice a day.

I guess I shouldn't be surprised that attention deficit hyperactivity disorder is still so frequently dismissed as childhood exuberance or "just a phase." Most adults do not realize how it differs from behavior that is simply on the active end of normal. Children with the disorder are 10 times as likely as the average child to drop out of high school. They have a higher incidence of drug abuse. This is a real psychiatric disorder and requires treatment.

The latest study, published in the Journal of the American Medical Association, found that between 1991 and 1995, there was a twofold to threefold increase in the use of Ritalin and similar drugs in children aged 2 to 4. About 1 in 100 children received Ritalin in 1995. Is 1 percent of children taking such medications too high?

Unfortunately we have no information about the percentage of very young children who meet the criteria for an accurate diagnosis of A.D.H.D. For those who do, medications like Ritalin are the best treatment we have.

Understandably, there is concern that medications may affect brain development. Encouragingly, the evidence we have, although limited and crude, does not suggest that development is compromised by Ritalin.

Critics are also concerned that some medications for psychiatric illness are prescribed for preschoolers without approval by the Food and Drug Administration for use in that age group. But this practice holds true in other areas of medical care. One asthma medication, for example, is frequently given to young kids even though the F.D.A. has not approved it for children. There is ample evidence of Ritalin's effectiveness for school-aged children with A.D.H.D., and some evidence that it



New York University
Child Study Center

helps younger children.

What should be at issue is not the clinical wisdom of giving Ritalin to young children, but who gives it and how the decision is made. Unfortunately, pediatricians and general practitioners are usually not trained to undertake the necessary clinical evaluations to make psychiatric diagnoses and monitor treatment.

Increasing use of Ritalin is not necessary cause for alarm. The real outrage is that an estimated 20 percent of the nearly 10 million American children and teenagers who suffer from diagnosable psychiatric illnesses ever receive help.

The reader is also referred to the following on this web site: In the Mental Health Guide: Attention-Deficit/ Hyperactivity Disorder, in Programs: Institute for Attention Deficit-Hyperactivity and Related Disorders.

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OUR DISCLAIMER

Viewers of this website are advised that materials contained on this site are made available solely for educational purposes and as part of an effort to raise general awareness of the mental health issues affecting children. These materials are not intended to be, and are not, a substitute for direct professional medical or psychological care based on your individual condition and circumstances or those of your child. While this site may contain descriptions of pharmacological, psychiatric and psychological treatments, such descriptions and any related materials should not be used to diagnose or treat a mental health problem without consulting a qualified mental health care provider. You are advised to consult your mental health provider about your personal questions or concerns.

THE WHITE HOUSE
WASHINGTON

June 27, 2000

MEMORANDUM FOR HILLARY RODHAM CLINTON

FROM: HEATHER HOWARD^{HH}

CC: MELANNE VERVEER
LISSA MUSCATINE
ANN O'LEARY

SUBJECT: UPDATE ON EFFORTS TO IMPROVE THE TREATMENT OF
CHILDREN WITH EMOTIONAL AND BEHAVIORAL
CONDITIONS

Before your interview with the Medical Editor of CBS, I wanted to briefly update you on what has happened since your event in March announcing new Federal efforts to improve the diagnosis and treatment of children with emotional and behavioral conditions.

- **New guidelines for the diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) from the American Academy of Pediatrics.** At your Roosevelt Room event, you announced that the Academy was developing new guidelines for the diagnosis and treatment of ADHD. In May, the Academy released the new treatment guidelines to their 55,000 members. The new guidelines require that ADHD symptoms be present in two or more of a child's settings, and that the symptoms adversely affect the child's academic or social functioning for at least six months. The new guidelines recommend that the assessment of ADHD include information obtained directly from parents or caregivers, as well as a classroom teacher or other school professional, regarding the core symptoms of ADHD in various settings. They also recommend that evaluation include assessment for co-existing conditions, such as learning and language problems, aggression, disruptive behavior, depression or anxiety. The Academy is currently developing the new ADHD treatment guidelines, which are expected to be released this fall.
- **NIMH research.** NIMH is in the process of funding a \$5 million multi-site trial on the use of Ritalin to treat ADHD in preschoolers.
- **FDA efforts.** Due in large part to the attention you have focused on this issue, the FDA is now working to develop the science base necessary to create protocols for developing new labeling information for pediatric dosages. In September, the FDA's Pediatric Advisory Subcommittee will be meeting to discuss the ethical issues surrounding studying children, and in October, the FDA and NIMH are holding a joint meeting entitled "Psychopharmacology for Young Children: Clinical Needs and Research Opportunities."

- **Planning for the Fall Surgeon General's Conference on the Treatment of Children with Behavioral and Mental Disorders.** Planning for the conference, scheduled for September 17th and 18th, 2000, is ongoing. On Monday, June 26, 2000, the Surgeon General held a "listening session," to which he invited 50 groups representing healthcare providers, educators, parents, and consumers. Representatives from NIMH, the FDA, SAMSA, and the Center for Mental Health Services also participated. The meeting, which I attended, solicited input on four key questions:
 - What are the key barriers to identifying, recognizing or referring children with mental health needs (e.g., definitional, systems, training, assessment issues, costs, etc.)?
 - What are the major challenges to using evidence-based strategies to identify and treat children with mental health problems?
 - What are the major service obstacles to delivering mental health care to children and families?
 - What are the key research and service priorities in children's mental health?

The overarching themes in the comments were:

- The importance of coordination between the different providers in children's lives, including those in the health care, education, and child care systems.
- The need for better training for health providers and educators, to help them assess children's behavioral and mental problems.
- The critical importance of proper assessment, which everyone agreed cannot happen during a ten-minute doctor's visit.
- The importance of involving families in all aspects of treatment, including diagnoses, service design and delivery.
- The need for research on the zero to five population.
- The difficulties in translating research into practice.

As you mentioned in your speech at the March event, pharmaceutical companies and health insurers need to be included in this discussion. The Surgeon General's office has assured me that they will be included in the fall conference.

THE WHITE HOUSE

WASHINGTON

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6/26

Planning Meeting for SG's Conference

Kelly Henderson - DOE

Group 4

Barriers / Obstacles / Challenges - YCI

① Costs / Resources

costs, limits, inequities across funding + service systems

human resources / training - lack of, not enough in pipeline

not enough incentive to get people to go into public sector

training teacher training - to address early childhood with

early identification of kids w/ problems

training - making latest research available to practitioners

② Coordination

insurers / providers

public / private system

between acute, crisis, long term care providers

- public system has turned into acute system ^{can}

in mechanism for long term

between providers - diff systems - schools + homes

between agencies

③

Communication + Connection

- gaps in research

- research to practice

- research / practice to public

Stigma - huge barrier to overcome

④ Context / Community

- family centered
- multi-cultural
- importance of culture in practice
- policy issues - regulations at state + federal level
 - ex: Medicaid waiver definitions - Things designed to provide provide flexibility make it harder
- social & economic policy - why we are treating things as we are

Key research + service priorities:

- * Meeting demand to best service systems, based on comprehensive assessment
- * Conducting NCI research agenda
 - comprehensive synthesis of what is known
 - pharmacological impact on children
 - functional ~~and~~ outcome research
- * Better connections between research + practice

Group 5

primary care providers have little background

barriers ①

stigma / myths

cultural competence

Need for a diagnosis - too much focus on ~~symptoms~~ ^{symptoms} + not enough on daily life functioning - ~~to~~ see big picture

challenge ②

- lack of knowledge + training - what are evidence based treatments ^{lack of knowl.}
- translate research into practice ^{schools}
- ~~lack of evidence~~ ^{providers}

(2)

service
obstacles

- ③ ~~and~~ public health approach - have hidden the
lack of coordination
with involvement for care management
increased collaboration b/w system
training throughout system

④ Key research + service priorities

Research: continued development of evidence based practices

Service: coordination b/w primary health care + health providers
family strategies

Group
2

overarching concern:

~~public~~ public health approach

- need for framework linking primary prevention, diagnosis, treatment + long term care through:
 - coordination of agencies
 - a developmental approach
 - appropriate care for appropriate need
 - cost-sharing on basis of family needs
- * incentives for effective treatment

priority needs

overall - adequately trained personnel
family involvement

10/Screening - reducing stigma

~~family involvement~~ focus on prevention & developmental issues

services - need ^{to do} better job connecting evidence - ~~base~~ ^{base} of practice

research - more ~~or~~ ^{or} ~~not~~ ^{not} ~~benefit~~ ^{benefit} studies

more real world applications studies

Resource implications

need to increase public & city commitment to children's ^{with}

redistribution - need \$ in services also strong evidence base
invest in people

Group 1

on reaching goals

- cultural competence / infusion - & way people think about diff
- stigma - ^{need to} overcome
- family engagement
- policy

① lack of education & training -

lack of coordination among agencies - ^{Schools, child care} providers, ^{health,} ^{policy,} ^{specialty}

focus on immunization - success - all kids

concerted effort - get everyone to talk about it ^{why} ^{when}

lack of community support - public housing, school-based ^{services}

(3)

evidence based strategies - research + translate into real world practice

⑥ obstacles to service

- mod. + inapp. diagnosis + service
- financing, stigma, training + education
- lack of integrated services

⑦ service + research priorities

- effectiveness / efficiency /
- better diagnostic categories
 - what works for who

* lack of atten to zero to 5 pop.
prevention / resiliency

impact of MC financing vs. financing access to service

interagency / inter disc.

child care, educators - everyone involved
in life of child

Group 3

overarching themes:

- focus on developmental model - not medical
look at context of child development
- greater involvement of families - assessment,
service design + delivery, test + research
- funding - not being used in right ways
- include funders at table
- need for stable funding stream

* first assessment - can assess kid in 10 minutes
look at family

① barriers -

multiple assessment (schools, MHC clinic, ^{many} ^{assess} ^{diff} ^{choice})
- need to coordinate - family system
focus on strengths & resilience - imp. of context

② challenges

research on effectiveness
in...

③ obstacles to service delivery

- current focus is on teachers & adults

DSM-IV is adult oriented

need measures of child functioning

attn to child abuse & neglect

Satcher:

Satcher's Deputy

Bernie O'Leary

new areas - training - teachers, parents, coaches, etc
children, MHC

public health model - start w/ surveillance & prevention

Rafael
Nakimura

Deputy - NIMH

- research

started clinical trials - more like real world

American Academy of Pediatrics
Department of Government Liaison
Suite 400 North
601 13th Street, N.W.
Washington, D.C. 20005

Phone: 800/336-5475 or 202/347-8600
Fax: 202/393-6137

To: Heather Howard

Fax #: 456-2878

From: Joanna Parzakonis
(x3006)

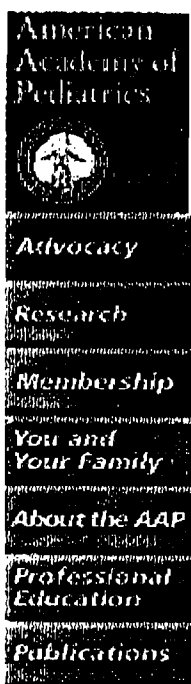
Date: June 27, 2000

Page 1 of 21 15

Re: AAP Guidelines on diagnosis of ADHD

Heather:

Don't hesitate to call if you have questions.

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Press Release

AAP RELEASES NEW GUIDELINES FOR DIAGNOSIS OF ADHD

Below is a news release of a policy published in the May issue of Pediatrics, the peer-reviewed scientific journal of the American Academy of Pediatrics (AAP).

For Release: May 1, 2000, 5:00 p.m. (ET)

CHICAGO - The American Academy of Pediatrics (AAP) released new recommendations today for the assessment of school-age children with attention-deficit/hyperactivity disorder (ADHD).

Research in various community and practice settings shows that between 4 and 12 percent of all school-age children may have ADHD, making it the most common childhood neurobehavioral disorder. Children with ADHD may experience significant functional problems such as school difficulties, academic underachievement, troublesome relationships with family members and peers, and behavioral problems.

In recent years, there has been growing interest in ADHD as well as concerns about possible over diagnosis. In surveys among pediatricians and family physicians across the country, wide variations were found in diagnostic criteria and treatment methods for ADHD.

The new standardized AAP guidelines were developed by a panel of medical, mental health and educational experts. The Agency for Healthcare Research and Quality provided significant research and background information for the new policy.

The new guidelines, designed for primary care physicians diagnosing ADHD in children age 6 to 12, include the following recommendations:

- ADHD evaluations should be initiated by the primary care clinician for children who show signs of school difficulties, academic underachievement, troublesome relationships with teachers, family members and peers, and other behavioral problems. Questions to parents, either directly or through a pre-visit questionnaire, regarding school and behavioral issues may help alert physicians to possible ADHD.
- In diagnosing ADHD, physicians should use DSM-IV criteria developed by the American Psychiatric Association. These guidelines require that ADHD symptoms be present in two or more of a child's settings, and that the symptoms adversely affect the child's academic or social functioning for at least six months.
- The assessment of ADHD should include information obtained directly from parents or caregivers, as well as a classroom teacher or other school professional, regarding the core symptoms of ADHD in various settings, the age of onset, duration of symptoms and degree of functional impairment.
- Evaluation of a child with ADHD should also include assessment for co-existing conditions: learning and language problems, aggression, disruptive behavior, depression or anxiety. As many as one-third of children diagnosed with ADHD also have a co-existing condition.

Other diagnostic tests, sometimes considered positive indicators for ADHD, have been reviewed and considered not effective. These tests include lead screening, tests for generalized resistance to thyroid hormone, and brain image studies.

Comprehensive ADHD treatment guidelines are also in development.

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Diagnosis and Evaluation of the Child With Attention-Deficit/Hyperactivity Disorder (AC0002)

AMERICAN ACADEMY OF PEDIATRICS

Committee on Quality Improvement, Subcommittee on Attention-Deficit/Hyperactivity Disorder

PDF FORMAT, 222K (get Adobe Acrobat Reader software)
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ABSTRACT. This clinical practice guideline provides recommendations for the assessment and diagnosis of school-aged children with attention-deficit/hyperactivity disorder (ADHD). This guideline, the first of 2 sets of guidelines to provide recommendations on this condition, is intended for use by primary care clinicians working in primary care settings. The second set of guidelines will address the issue of treatment of children with ADHD.

The Committee on Quality Improvement of the American Academy of Pediatrics selected a committee composed of pediatricians and other experts in the fields of neurology, psychology, child psychiatry, development, and education, as well as experts from epidemiology and pediatric practice. In addition, this panel consists of experts in education and family practice. The panel worked with Technical Resources International, Washington, DC, under the auspices of the Agency for Healthcare Research and Quality, to develop the evidence base of literature on this topic. The resulting evidence report was used to formulate recommendations for evaluation of the child with ADHD. Major issues contained within the guideline address child and family assessment; school assessment, including the use of various rating scales; and conditions seen frequently among children with ADHD. Information is also included on the use of current diagnostic coding strategies. The deliberations of the committee were informed by a systematic review of evidence about prevalence, coexisting conditions, and diagnostic tests. Committee decisions were made by consensus where definitive evidence was not available. The committee report underwent review by sections of the American Academy of Pediatrics and external organizations before approval by the Board of Directors.

The guideline contains the following recommendations for diagnosis of ADHD: 1) in a child 6 to 12 years old who presents with inattention, hyperactivity, impulsivity, academic underachievement, or behavior problems, primary care clinicians should initiate an evaluation for ADHD; 2) the diagnosis of ADHD requires that a child meet *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* criteria; 3) the assessment of ADHD requires evidence directly obtained from parents or caregivers regarding the core symptoms of ADHD in various settings, the age of onset, duration of symptoms, and degree of functional impairment; 4) the assessment of ADHD requires evidence directly obtained from the classroom teacher (or other school professional) regarding the core symptoms of ADHD, duration of symptoms, degree of functional impairment, and associated conditions; 5) evaluation of the child with ADHD should include assessment for associated (coexisting) conditions; and 6) other diagnostic tests are not routinely indicated to establish the diagnosis of ADHD but may be used for the assessment of other coexisting conditions (eg, learning disabilities and mental retardation).

This clinical practice guideline is not intended as a sole source of guidance in the evaluation of children with ADHD. Rather, it is designed to assist primary care clinicians by providing a framework for diagnostic decisionmaking. It is not intended to replace clinical judgment or to

establish a protocol for all children with this condition and may not provide the only appropriate approach to this problem.

ABBREVIATIONS. ADHD, attention-deficit/hyperactivity disorder; *DSM-IV*, *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*; AAP, American Academy of Pediatrics; *DSM-PC*, *Diagnostic and Statistical Manual for Primary Care*.

Attention-deficit/hyperactivity disorder (ADHD) is the most common neurobehavioral disorder of childhood. ADHD is also among the most prevalent chronic health conditions affecting school-aged children. The core symptoms of ADHD include inattention, hyperactivity, and impulsivity.^{1,2} Children with ADHD may experience significant functional problems, such as school difficulties, academic underachievement,³ troublesome interpersonal relationships with family members^{4,5} and peers, and low self-esteem. Individuals with ADHD present in childhood and may continue to show symptoms as they enter adolescence⁶ and adult life.⁷ Pediatricians and other primary care clinicians frequently are asked by parents and teachers to evaluate a child for ADHD. Early recognition, assessment, and management of this condition can redirect the educational and psychosocial development of most children with ADHD.^{8,9}

Recorded prevalence rates for ADHD vary substantially, partly because of changing diagnostic criteria over time,¹⁰⁻¹³ and partly because of variations in ascertainment in different settings and the frequent use of referred samples to estimate rates. Practitioners of all types (primary care, subspecialty, psychiatry, and nonphysician mental health providers) vary greatly in the degree to which they use *Diagnostic and Statistical Manual of Mental Health Disorders, Fourth Edition (DSM-IV)* criteria to diagnose ADHD. Reported rates also vary substantially in different geographic areas and across countries.¹⁴

With increasing epidemiologic and clinical research, diagnostic criteria have been revised on multiple occasions over the past 20 years.¹⁰⁻¹³ A recent review of prevalence rates in school-aged community samples (rather than referred samples) indicates rates varying from 4% to 12%, with estimated prevalence based on combining these studies of ~8% to 10%. In the general population,^{15-23,24} 9.2% (5.8%-13.6%) of males and 2.9% (1.9%-4.5%) of females are found to have behaviors consistent with ADHD. With the *DSM-IV* criteria (compared with earlier versions), more females have been diagnosed with the predominantly inattentive type.^{25,26} Prevalence rates also vary significantly depending on whether they reflect school samples 6.9% (5.5%-8.5%) versus community samples 10.3% (8.2%-12.7%).

Public interest in ADHD has increased along with debate in the media concerning the diagnostic process and treatment strategies.²⁷ Concern has been expressed about the over-diagnosis of ADHD by pointing to the several-fold increase in prescriptions for stimulant medication among children during the past decade.²⁸ In addition, there are significant regional variations in the amount of stimulants prescribed by physicians.²⁹ Practice surveys among primary care pediatricians and family physicians reveal wide variations in practice patterns about diagnostic criteria and methods.³⁰

ADHD commonly occurs in association with oppositional defiant disorder, conduct disorder, depression, anxiety disorder,¹⁶ and with many developmental disorders, such as speech and language delays and learning disabilities.

This diagnostic guideline is intended for use by primary care clinicians to evaluate children between 6 and 12 years of age for ADHD, consistent with best available empirical studies. Special attention is given to assessing school performance and behavior, family functioning, and adaptation. In light of the high prevalence of ADHD in pediatric practice, the guideline should assist primary care clinicians in these assessments. The diagnosis usually requires several steps. Clinicians will generally need to carry out the evaluation in more than 1 visit, often indeed 2 to 3 visits. The guideline is not intended for children with mental retardation, pervasive developmental disorder, moderate to severe sensory deficits such as visual and hearing impairment, chronic disorders associated with medications that may affect

behavior, and those who have experienced child abuse and sexual abuse. These children too may have ADHD, and this guideline may help clinicians in considering this diagnosis; nonetheless, this guideline primarily reviews evidence relating to the diagnosis of ADHD in relatively uncomplicated cases in primary care settings.

METHODOLOGY

To initiate the development of a practice guideline for the diagnosis and evaluation of children with ADHD directed toward primary care physicians, the American Academy of Pediatrics (AAP) worked with several colleague organizations to organize a working panel representing a wide range of primary care and subspecialty groups. The committee, chaired by 2 general pediatricians (1 with substantial additional experience and training in developmental and behavioral pediatrics), included representatives from the American Academy of Family Physicians, the American Academy of Child and Adolescent Psychiatry, the Child Neurology Society, and the Society for Pediatric Psychology, as well as developmental and behavioral pediatricians and epidemiologists.

This group met over a period of 2 years, during which it reviewed basic literature on current practices in the diagnosis of ADHD and developed a series of questions to direct an evidence-based review of the prevalence of ADHD in community and primary care practice settings, the rates of coexisting conditions, and the utility of several diagnostic methods and devices. The AAP committee collaborated with the Agency for Healthcare Research and Quality in its support of an evidence-based review of several of these key items in the diagnosis of ADHD. David Atkins, MD, provided liaison from the Agency for Healthcare Research and Quality, and Technical Resources International conducted the evidence review.

The Technical Resources International report focused on 4 specific areas for the literature review: the prevalence of ADHD among children 6 to 12 years of age in the general population and the coexisting conditions that may occur with ADHD; the prevalence of ADHD among children in primary care settings and the coexisting conditions that may occur; the accuracy of various screening methods for diagnosis; and the prevalence of abnormal findings on commonly used medical screening tests. The literature search was conducted using Medline and PsycINFO databases, references from review articles, rating scale manuals, and articles identified by the subcommittee. Only articles published in English between 1980 and 1997 were included. The study population was limited to children 6 to 12 years of age, and only studies using general, unselected populations in communities, schools, or the primary clinical setting were used. Data on screening tests were taken from studies conducted in any setting. Articles accepted for analysis were abstracted twice by trained personnel and a clinical specialist. Both abstracts for each article were compared and differences between them resolved. A multiple logistic regression model with random effects was used to analyze simultaneously for age, gender, diagnostic tool, and setting using EGRET software. Results were presented in evidence tables and published in the final evidence report.²⁴

The draft practice guideline underwent extensive peer review by committees and sections within the AAP, by numerous outside organizations, and by other individuals identified by the subcommittee. Liaisons to the subcommittee also were invited to distribute the draft to entities within their organizations. The resulting comments were compiled and reviewed by the subcommittee co-chairpersons, and relevant changes were incorporated into the draft based on recommendations from peer reviewers.

The recommendations contained in the practice guideline are based on the best available data (Fig 1). Where data were lacking, a combination of evidence and expert consensus was used. Strong recommendations were based on high-quality scientific evidence, or, in the absence of high-quality data, strong expert consensus. Fair and weak recommendations were based on lesser quality or limited data and expert consensus. Clinical options were identified as interventions because the subcommittee could not find compelling evidence for or against. These clinical options are interventions that a reasonable health care provider might or might not wish to implement in his or her practice.

RECOMMENDATION 1: *In a child 6 to 12 years old who presents with inattention, hyperactivity,*

impulsivity, academic underachievement, or behavior problems, primary care clinicians should initiate an evaluation for ADHD (strength of evidence: good; strength of recommendation: strong).

The major justification for this recommendation is the high prevalence of ADHD in school-aged populations. School-aged children with a variety of developmental and behavioral concerns present to primary care clinicians.³¹ Primary care pediatricians and family physicians recognize behavior problems that may impact academic achievement in 18% of school-aged children seen in their offices and clinics. Hyperactivity or inattention is diagnosed in 9% of children.³²

Presentations of ADHD in clinical practice vary. In many cases, concerns derive from parents, teachers, other professionals, or nonparental caregivers. Common presentations include referral from school for academic underachievement and failure, disruptive classroom behavior, inattentiveness, problems with social relationships, parental concerns regarding similar phenomena, poor self-esteem, or problems with establishing or maintaining social relationships. Children with core ADHD symptoms of hyperactivity and impulsivity are identified by teachers, because they often disrupt the classroom. Even mild distractibility and motor symptoms, such as fidgetiness, will be apparent to most teachers. In contrast, children with the inattentive subtype of ADHD, where hyperactive and impulsive symptoms are absent or minimal, may not come to the attention of teachers. These children may present with school underachievement.

Symptoms may not be apparent in a structured clinical setting that is free from the demands and distraction of the home and school.³³ Thus, if parents do not bring concerns to the primary clinician, then early detection of ADHD in primary care may not occur. Clinical practices during routine health supervision may assist in early recognition of ADHD.^{34,35} Options include direct history from parents and children. The following general questions may be useful at all visits for school-aged children to heighten attention about ADHD and as an initial screening for school performance.

1. How is your child doing in school?
2. Are there any problems with learning that you or the teacher has seen?
3. Is your child happy in school?
4. Are you concerned with any behavioral problems in school, at home, or when your child is playing with friends?
5. Is your child having problems completing classwork or homework?

Alternatively, a previsit questionnaire may be sent to parents or given while the family is waiting in the reception area.³⁶ When making an appointment for a health supervision visit for a school-aged child, 1 or 2 of these questions may be asked routinely to sensitize parents to the concerns of their child's clinician. For example, "Your child's clinician is interested in how your child is doing in school. You might check with her teacher and discuss any concerns with your child's physician." Wall posters, pamphlets, and books in the waiting area that focus on educational achievements and school-aged behaviors send a message that this is an office or clinic that considers these issues important to a child's development.³⁷

RECOMMENDATION 2: The diagnosis of ADHD requires that a child meet DSM-IV criteria (strength of evidence: good; strength of recommendation: strong).

Establishing a diagnosis of ADHD requires a strategy that minimizes over-identification and under-identification. Pediatricians and other primary care health professionals should apply *DSM-IV* criteria in the context of their clinical assessment of a child. The use of specific criteria will help to ensure a more accurate diagnosis and decrease variation in how the diagnosis is made. The *DSM-IV* criteria, developed through several iterations by the American Psychiatric Association, are based on clinical experience and an expanding research foundation.¹³ These criteria have more support in the literature than other available diagnostic criteria. The *DSM-IV* specification of behavior items, required numbers of items, and levels of impairment reflect the current consensus among clinicians, particularly psychiatry. The consensus includes increasing research evidence, particularly in the distinctions that the *DSM-IV* makes for the dimensions of attention and hyperactivity-impulsivity.³⁸

The *DSM-IV* criteria define 3 subtypes of ADHD (see [Table 1](#) for specific inattention and hyperactive-impulsive items).

- ADHD primarily of the inattentive type (ADHD/I, meeting at least 6 of 9 inattention behaviors)
- ADHD primarily of the hyperactive-impulsive type (ADHD/HI, meeting at least 6 of 9 hyperactive-impulsive behaviors)
- ADHD combined type (ADHD/C, meeting at least 6 of 9 behaviors in both the inattention and hyperactive-impulsive lists)

Children who meet diagnostic criteria for the behavioral symptoms of ADHD but who demonstrate no functional impairment do not meet the diagnostic criteria for ADHD.¹³ The symptoms of ADHD should be present in 2 or more settings (eg, at home and in school), and the behaviors must adversely affect functioning in school or in a social situation. Reliable and clinically valid measures of dysfunction applicable to the primary care setting have been difficult to develop. The diagnosis comes from a synthesis of information obtained from parents; school reports; mental health care professionals, if they have been involved; and an interview/examination of the child. Current *DSM-IV* criteria require evidence of symptoms before 7 years of age. In some cases, the symptoms of ADHD may not be recognized by parents or teachers until the child is older than 7 years of age, when school tasks become more challenging. Age of onset and duration of symptoms may be obtained from parents in the course of a comprehensive history.

Teachers, parents, and child health professionals typically encounter children with behaviors relating to activity, impulsivity, and attention who may not fully meet *DSM-IV* criteria. The *Diagnostic and Statistical Manual for Primary Care (DSM-PC), Child and Adolescent Version*,³⁹ provides a guide to the more common behaviors seen in pediatrics. The manual describes common variations in behavior, as well as more problematic behaviors, at levels less than those specified in the *DSM-IV* (and with less impairment). The behavioral descriptions of the *DSM-PC* have not yet been tested in community studies to determine the prevalence or severity of developmental variations and moderate problems in the areas of inattention and hyperactivity or impulsivity. They do, however, provide guidance to clinicians in the evaluation of children with these symptoms and help to direct clinicians to many elements of treatment for children with problems with attention, hyperactivity, or impulsivity ([Table 2](#) and [Table 3](#)). The *DSM-PC* also considers environmental influences on a child's behavior and provides information on differential diagnosis with a developmental perspective.

Given the lack of methods to confirm the diagnosis of ADHD through other means, it is important to recognize the limitations of the *DSM-IV* definition. Most of the development and testing of the *DSM-IV* has occurred through studies of children seen in psychiatric settings. Much less is known about its use in other populations, such as those seen in general pediatric or family practice settings. Despite the agreement of many professionals working in this field, the *DSM-IV* criteria remain a consensus without clear empirical data supporting the number of items required for the diagnosis. Current criteria do not take into account gender differences or developmental variations in behavior. Furthermore, the behavioral characteristics specified in the *DSM-IV*, despite efforts to standardize them, remain subjective and may be interpreted differently by different observers. Continuing research will likely clarify the validity of the *DSM-IV* criteria (and subsequent modifications) in the diagnosis. These complexities in the diagnosis mean that clinicians using *DSM-IV* criteria must apply them in the context of their clinical judgment.

No instruments used in primary care practice reliably assess the nature or degree of functional impairment of children with ADHD. With information obtained from the parent and school, the clinician can make a clinical judgment about the effect of the core and associated symptoms of ADHD on academic achievement, classroom performance, family and social relationships, independent functioning, self-esteem, leisure activities, and self-care (such as bathing, toileting, dressing, and eating).

The following 2 recommendations establish the presence of core behavior symptoms in multiple settings.

RECOMMENDATION 3: *The assessment of ADHD requires evidence directly obtained from parents or caregivers regarding the core symptoms of ADHD in various settings, the age of onset, duration of symptoms, and degree of functional impairment (strength of evidence: good; strength of recommendation: strong).*

Behavior symptoms may be obtained from parents or guardians using 1 or more methods, including open-ended questions (eg, "What are your concerns about your child's behavior in school?"), focused questions about specific behaviors, semi-structured interview schedules, questionnaires, and rating scales. Clinicians who obtain information from open-ended or focused questions must obtain and record the relevant behaviors of inattention, hyperactivity, and impulsivity from the *DSM-IV*. The use of global clinical impressions or general descriptions within the domains of attention and activity is insufficient to diagnose ADHD. As data are gathered about the child's behavior, an opportunity becomes available to evaluate the family environment and parenting style. In this way, behavioral symptoms may be evaluated in the context of the environment that may have important characteristics for a particular child.

Specific questionnaires and rating scales have been developed to review and quantify the behavioral characteristics of ADHD (Table 4). The ADHD-specific questionnaires and rating scales have been shown to have an odds ratio greater than 3.0 (equivalent to sensitivity and specificity greater than 94%) in studies differentiating children with ADHD from normal, age-matched, community controls.²⁴ Thus, ADHD-specific rating scales accurately distinguish between children with and without the diagnosis of ADHD. Almost all studies of these scales and checklists have taken place under ideal conditions, ie, comparing children in referral sites with apparently healthy children. These instruments may function less well in primary care clinicians' offices than indicated in the tables. In addition, questions on which these rating scales are based are subjective and subject to bias. Thus, their results may convey a false sense of validity and must be interpreted in the context of the overall evaluation of the child. Whether these scales provide additional benefit beyond careful clinical assessment informed by *DSM-IV* criteria is not known. **RECOMMENDATION 3A:** *Use of these scales is a clinical option when evaluating children for ADHD (strength of evidence: strong; strength of recommendation: strong).*

Global, nonspecific questionnaires and rating scales that assess a variety of behavioral conditions, in contrast with the ADHD-specific measures, generally have an odds ratio <2.0 (equivalent to sensitivity and specificity $<86\%$) in studies differentiating children referred to psychiatric practices from children who were not referred to psychiatric practices (Table 5). Thus, these broadband scales do not distinguish well between children with and without ADHD. **RECOMMENDATION 3B:** *Use of broadband scales is not recommended in the diagnosis of children for ADHD, although they may be useful for other purposes (strength of evidence: strong; strength of recommendation: strong).*

More research is needed on the use of the ADHD-specific and global rating scales in pediatric practices for the purposes of differentiating children with ADHD from other children with different behavior or school problems.

RECOMMENDATION 4: *The assessment of ADHD requires evidence directly obtained from the classroom teacher (or other school professional) regarding the core symptoms of ADHD, the duration of symptoms, the degree of functional impairment, and coexisting conditions. A physician should review any reports from a school-based multidisciplinary evaluation where they exist, which will include assessments from the teacher or other school-based professional (strength of evidence: good; strength of recommendation: strong).*

The evaluation of ADHD must establish whether core behavior symptoms of inattention, hyperactivity, and impulsivity are present in >1 setting to meet *DSM-IV* criteria for the condition. Children 6 to 12 years of age generally are students in an elementary school setting, where they spend a substantial proportion of waking hours. Therefore, a description of their behavioral characteristics in the school setting is highly important to the evaluation. With permission from the legal guardian, the clinician should review a report from the child's school. The classroom teacher typically has more information about the child's behavior than do other professionals at the school and, when possible, should provide the report. Alternatively, a school counselor or principal often is helpful in coordinating the teacher's reporting and may be able to provide the required information.

Behavior symptoms may be obtained using 1 or more methods such as verbal narratives, written narratives, questionnaires, or rating scales. Clinicians who obtain information from narratives or interviews must obtain and record the relevant behaviors of inattention, hyperactivity, and impulsivity from the *DSM-IV*. The use of global clinical impressions or general descriptions within the domains of attention and activity is insufficient to diagnose ADHD.

The ADHD-specific questionnaires and rating scales also are available for teachers (Table 4). Teacher ADHD-specific questionnaires and rating scales have been shown to have an odds ratio >3.0 (equivalent to sensitivity and specificity greater than 94%) in studies differentiating children with ADHD from normal peers in the community.²⁴ Thus, teacher ADHD-specific rating scales accurately distinguish between children with and without the diagnosis of ADHD. Whether these scales provide additional benefit beyond narratives or descriptive interviews informed by *DSM-IV* criteria is not known.

RECOMMENDATION 4A: Use of these scales is a clinical option when diagnosing children for ADHD (strength of evidence: strong; strength of recommendation: strong).

Teacher global questionnaires and rating scales that assess a variety of behavioral conditions, in contrast with the ADHD-specific measures, generally have an odds ratio <2.0 (equivalent to sensitivity and specificity $<86\%$) in studies differentiating children referred to psychiatric practices from children who were not referred to psychiatric practices (Table 5). Thus, these broadband scales do not distinguish between children with and without ADHD. **RECOMMENDATION 4B: Use of teacher global questionnaires and rating scales is not recommended in the diagnosing of children for ADHD, although they may be useful for other purposes (strength of evidence: strong; strength of recommendation: strong).**

If a child 6 to 12 years of age routinely spends considerable time in other structured environments such as after-school care centers, additional information about core symptoms can be sought from professionals in those settings, contingent on parental permission. The ADHD-specific questionnaires may be used to evaluate the child's behavior in these settings. For children who are educated in their homes by parents, evidence of the presence of core behavior symptoms in settings other than the home should be obtained as an essential part of the evaluation.

Frequently there are significant discrepancies between parent and teacher ratings.⁴⁰ These discrepancies may be in either direction; symptoms may be reported by teachers and not parents or vice versa. These discrepancies may be attributable to differences between the home and school in terms of expectations, levels of structure, behavioral management strategies, and/or environmental circumstances. The finding of a discrepancy between the parents and teachers does not preclude the diagnosis of ADHD. A helpful clinical approach for understanding the sources of the discrepancies and whether the child meets *DSM-IV* criteria is to obtain additional information from other informants, such as former teachers, religious leaders, or coaches.

RECOMMENDATION 5: Evaluation of the child with ADHD should include assessment for coexisting conditions (strength of evidence: strong; strength of recommendation: strong).

A variety of other psychological and developmental disorders frequently coexist in children who are being evaluated for ADHD. As many as one third of children with ADHD have 1 or more coexisting conditions (Table 6). Although the primary care clinician may not always be in a position to make a precise diagnosis of coexisting conditions, consideration and examination for such a coexisting condition should be an integral part of the evaluation. A review of all coexisting conditions (such as motor disabilities, problems with parent-child interaction, or family violence) is not possible within the scope of this review. More common psychological disorders include conduct and oppositional defiant disorder, mood disorders, anxiety disorders, and learning disabilities. The pediatrician should also consider ADHD as a coexisting condition when considering these other conditions. Evidence for most of these coexisting disorders may be readily detected by the primary care clinician. For example, frequent sadness and preference for isolated activities may alert the physician to the presence of depressive symptoms, whereas a family history of anxiety disorders coupled with a patient history characterized by frequent fears and difficulties with separation from caregivers may be suggestive of symptoms

associated with an anxiety disorder. Several screening tests are available that can detect areas of concern for many of the mental health disorders that coexist with ADHD. Although these scales have not been tested for use in primary care settings and are not diagnostic tests for either ADHD or associated mental health conditions, some clinicians may find them useful to establish high risk for coexisting psychological conditions. Similarly, poor school performance may indicate a learning disability. Testing may be required to determine whether a discrepancy exists between the child's learning potential (intelligence quotient) and his actual academic progress (achievement test scores), indicating the presence of a learning disability. Most studies of rates of coexisting conditions have come from referral populations. The following data generally reflect the relatively small number of studies from community or primary care settings.

Conduct Disorder and Oppositional Defiant Disorder

Oppositional defiant or conduct disorders coexist with ADHD in ~35% of children.²⁴ The diagnostic features of conduct disorder include "a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate social norms or rules are violated."¹³ Oppositional defiant disorder (a less severe condition) includes persistent symptoms of "negativistic, defiant, disobedient, and hostile behaviors toward authority figures."¹³ Frequently, children and adolescents with persisting oppositional defiant disorder later develop symptoms of sufficient severity to qualify for a diagnosis of conduct disorder. Longitudinal follow-up for children with conduct disorders that coexist with ADHD indicates that these children fare more poorly in adulthood relative to their peers diagnosed with ADHD alone.⁴¹ For example, 1 study has reported the highest rates of police contacts and self-reported delinquency in children with ADHD and coexisting conduct disorder (30.8%) relative to their peers diagnosed with ADHD alone (3.4%) or conduct disorder alone (20.7%). Preliminary studies suggest that these coexisting conditions are more frequent in children with the predominantly hyperactive-impulsive and combined subtypes.^{25,26}

Mood Disorders/Depression

The coexistence of ADHD and mood disorders (eg, major depressive disorder and dysthymia) is ~18%.³⁹ Frequently, the family history of children with ADHD includes other family members with a history of major depressive disorder.⁴² In addition, children who have coexisting ADHD and mood disorders also may have a poorer outcome during adolescence relative to their peers who do not have this pattern of co-occurrence.⁴³ For example, adolescents with coexisting mood disorders and ADHD are at increased risk for suicide attempts.⁴⁴ Preliminary studies suggest that these coexisting conditions are more frequent in children with the predominantly inattentive and combined subtypes.^{25,26}

Anxiety

The coexisting association between ADHD and anxiety disorders has been estimated to be ~25%.²⁴ In addition, the risk for anxiety disorders among relatives of children and adolescents diagnosed with ADHD is higher than for typically developing children, although some research suggests that ADHD and anxiety disorders transmit independently from families.⁴⁵ In either case, it is important to obtain a careful family history. Preliminary studies suggest that these coexisting conditions are more frequent in children with the predominantly inattentive and combined subtypes.^{25,26}

Learning Disabilities

Only 1 published study examined the coexistence of ADHD and learning disabilities in children evaluated in general pediatric settings using *DSM-IV* criteria for the diagnosis of ADHD.⁴⁶ The prevalence of learning disabilities as a coexisting condition cannot be determined in the same manner as other psychological disorders because studies have employed dimensional (looking at the condition on a spectrum) rather than categorical diagnoses. Rates of learning disabilities that coexist with ADHD in settings other than primary care have been reported to range from 12% to 60%.²⁴

To date, no definitive data describe the differences among groups of children with different learning disabilities coexisting with ADHD in the areas of sociodemographic characteristics, behavioral and emotional functioning, and response to various interventions. Nonetheless, the subgroup of children with learning disabilities, compared with their ADHD peers who do not have a learning disability, is most in need of special education services. Preliminary studies suggest that these coexisting conditions are more frequent in children with the predominantly inattentive and combined subtypes.^{25,26}

RECOMMENDATION 6: Other diagnostic tests are not routinely indicated to establish the diagnosis of ADHD (strength of evidence: strong; strength of recommendation: strong).

Other diagnostic tests contribute little to establishing the diagnosis of ADHD. A few older studies have indicated associations between blood lead levels and child behavior symptoms, although most studies have not.⁴⁷⁻⁴⁹ Although lead encephalopathy in younger children may predispose to later behavior and developmental problems, very few of these children will have elevated lead levels at school age. Thus, regular screening of children for high lead levels does not aid in the diagnosis of ADHD.

Studies have shown no significant associations between abnormal thyroid hormone levels and the presence of ADHD.⁵⁰⁻⁵² Children with the rare disorder of generalized resistance to thyroid hormone have higher rates of ADHD than other populations, but these children demonstrate other characteristics of that condition. This association does not argue for routine screening of thyroid function as part of the effort to diagnose ADHD.

Brain imaging studies and electroencephalography do not show reliable differences between children with ADHD and controls. Although some studies have demonstrated variation in brain morphology comparing children with and without ADHD, these findings do not discriminate reliably between children with and without this condition. In other words, although group means may differ significantly, the overlap in findings among children with and without ADHD creates high rates of false-positives and false-negatives.⁵³⁻⁵⁵ Similarly, some studies have indicated higher rates of certain electroencephalogram abnormalities among children with ADHD,⁵⁶⁻⁵⁸ but again the overlap between children with and without ADHD and the lack of consistent findings among multiple reports indicate that current literature do not support the routine use of electroencephalograms in the diagnosis of ADHD.

Continuous performance tests have been designed to obtain samples of a child's behavior (generally measuring vigilance or distractibility), which may correlate with behaviors associated with ADHD. Several such tests have been developed and tested, but all of these have low odds ratios (all <1.2, equivalent to a sensitivity and specificity <70%) in studies differentiating children with ADHD from normal comparison controls.^{24,45,59,60} Therefore, current data do not support the use of any available continuous performance tests in the diagnosis of ADHD.

AREAS FOR FUTURE RESEARCH

The research issues pertaining to the diagnosis of ADHD relate to the diagnostic criteria themselves as well as the methods used to establish the diagnosis. The *DSM-IV* has helped to define behavioral criteria for ADHD more specifically. Although research has established the dimensional concepts of inattention and hyperactivity-impulsivity, further research is required to validate these subtypes. Because most of the existing research has been conducted with referred convenience samples, primarily in psychiatric settings, further research is required to determine whether the findings of previous research are generalizable to the type of children currently diagnosed and treated by primary care clinicians. Although the current *DSM-IV* criteria are appropriate for the age range included in this guideline, there is, as yet, inadequate information about its applicability to individuals younger or older than the age range for this guideline. Further research should clarify the developmental course of ADHD symptomatology. An additional difficulty for primary care is that existing evidence indicates that the behaviors used in making a *DSM-IV* diagnosis of ADHD fall on a spectrum. Currently, decisions about the inappropriateness of the behaviors in children depend on subjective judgments of observers/reporters. There are no data to offer precise estimates of when diagnostic behaviors become

inappropriate. This is particularly problematic to primary care clinicians, who care for a number of patients who fit into borderline or gray areas. The inadequacy of research on this aspect is central to the issue of which children should be diagnosed with ADHD and treated with stimulant medication. Further research using normative or community-based samples to develop more valid and precise diagnostic criteria is essential.

The diagnostic process is also an area requiring further research. Because no pathognomonic findings currently establish the diagnosis, further research should examine the utility of existing methods, with the goal of developing a more definitive process. Specific examples include the need for additional information about the reliability and validity of teacher and parent rating scales and the reliability and validity of different interviewing methods. Further, given the prominence of impairment in the current diagnostic requirements, it is imperative to develop and assess better measurements of impairment that can be applied practically in the primary care setting. The research into diagnostic methods also should include those methods helpful in identifying clinically relevant coexisting conditions.

Lastly, research is required to identify more clearly the current practices of primary care physicians beyond using self-report. Such research is critical in determining the practicality of guideline recommendations as a method to determine changes in practice and to determine whether changes have an actual impact on the treatment and outcome of children with the diagnosis of ADHD.

CONCLUSION

This guideline offers recommendations for the diagnosis and evaluation of school-aged children with ADHD in primary care practice. The guideline emphasizes: 1) the use of explicit criteria for the diagnosis using *DSM-IV* criteria; 2) the importance of obtaining information regarding the child's symptoms in more than 1 setting and especially from schools; and 3) the search for coexisting conditions that may make the diagnosis more difficult or complicate treatment planning. The guideline further provides current evidence regarding various diagnostic tests for ADHD. It should help primary care providers in their assessment of a common child health problem.

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ACKNOWLEDGMENTS

The Practice Guideline, "Diagnosis and Evaluation of the Child With Attention-Deficit/Hyperactivity Disorder," was reviewed by appropriate committees and sections of the AAP, including the Chapter Review Group, a focus group of office-based pediatricians representing each AAP District: Gene R. Adams, MD; Robert M. Corwin, MD; Diane Fuquay, MD; Barbara M. Harley, MD; Thomas J. Herr, MD, Chair Person; Kenneth E. Mathews, MD; Robert D. Mines, MD; Lawrence C. Pakula, MD; Howard B. Weinblatt, MD; and Delosa A. Young, MD. The Practice Guideline was also reviewed by relevant outside medical organizations as part of the peer review process as well as by several patient advocacy organizations.

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WEB SITE: <http://www.aap.org>

TO: Heather Howard

FAX # TO: 456-2878

FROM: Joanna Parzakonis

DATE:

PAGE: 15-2 of

RE:

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TABLE 1
Diagnostic Criteria for ADHD

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 homework)
- g) Often loses things necessary for tasks or activities (eg, 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 (eg, butts into conversations or games)

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

C. Some impairment from the symptoms is present in 2 or more settings (eg, at school [or work] or 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 (eg, mood disorder, anxiety disorder, dissociative disorder, or personality disorder).

Code based on type:

314.01 Attention-Deficit/Hyperactivity Disorder, Combined Type: if both criteria A1 and A2 are met for the past 6 months

314.00 Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type: if criterion A1 is met but criterion A2 is not met for the past 6 months

314.01 Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive, Impulsive Type: if criterion A2 is met but criterion A1 is not met for the past 6 months

314.9 Attention-Deficit/Hyperactivity Disorder Not Otherwise Specified

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TABLE 2**DSM-PC: Developmental Variation: Impulsive/Hyperactive Behaviors**

Developmental Variation	Common Developmental Presentations
<i>V65.49 Hyperactive/impulsive variation</i>	<i>Early childhood</i>
Young children in infancy and in the preschool years are normally very active and impulsive and may need constant supervision to avoid injury. Their constant activity may be stressful to adults who do not have the energy or patience to tolerate the behavior.	The child runs in circles, doesn't stop to rest, may bang into objects or people, and asks questions constantly.
During school years and adolescence, activity may be high in play situations and impulsive behaviors may normally occur, especially in peer pressure situations.	<i>Middle childhood</i>
High levels of hyperactive/impulsive behavior do not indicate a problem or disorder if the behavior does not impair function.	The child plays active games for long periods.
	The child may occasionally do things impulsively, particularly when excited.
	<i>Adolescence</i>
	The adolescent engages in active social activities (eg, dancing) for long periods, may engage in risky behaviors with peers.
	<i>Special Information</i>
	Activity should be thought of not only in terms of actual movement, but also in terms of variations in responding to touch, pressure, sound, light, and other sensations. Also, for the infant and young child, activity and attention are related to the interactions between the child and caregiver, eg, when sharing attention and playing together.
	Activity and impulsivity often normally increase when the child is tired or hungry and decrease when sources of fatigue or hunger are addressed.
	Activity normally may increase in new situations or when the child may be anxious. Familiarity then reduces activity.
	Both activity and impulsivity must be judged in the context of the caregiver's expectations and the level of stress experienced by the caregiver. When expectations are unreasonable, the stress level is high, and/or the parent has an emotional disorder (especially depression), the adult may exaggerate the child's level of activity/impulsivity.
	Activity level is a variable of temperature. The activity level of some children is on the high end of normal from birth and continues to be high throughout their development.

Taken from: American Academy of Pediatrics. *The Classification of Child and Adolescent Mental*

Diagnoses in Primary Care. Diagnostic and Statistical Manual for Primary Care (DSM-PC), Child and Adolescent Version. Elk Grove Village, IL: American Academy of Pediatrics; 1996

TABLE 3**DSM-PC: Developmental Variation: Inattentive Behaviors**

Developmental Variation	Common Developmental Presentations
V65.49 Inattention variation A young child will have a short attention span that will increase as the child matures. The inattention should be appropriate for the child's level of development and not cause any impairment.	Early childhood The preschooler has difficulty attending, except briefly, to a storybook or a quiet task such as coloring or drawing.
	Middle childhood The child may not persist very long with a task the child does not want to do such as read an assigned book, homework, or a task that requires concentration such as cleaning something.
	Adolescence The adolescent is easily distracted from tasks he or she does not desire to perform.
	Special Information Infants and preschoolers usually have very short attention spans and normally do not persist with activities for long, so that diagnosing this problem in younger children may be difficult. Some parents may have a low tolerance for developmentally appropriate inattention. Although watching television cartoons for long periods of time appears to reflect a long attention span, it does not reflect longer attention spans because most television segments require short (2- to 3-minute) attention spans and they are very stimulating. Normally, attention span varies greatly depending upon the child's or adolescent's interest and skill in the activity, so much so that a short attention span for a particular task may reflect the child's skill or interest in that task.

Taken from: American Academy of Pediatrics. *The Classification of Child and Adolescent Mental Diagnoses in Primary Care. Diagnostic and Statistical Manual for Primary Care (DSM-PC), Child and Adolescent Version.* Elk Grove Village, IL: American Academy of Pediatrics; 1996

TABLE 4**Total ADHD-Specific Checklists: Ability to Detect ADHD vs Normal Controls**

Study	Behavior Rating Scale	Age	Gender	Effect Size	95% Confidence Limits
Conners (1997)	CPRS-R:L-ADHD Index(Conners Parent Rating Scale—1997 Revised Version: Long Form, ADHD Index Scale)	6-17	MF	3.1	2.5, 3.7
Conners (1997)	CTRS-R:L-ADHD Index(Conners Teacher Rating Scale—1997 Revised Version: Long Form, ADHD Index Scale)	6-17	MF	3.3	2.8, 3.8
Conners (1997)	CPRS-R:L- <i>DSM-IV</i> Symptoms(Conners Parent Rating Scale—1997 Revised Version: Long Form, <i>DSM-IV</i> Symptoms Scale)	6-17	MF	3.4	2.8, 4.0
Conners (1997)	CTRS-R:L- <i>DSM-IV</i> Symptoms(Conners Teacher Rating Scale—1997 Revised Version: Long Form, <i>DSM-IV</i> Symptoms Scale)	6-17	MF	3.7	3.2, 4.2
Breen (1989)	SSQ-O-IBarkley's School Situations Questionnaire-Original Version, Number of Problem Settings Scale	6-11	F	1.3	0.5, 2.2
Breen (1989)	SSQ-O-IBarkley's School Situations Questionnaire-Original Version, Mean Severity Scale	6-11	F	2.0	1.0, 2.9
Combined				2.9	2.2, 3.5

Taken from: Green M, Wong M, Atkins D, et al. *Diagnosis of Attention Deficit/Hyperactivity Disorder Technical Review 3*. Rockville, MD: US Department of Health and Human Services, Agency for Health Care Policy and Research; 1999. AHCPR publication 99-0050

TABLE 5**Total Scales of Broadband Checklists: Ability to Detect Referred vs Nonreferred**

Study	Behavior Rating Scale	Age	Gender	Effect Size	95% Confidence Limits
Achenbach (1991b)	CBCL/4-18-R, Total Problem Scale (Child Behavior Checklist for Ages 4-18, Parent Form)	4-11	M	1.4	1.3, 1.5
Achenbach (1991b)	Same as above	4-11	F	1.3	1.2, 1.4
Achenbach (1991c)	CBCL/TRF-R, Total Problem Scale(Child Behavior Checklist, Teacher Form)	5-11	M	1.2	1.0, 1.4
Achenbach (1991c)	Same as above	5-11	F	1.1	1.0, 1.3
Naglieri, LeBuffe, Pfeiffer (1994)	DSMD-Total Scale (Devereaux Scales of Mental Disorders)	5-12	MF	1.0	0.8, 1.3
Conners (1997)	CPRS-R:L-Global Problem Index (1997 Revision of Conners Parent Rating Scale, Long Version)	—	MF	2.3	1.9, 2.6
Conners (1997)	CTRS-R:L-Global Problem Index (1997 Revision of Conners Teacher Rating Scale, Long Version)	—	MF	2.0	1.7, 2.3
Combined				1.5	1.2, 1.8

Taken from: Green M, Wong M, Atkins D, et al. *Diagnosis of Attention Deficit/Hyperactivity Disorder. Technical Review 3*. Rockville, MD: US Department of Health and Human Services, Agency for Health Care Policy and Research; 1999. AHCPR publication 99-0050.

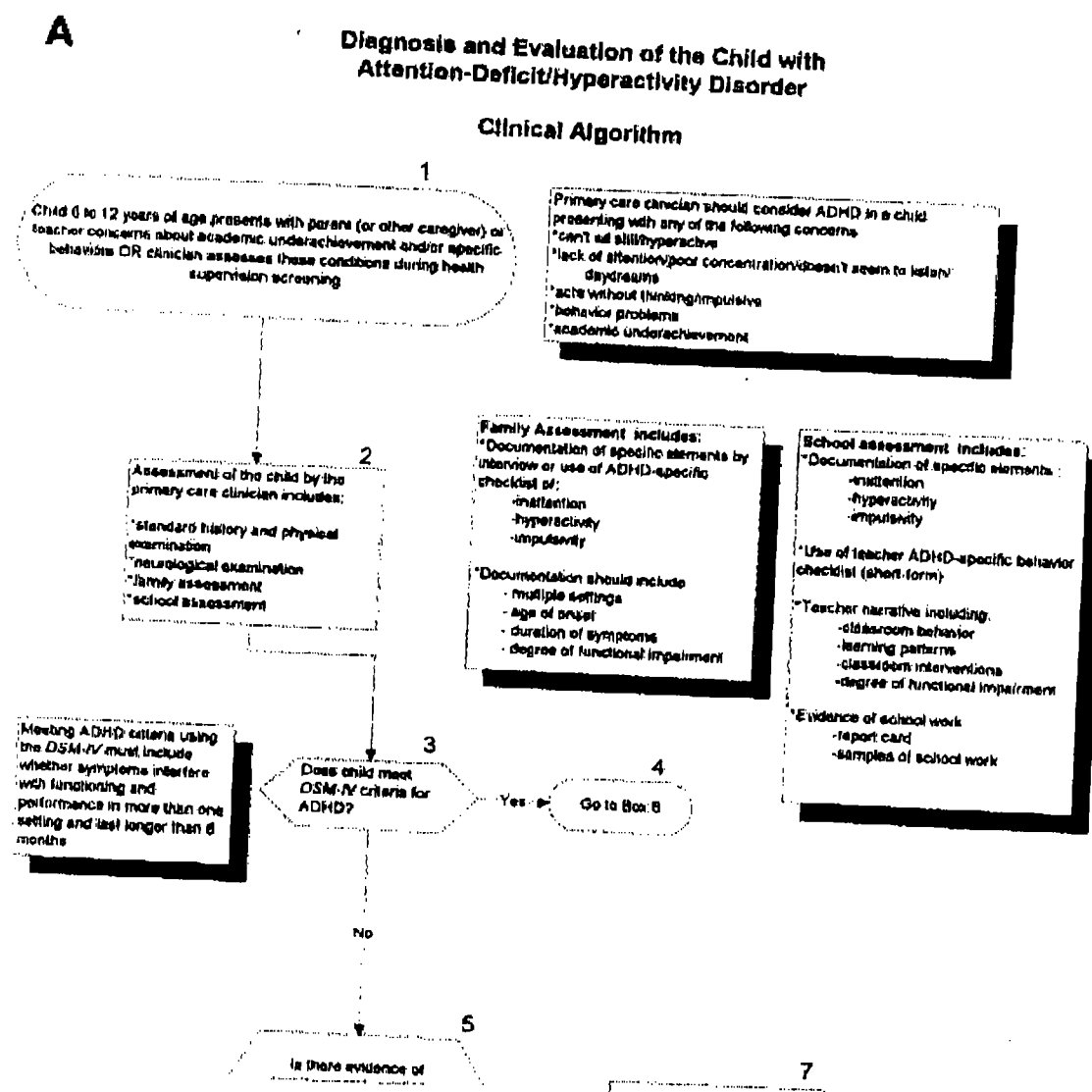
TABLE 6

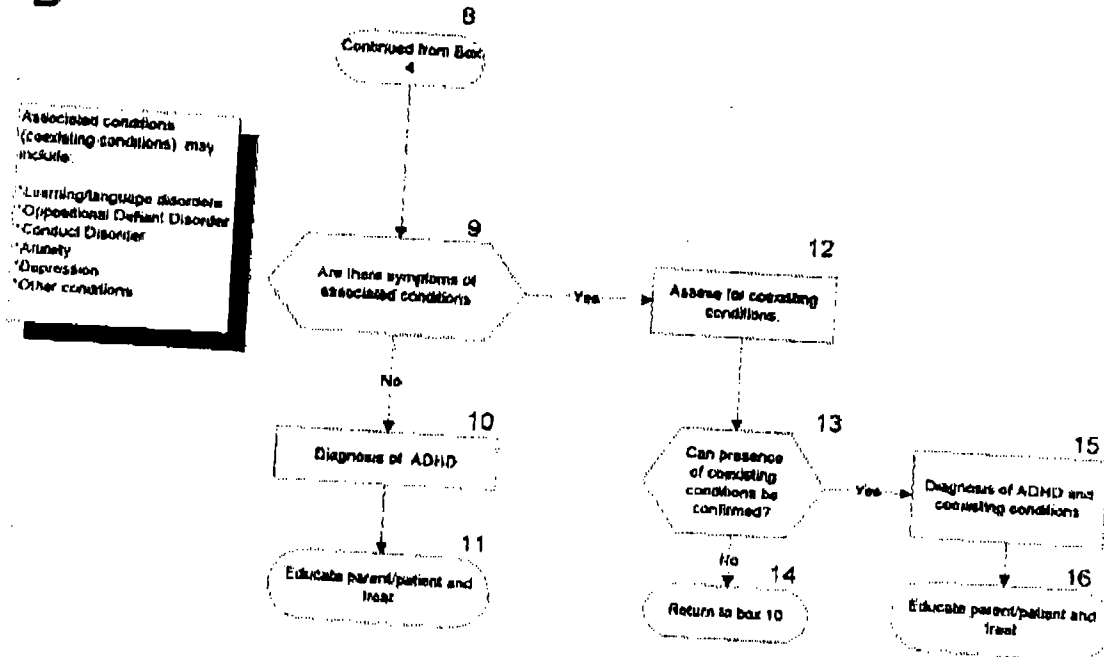
Summary of Prevalence of Selected Coexisting Conditions in Children With ADHD

Comorbid Disorder	Estimated Prevalence (%)	Confidence Limits for Estimated Prevalence (%)
Oppositional defiant disorder	35.2	27.2, 43.8
Conduct disorder	25.7	12.8, 41.3
Anxiety disorder	25.8	17.6, 35.3
Depressive disorder	18.2	11.1, 26.6

Taken from: Green M, Wong M, Atkins D, et al. *Diagnosis of Attention Deficit/Hyperactivity Disorder. Technical Review 3*. Rockville, MD: US Dept of Health and Human Services, Agency for Health Care Policy and Research; 1999. AHCPR publication 99-0050

Fig 1 Clinical algorithm.



B

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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To: *Heather Howard*

Date: June 21, 2000

Fax #: *456-2878*

Pages: 7, including this cover sheet.

From: Beverly Malone

Subject: Surgeon General's National Conference on children's mental health

COMMENTS: ATTACHED FOR YOUR INFORMATION ARE MATERIALS REGARDING THE
SURGEON GENERAL'S NATIONAL CONFERENCE ON CHILDREN'S MENTAL HEALTH:

1. Letter of June 19 sent to invitees to the June 26

Listening Session

2. Tentative Agenda for June 26, 2000

3. List of Confirmed attendees for June 26 session

4. List of nominations of attendees for June 26 session

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary
Office of Public Health and ScienceAssistant Secretary for Health
Surgeon General
Washington, D.C. 20201

JUN 19 2000

Dear Colleague:

The Office of the Surgeon General is planning a national conference on children's mental health September 18-19, 2000. The purpose of the conference is to engage families, professionals, and scientists in a meaningful dialogue about issues involved in identifying, recognizing, and referring children with mental health problems for appropriate, evidence-based treatment or services. In preparation for this major undertaking, we are requesting your participation in a full-day *listening session* with the Office of the Surgeon General this Monday, June 26th. The objective of this meeting will be to help us shape the agenda of the September conference.

A Federal interdepartmental coordinating committee, representing a broad range of children's mental health concerns, solicited input from interested groups, associations, and individuals. Because of the extraordinary e-mail and fax responses received, we will need to focus on synthesizing these comments in a coordinated fashion. In order to meet this objective, we are inviting approximately 50 persons, representing major professional and advocacy groups as well as private individuals.

Because the issues raised during this *listening session* will be summarized in a briefing for the Surgeon General to craft the agenda for the September meeting, we ask that you focus on the following questions:

- What are the key barriers to identifying, recognizing or referring children with mental health needs (e.g., definitional, systems, training, assessment issues, costs, etc.)?
- What are the major challenges to using evidence-based strategies to identify and treat children with mental health problems?
- What are the major service obstacles to delivering mental health care to children and families?
- What are the key research and service priorities in children's mental health?

The meeting will be held June 26th, from 10:00 AM to 4:00 PM, in the NASSIF Building, Department of Transportation, 400 7th Street SW, Room 2230, Washington, DC.

We greatly value your input and look forward to your participation. Please confirm your availability by Thursday, June 22, by calling Pam Mitchell on (301) 443-4627.

Sincerely yours,

A handwritten signature in dark ink, appearing to read "Beverly L. Malone", is written over the typed name and title.

Beverly L. Malone, Ph.D., R.N., F.A.A.N.
Deputy Assistant Secretary for Health

SURGEON GENERAL LISTENING SESSION

JUNE 26TH, 2000

**NASSIF Building
Department of Transportation
400 7th Street, Sw, Room 2230
Washington, DC.**

10:00 - 10:30	OPENING WELCOME AND PURPOSE OF MEETING Kenneth Moritsugu, M.D., MPH Office of the Surgeon General Kimberly Hoagwood, Ph.D. Associate Director for Child and Adolescent Research National Institute of Mental Health
10:30 - 12:45	BREAK-OUT GROUPS See assignment sheet
12:45 - 1:00	LUNCH PICK-UP
1:00 - 1:30	RETURN TO BREAK-OUT GROUPS
1:30 - 2:00	BREAK
	RECORDERS SYNTHESIZE RESPONSES TO TARGET QUESTIONS
2:00 - 3:30	REPORTS FROM BREAK-OUT GROUPS TO THE SURGEON GENERAL, DAVID SATCHER, M.D., Ph.D.
3:30 - 4:00	WRAP-UP

**CONFIRMED ATTENDEES AS OF 6/21/00
ASSOCIATIONS**

American Academy of Child and Adolescent Psychiatry

Laurence (Larry) Greenhill

American Association of Health Plans

John Fontanesi, Ph.D.

American Psychiatric Association

David Fassler, M.D.

American Psychological Association

Robert Resnick, Ph.D.

Association of Black Psychologists

Mawiyah Kambon, Ph.D.

Association of State and Territorial Health Officials

Christa-Marie Singleton, MD, MPH

Casey Family Program

Eileen O'Brien, Ph.D.

Child & Adolescent Bipolar Foundation

Diane La Voy

Children's Defense Fund

MaryLee Allan

Duke University Medical Center

E. Jane Costello, Ph.D.

Judge David L. Bazelon Center for Mental Health Law

Chris Koyanagi

National Alliance for the Mentally Ill (NAMI)

Brenda Suoto, M.A.

National Assoc. of State Alcohol & Drug Abuse Directors

Kathleen Sheehan

National Assoc. of State Mental Health Program Directors

Roy Praschil

National Association of Psychiatric Health Systems

Mark Covall

National Head Start Association

National Indian Child Welfare Association

Holly Echo-Hawk Solie, M.S.

**Nat'l Tech Assistance Center for Children's Mental Health
Georgetown Child Development Center**

Sybil Goldman, MSW

Panamerican Health Organization

Claudio Miranda, M.D.

Robert Wood Johnson Foundation

Ruby Hearn, Ph.D.

Washington Business Group on Health

Kristen Appar

ZERO TO THREE- Nat.Cntr for Infants, Toddlers & Families

Emily Feinschel

National Mental Health Association

Jennifer Wond

American Academy of Pediatrics

Mark Wolraich

American Academy of Pediatrics
AAP Committee on Drugs

Phil Walson

INDIVIDUALS

Grandparent

Senora Simpson

Parent

Anita B. Skelton

SUNY, Buffalo

William E. Felham, Ph.D.

Guidance Center, Inc.

Susan Ayers, LICSW

FEDERAL

Center for Drug Evaluation and Research
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Terris Crescenzi
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Delores L. Parron
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Heather Ringelsen, Ph.D.
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Beverly Malone, Ph.D., R.N., F.A.A.N.
Kenneth Moritsugu, M.D., M.P.H.

Office of the Surgeon General
Office of the Surgeon General

NOMINATIONS OF ATTENDEES
FOR THE SURGEON GENERAL LISTENING SESSION ON 6/26/2000

From 6/19 Meeting Downtown

Associations

1. Children's Defense Fund
2. American Academy of Family Physicians
3. Federation of Families for Children's Mental Health
4. National Association of School Psychologists
5. National Mental Health Association
6. School Social Work Association of America
7. American Nurses Association
8. American Federation of Teachers
9. Children and Adults with Attention-Deficit/Hyperactivity Disorder
10. American Academy of Child & Adolescent Psychiatry
11. American Psychological Association
12. American Academy of Pediatrics
13. Council for Exceptional Children
14. American Psychiatric Association
15. National Association of School Nurses
16. American Orthopsychiatric Association
17. National Education Association
18. Association of Maternal and Child Health Programs
19. National Association of Social Workers
20. Child Psychiatry Nursing
21. National Alliance for the Mentally Ill
22. (Autism and Developmental Disorder Association)
23. Association of State and Territorial Health Officers
24. National Association of City and County Health Officers
25. National Center and Education Disability and Juvenile Justice
26. American School Counselor Association
27. American Public Health Association
28. Society for Developmental and Behavioral Pediatrics
29. Ambulatory Pediatric Association
30. YMCA of the USA
31. American Pediatric Society & Society for Pediatric Research
32. Washington Business Group on Health: Mary Jane England
33. Boys and Girls Club
34. COSSMHO
35. National Indian Child Welfare Association: Holly
36. National Association of Black Social Workers
37. National Association of Black Psychiatrists

38. National Association of Black Psychologists
39. Bazelon Center for Mental Health Law
40. Department of Defense
41. National Association of Psychiatric Health Systems
42. Family Voices
43. Child and Adolescent Bipolar Disorder Foundation
44. Anxiety Disorders Association of America
45. Parent Teacher Association
46. Head Start Association
47. National Association of State Mental Health Program Directors
48. National Association of State Alcohol and Drug Abuse Directors
49. United Nations Infant and Children Education Fund
50. Zero to Three National Center for Infants, Toddlers and Families
51. Pan American Health Organization
52. National Association for Rural Mental Health
53. Society for Research and Child Development
54. The Casey Family Program
55. Robert Wood Johnson Foundation
56. Packard Foundation
57. MacArthur Foundation
58. Kaiser Foundation Health Plan
59. American Occupational Therapy Associations

Individuals

60. Audrey Russell, Friends Neighborhood Guild in Philadelphia
61. Cindy Ruston, University of Pennsylvania
62. Chris Deyeso, Special Education Teacher
63. William Pelham, Ph.D., SUNY
64. Steve Hinshaw, Ph.D., University of Berkeley
65. Howard Abikoff, Ph.D., New York University
66. Neal Halfon, M.D., UCLA
67. Lawrence Diller, M.D. Author and Private Practice
68. Robert Coles, M.D., Harvard University
69. William Carey, M.D., Children's Hospital of Philadelphia
70. Erik Parens, Ph.D. Hastings Center for Biomedical Ethics
71. Susan Ayers, Community Mental Health, Guidance Center, Inc.
72. Karl Dennis, Kaleidoscope
73. Vera Pena, Consultant Children's Wrap-around Milwaukee
74. Walter Harvey, University of Maryland, School of Social Work
75. Nancy Boyd-Franklin, author and psychologist
76. Senora Simpson, Grandparent
77. Anita Shelton, Parent



To: BEVERLY MALONE

Telephone: Fax: 690-7694

From: Heather Howard

Telephone: 456-7263 Fax: 456-2878

Subject: Surgeon General's Conference

Pages: _____1_____ (Including this cover sheet)

Comments: Thanks for sending the invite list – looks great. Just 2 suggested additions:

Rhonda Talley, Executive Director
Rosslyn Carter Institute for Human Development
800 Wheatley Street
Americus, GA 31709
912-928-1234 – phone

Joseph Bellanti, M.D.
Professor of Pediatrics and Microbiology-Immunology
Georgetown University Medical Center
3800 Reservoir Road, NW
Washington, DC 20007
(202) 687-8227

also – was Dr. Bruce Perry of Texas Children's Hospital and Baylor College of Medicine included in the planning session? I remember submitting his name but don't recall whether he was invited to the planning meeting.

*** TX REPORT ***

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Rhonda Talley, Executive Director
Rosslyn Carter Institute for Human Development
800 Wheatley Street
Alameda, CA 94700

June 27, 2000

MEMORANDUM FOR HILLARY RODHAM CLINTON

FROM: HEATHER HOWARD

CC: MELANNE VERVEER
LISSA MUSCATINE
ANN O'LEARY

SUBJECT: UPDATE ON EFFORTS TO IMPROVE THE TREATMENT OF CHILDREN WITH EMOTIONAL AND BEHAVIORAL CONDITIONS

Before your interview with the Medical Editor of CBS, I wanted to briefly update you on what has happened since your event in March announcing new Federal efforts to improve the diagnosis and treatment of children with emotional and behavioral conditions.

- **New guidelines for the diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) from the American Academy of Pediatrics.** At your Roosevelt Room event, you announced that the Academy was developing new guidelines for the diagnosis and treatment of ADHD. In May, the Academy released the new treatment guidelines to their 55,000 members. The new guidelines require that ADHD symptoms be present in two or more of a child's settings, and that the symptoms adversely affect the child's academic or social functioning for at least six months. The new guidelines recommend that the assessment of ADHD include information obtained directly from parents or caregivers, as well as a classroom teacher or other school professional, regarding the core symptoms of ADHD in various settings. They also recommend that evaluation include assessment for co-existing conditions, such as learning and language problems, aggression, disruptive behavior, depression or anxiety. The Academy is currently developing the new ADHD treatment guidelines, which are expected to be released this fall.
- **NIMH research.** NIMH is in the process of funding a \$5 million multi-site trial on the use of Ritalin to treat ADHD in preschoolers.
- **FDA efforts.** Due in large part to the attention you have focused on this issue, the FDA is now working to develop the science base necessary to create protocols for developing new labeling information for pediatric dosages. In September, the FDA's Pediatric Advisory Subcommittee will be meeting to discuss the ethical issues surrounding studying children, and in October, the FDA and NIMH are holding a joint meeting entitled "Psychopharmacology for Young Children: Clinical Needs and Research Opportunities."

- **Planning for the Fall Surgeon General's Conference on the Treatment of Children with Behavioral and Mental Disorders.** Planning for the conference, scheduled for September 17th and 18th, 2000, is ongoing. On Monday, June 26, 2000, the Surgeon General held a "listening session," to which he invited 50 groups representing healthcare providers, educators, parents, and consumers. Representatives from NIMH, the FDA, SAMSA, and the Center for Mental Health Services also participated. The meeting, which I attended, solicited input on four key questions:
 - What are the key barriers to identifying, recognizing or referring children with mental health needs (e.g., definitional, systems, training, assessment issues, costs, etc.)?
 - What are the major challenges to using evidence-based strategies to identify and treat children with mental health problems?
 - What are the major service obstacles to delivering mental health care to children and families?
 - What are the key research and service priorities in children's mental health?

The overarching themes in the comments were:

- The importance of coordination between the different providers in children's lives, including those in the health care, education, and child care systems.
- The need for better training for health providers and educators, to help them assess children's behavioral and mental problems.
- The critical importance of proper assessment, which everyone agreed cannot happen during a ten-minute doctor's visit.
- The importance of involving families in all aspects of treatment, including diagnoses, service design and delivery.
- The need for research on the zero to five population.
- The difficulties in translating research into practice.

As you mentioned in your speech at the March event, pharmaceutical companies and health insurers need to be included in this discussion. The Surgeon General's office has assured me that they will be included in the fall conference.

The Associated Press State & Local Wire

View Related Topics

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September 9, 2000, Saturday, BC cycle

SECTION: State and Regional

LENGTH: 1287 words

HEADLINE: Family court decision sparks debate on behavior-modifying drugs

BYLINE: By LYNN BREZOSKY, Associated Press Writer

DATELINE: BERNE, N.Y.

BODY:

Kyle Carroll was past his twos and still not talking. Or rather, he was speaking, but in a language that seemed all his own. It was the first hint Jill and Michael Carroll had that something was different about their son.

In kindergarten, it became clear Kyle wasn't about to focus in the classroom. A pediatrician diagnosed Kyle with Attention Deficit Hyperactivity Disorder and prescribed a trial run of **Ritalin**.

That trial has lasted three years now, in the Carroll's view long enough. But at the end of a torturous yearlong battle with the Berne-Knox-Westerlo school district, they learned they don't have the choice of stopping it, despite their arguments the drug is wiping out sectors of their son's personality and turning him into a sickly, staring, insomniac.

Under a consent order signed by Albany County Family Court Judge Gerald Maney in May, the couple must continue administering medications prescribed by a physician meeting court approval. That means unless they find a doctor who recommends taking their child off medication, and they haven't yet, they must continue giving Kyle **Ritalin** or risk losing him on grounds of neglect.

What makes the order landmark is that **Ritalin** is a different kind of medicine, part of an emerging class of pills that treat behavior rather than disease. The Carroll's case is believed to be the first in which the state has mandated a chemical change in personality in a child who's not deemed homicidal or suicidal. It raises a national question - whose decision is it to administer behavior-modifying drugs?

To Dr. Peter Breggin, consultant in a **class-action** suit accusing the American Psychiatric Association (APA) of conspiring with Novartis (the pharmaceutical company that makes **Ritalin**) to sell as much of the drug as possible - the ruling speaks of the loss of the most basic of constitutional rights, of mind control, of Big Brother. Only now, he says, Big Brother is Big Business. And by introducing youths to the notion there are biological defects in their brains and capitalizing on the idea of a quick-fix cure, Breggin says, the drug companies are no better than the cigarette manufacturers now paying out millions for encouraging addiction to their product.

On the flip side is the possibility raised by **Ritalin's** many defendants - that millions of children are part of the first generation of humans to have a medicine that allows them to focus and succeed, both in the classroom and the schoolyard, the microcosms of the professional world

and society. Stimulant medications can then seem as progressive as insulin or penicillin.

Yet even the staunchest proponents of stimulant medications such as **Ritalin**, the APA is one proponent, express surprise at Maney's ruling.

"It's an unusual case up there," said Dr. Richard Harding, professor of clinical sociology and pediatrics at the University of South Carolina and president-elect of the APA. Ideally, Harding said, the decision will be made jointly between parents and doctors, never forced.

Breggin, author of several books on the subject, crusades against psychotropic drugs as a whole, and calls Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder "a fabrication."

"The diagnosis is if the kid squirms in his chair, interrupts, is sloppy - a list of things that annoy teachers and make it hard to teach," he said. There's no real diagnostic evidence of ADD, he says, none of the different colored brain clusters one sees in cases of Alzheimer's Disease or strokes.

Jeffrey Schaler, a psychologist who teaches at American University's School of Public Affairs, agrees.

"There's no deficiency that **Ritalin** is fixing," he says, "what it's doing is changing a behavior so the child complies with expectations and behaviors expected of him. You drug the child and get him to comply by drugging."

Albany County Family Court, Schaler says, has invaded the Carroll's privacy.

Beyond that, he sees the decision as a fearsome precedent, an entry into a new gray area socially, with consequences no one can even guess at.

"Psychologists and psychiatrists are going back over history saying just about every great person, every person who had some great contribution to society had some sort of mental problem. If you gave all those people drugs would that have stopped?" Schaler asks.

Schaler, however, thinks it's wrong to blame the companies, who are simply making a product, rather than the mindset of "thou shalt not have any difficulty in your life."

"The bottom line is studying's hard work," he says. "The bottom line is you just have to focus and discipline yourself."

It's an argument Jordan Lippman, a 22-year-old student at Union College in Schenectady, has grown tired of.

Until 11th grade, when he was diagnosed with dyslexia and ADD and prescribed a cocktail of the stimulant Adderall and the anti-depressant Welbutrin, Lippman was miserable.

"I always knew I was different because I was always in detention for forgetting my pens, forgetting my assignments," he says. "I knew I was intelligent, yet it didn't correspond to anything. I knew the material but I couldn't make it translate into anything like good grades."

Lippman's parents were well-off enough to send him to a private high school near their home in Tenafly, N.J., where he received plenty of one-on-one attention.

On the strength of a personal interview and an award-winning senior year project on Attention Deficit Disorder (the success he says started his momentum), he was accepted to Union College, a highly selective private college in Schenectady.

When a test was pulled away from him before he could finish it, Lippman realized he wasn't cutting it. He has since built a support group for students with ADD and ADHD, and lobbied deans and the college president. In effect, he has changed the campus climate for those with ADD.

His peers have been the hardest to convince. In a written debate with Lippman that played out in the campus newspaper, Concordensis, a former suite mate wrote "one of the aspects of Union that makes it a desirable college, is that not everyone can attend here. If a student cannot keep up with his or her peers in the classroom, perhaps Union is not the ideal college for him or her."

Lippman replied in part, "you know that I work just as hard, and three to four times as long as most other students here at Union. My strengths are abstract verbal reasoning, but it is extremely difficult for me to do the initial processing of written language."

He says ADD is misnamed because it's not an attention disorder but rather a control disorder, in which the part of the brain that organizes and plans isn't working. He says his medication combined with self-awareness and awareness on the part of the college has helped him succeed.

Lippman is now completing an internship with the New York City-based International Dyslexic Association, boasting a 3.676 finish for the last term, and meeting with editors from the Princeton Review to modify listings of services for the disabled listed by colleges.

He's impressed faculty and developed mentors, including Dr. Rudy Nydegger, a clinical psychologist who teaches management and psychology at the college.

In his own practice, Nydegger advocates a therapy that frequently includes writing prescriptions for stimulant medications.

"I don't look at solving problems by throwing drugs at them, but if we can get those kids calmed down and focused then we can help them learn techniques for managing their behavior," he says.

And he for one is convinced ADD and ADHD have long existed.

"We called it other things," he says. "We called kids stupid, underachievers."

GRAPHIC: With AP Photo

LANGUAGE: ENGLISH

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General News;ritalin and class action

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September 14, 2000, Thursday, Late Edition - Final

SECTION: Section A; Page 16; Column 1; National Desk

LENGTH: 452 words

HEADLINE: Suits Charge Conspiracy by Maker and Doctors' Group to Expand **Ritalin** Use

BYLINE: By BARRY MEIER

BODY:

Lawyers involved in **class-action** lawsuits against the tobacco industry, gun makers and health maintenance organizations filed two lawsuits yesterday against another target, the widely used drug **Ritalin**.

The lawsuits, filed in federal courts in California and New Jersey, say the Novartis Pharmaceuticals Corporation, the drug's manufacturer, and the American Psychiatric Association, a professional group, conspired to create a market for **Ritalin** and expand its use.

For more than a decade, **Ritalin** has been increasingly prescribed for children in whom attention deficit disorder or attention deficit hyperactivity disorder has been diagnosed. That has prompted debate among scientists, psychiatrists and government officials over whether children are receiving too much medication or their behavioral disorders are being diagnosed incorrectly.

Officials of Novartis Pharmaceuticals, a unit of Novartis AG, and the American Psychiatric Association said they could not comment on the lawsuits because they had not seen them.

But representatives of each group said the accusations in the new lawsuits sounded similar to those in a **class-action** lawsuit brought against them earlier this year in Texas.

At that time, Novartis said **Ritalin**, which is also known by its chemical name methylphenidate, had been used safely and effectively in thousands of children for more than 40 years and that it was the most studied drug used for attention deficit hyperactive disorder.

The psychiatric association called the accusations in the Texas suit "groundless" and an "opportunistic attack on the scientific process that underlies this effort."

The new lawsuits seek to halt what they call unlawful practices and ask that profits from sales of the drug be returned to consumers.

One of those bringing the latest lawsuits is Richard Scruggs, a lawyer from Pascagoula, Miss., who represented dozens of states in actions brought in recent years against cigarette makers. Earlier this year, Mr. Scruggs also filed lawsuits against several health maintenance organizations charging that they had defrauded consumers by failing to provide them with treatments.

John Coale, a Washington lawyer who is also involved in the **Ritalin** lawsuits, said the litigation was brought because Novartis and the psychiatric group promoted the idea that many children had attention deficit order and attention deficit hyperactivity disorder as a way of expanding the market for the drug.

"They were giving this stuff away like candy," Mr. Coale said.

In March, the White House announced an effort to reverse a sharp increase in the number of preschool children using **Ritalin**, Prozac and other psychiatric drugs.

<http://www.nytimes.com>

LANGUAGE: ENGLISH

LOAD-DATE: September 14, 2000

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General News;Ritalin

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September 12, 2000, Tuesday, Final Edition

SECTION: HEALTH; Pg. Z34

LENGTH: 1413 words

HEADLINE: TREATMENT OF CHOICE; ADHD: Too Many Diagnoses? Too Few? Both?

BYLINE: Kathleen F. Phalen , Special to The Washington Post

BODY:

Q: My 4-year-old son started preschool recently and his teacher says he's been acting out and can't stay in his seat. A friend suggested he might have ADHD. Can you tell me more about it?

A: It's a common sight: the kid who is driving his parents crazy, unable to follow through on even the simplest request. His teachers say he can't wait his turn, blurting out answers or bullying his classmates. His relationships are suffering and he's starting to believe he's bad.

While many children occasionally fit this description, for those with attention deficit hyperactivity disorder (ADHD), it's a chronic condition that can have widespread effects. Although researchers do not know what causes ADHD, studies suggest it is a disorder of the central nervous system that can be inherited.

Children with ADHD often have higher than average injury rates, due to acting before thinking; school can be more difficult for them because they cannot pay attention or complete tasks; peers may reject their aggressive advances; and many are depressed as a result of continuing negative attention.

According to a consensus conference convened by the National Institutes of Health (NIH) in 1998, ADHD is the most commonly diagnosed behavioral disorder of childhood, estimated to affect 3 to 5 percent of school-age children. Boys are three times as likely as girls to be diagnosed with the disorder, whose symptoms include inappropriate levels of attention, concentration, activity, distractibility and impulsivity.

The consensus statement cites variations in diagnosis and treatment among practitioners: "Data indicate that family practitioners diagnose more quickly and prescribe medication more frequently than psychiatrists or pediatricians." The quick diagnosis can be attributed to several factors, says Ann Abramowitz, who heads the Center for Learning and Attention Deficit Disorders at the Emory University School of Medicine in Atlanta, including a lack of time spent with the patient and family. "They may be inattentive or hyperactive, but we have to find out why," she says. There could be other things going on in a child's life--not enough sleep, nutrition problems, seasonal allergies, family crisis or unstructured home environment--that may be causing symptoms and behaviors that are typical of ADHD--or of something completely different.

While there's concern that many children are wrongly being diagnosed with ADHD, Peter S. Jensen, director of Columbia University's Center for Advancement of Children's Mental Health in New York, says about half of those who actually have the illness are not getting help. "This is one of the biggest health hazards," he says. "Even with all the [media] attention, a substantial number are still being missed."

As he explains it, an ADHD child who is inattentive but not hyperactive may get labeled as unmotivated, lazy or learning disabled. Girls with ADHD tend to get missed more than boys because they show less of the hyperactive behavior.

A study of Maryland children published in the September issue of the Journal of Pediatrics found that whites were much more likely than others to be taking **Ritalin**, one of the prescription drugs used to treat ADHD; black students had the lowest rate of use. "African Americans, Latinos, Asians get missed," Jensen says.

Paul H. Wender, a psychiatrist who conducted some of the first clinical trials on **Ritalin**, says it takes more than a 15-minute HMO visit to tell the difference between normal childhood behavior and ADHD. "It requires several hours with parents," says Wender, who practices in Andover, Mass. "You can't just write prescriptions."

Common Treatment Options

When ADHD is suspected, parents should consult a licensed practitioner familiar with the disorder, since self-prescribing with either traditional or alternative therapies could be dangerous.

Prescription drugs commonly used for ADHD are **Ritalin** and Adderall (dextedrine). While some parents fear these stimulants could lead to addiction and abuse, Jensen says there's a greater risk of drug abuse in adolescence if ADHD is not treated. "Ninety percent of data suggests that if we treat with medications now, we lower later substance abuse problems," he says.

Manufacturers are making these drugs more convenient to use. "The newer Adderall lasts longer," Jensen says, and Concerta, a timed-release form of **Ritalin's** active ingredient, methylphenidate, "gives true once-a-day dosing."

Many practitioners prefer multimodal therapies, combining drugs with behavioral strategies to help keep ADHD's symptoms under control.

Abramowitz says it can be very effective for families to establish clear rules, a high degree of structure in daily life and consequences for misbehavior. "There needs to be a defined place to put schoolwork when done; where does the student find work; what do they do when finished; break the day into clear time segments, and have the child get a brief behavior rating for each segment," she says.

Alternative Approaches

A recent investigation by The Washington Post revealed widespread marketing of dietary supplements to children, with some products being portrayed as nondrug options for treating ADHD. Public health officials consider this approach risky, since dietary supplements are largely unregulated and potentially hazardous.

Nonetheless, with many parents afraid of endangering their children with powerful drugs, they often consider alternative medicine. Among the treatments offered by practitioners in that field are meditation, biofeedback and herbs such as lemongrass and chamomile.

"**Ritalin** treats the symptoms," says Rockville medical acupuncturist Nader Soliman, who is also an anesthesiologist at Shady Grove Hospital. "With acupuncture, it is a method of normalizing the body energetics, and I have treated adults and children with no recurrence of symptoms."

With a small probe aimed at acupuncture points in the ear, he says he is able to pick up areas of electrical disturbance. "If there is an electrical variation," he says, "then we stimulate the area to restore it to normal function," using "microcurrent electrostimulation" instead of traditional acupuncture needles. He also uses homeopathic remedies.

Chris Meletis, chief medical officer at the National College of Naturopathic Medicine in Portland, Ore., says a recent study linked ADHD to sleep deprivation due to enlarged tonsils. In addition to considering dietary changes--he urges patients to avoid caffeine, peanuts, citrus, dairy and additives--he looks for a shortage of essential fatty acids and for deficiencies of such minerals as zinc and chromium.

According to Rick Cantrell, a pastoral psychologist and homeopathic physician in Asheville, N.C., "symptoms of ADHD are usually related to nutrition, hypoglycemia being the number one cause. . . . Ninety percent of the time, the child is suffering from hypoglycemia or allergies to chemicals, dyes or pesticides. When these causes are eliminated, the symptoms of ADHD go away."

Also claiming to have "a safe, effective alternative to **Ritalin**," Jeanette Farmer, a certified handwriting remediation specialist in Denver, has students perform handwriting movements that she likens to the old Palmer method of penmanship exercises. "These movements hone and stabilize the brain," she says. She cites her own research and European studies that connect these exercises with improving a child's emotional state, behavior, attentiveness in school, ability to learn and ability to get along with others.

RESOURCES

* National Attention Deficit Disorder Association:

1788 Second Street, Suite 200, Highland Park, IL 60035

847-432-ADDA; www.add.org.

* National Institute of Mental Health:

6001 Executive Boulevard, Rm. 8184, MSC 9663, Bethesda, MD 20892-9663

301-443-4513; www.nimh.nih.gov.

* Children and Adults with Attention-Deficit Hyperactivity Disorder (CHADD):

8181 Professional Place, Suite 201, Landover, MD 20785

800-233-4050 or 301-306-7070; www.chadd.org.

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GRAPHIC: IG,,ROBERT BARKIN

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THE BALTIMORE SUN

September 6, 2000, Wednesday ,FINAL

SECTION: TELEGRAPH ,1A

LENGTH: 722 words

HEADLINE: **Ritalin** used far more by white pupils than blacks
Nearly half on drug are in special ed

BYLINE: Gary Dorsey

SOURCE: SUN STAFF

BODY:

A new study of Maryland school children shows that whites are up to five times more likely to be using **Ritalin**, the drug prescribed to control attention deficit disorder, than minorities.

Findings also showed that nearly half of **Ritalin** users are enrolled in special education classes, which include many students with multiple learning problems.

The study, published in the September issue of the journal Pediatrics, suggests that **Ritalin** is being prescribed in a more conservative fashion than has been popularly believed, said Michael Malever, co-author and a researcher at the State Department of Education.

Ritalin has often been criticized as being over- prescribed for children who have no real medical problem but are merely unruly.

"The public perception is that relatively healthy kids are going into the doctor's office and get hit with **Ritalin**," said Mark Riddle, director of child and adolescent psychiatry at the Johns Hopkins School of Medicine. "This makes the point that kids who use **Ritalin** are having special problems and often attention deficit is just one part of it."

The study came from data collected by a task force called by the General Assembly in 1997 to look into prescription practices for **Ritalin**, which is commonly used to treat a condition known as Attention Deficit Hyperactivity Disorder (ADHD).

Some earlier results from the study, which had been presented to the legislature in 1998, showed that only 3 percent of Maryland students - almost 24,000 children - were getting **Ritalin** and other drugs to treat ADHD. Even that usage appears to decline as students age.

Based on a survey of more than 816,000 students, the study revealed that 45 percent of the **Ritalin** users were in special education and 8 percent had a separate school- documented impairment.

"The majority of kids were identified as having some kind of handicapped condition," said Daniel Safer, lead author of the study and an adjunct associate professor at the Johns Hopkins Children's Center. "That's especially interesting because there are some critics who claim that we're just giving **Ritalin** to kids to keep them quiet."

The finding about **Ritalin** use among minorities was more difficult for the authors and experts to comprehend.

The survey showed that white children are two times more likely to use **Ritalin** in grade school than African-American children, a ratio that escalates through high school, when whites are five times more

likely to use the drug. The authors found that a similar pattern emerged among Hispanics and Asians.

Interestingly, Safer said, the two school districts with the lowest rate of **Ritalin** usage, Prince George's County and Baltimore City, also had the highest percentages of black students. Noting that the median income in Prince George's County is much higher than in Baltimore, he said, suggests that income is probably less an influence than race alone.

"I believe there has been a feeling in the black community that there's been a tendency to over-medicate black kids, when actually the opposite is the case - relatively speaking, they may be under-medicating," Safer said.

Julie Zito, a professor at the University of Maryland School of Pharmacy who has published numerous studies about **Ritalin** use, said it is difficult to know whether the racial differences point out a cultural phenomenon or represent a problem of medical access.

In a study she published two years ago, Zito observed that among Medicaid recipients, white children were two to two-and-a-half times more likely to receive psychotropic drugs than African-Americans.

Without proper studies, she said, "we are in the realm of hypothesizing." Zito said she had heard an African-American psychiatrist note at the American Psychological Association in 1998 that African-Americans have reservations about the use of psychotropics to treat behavioral problems. Also, biases among health care providers or teachers who help identify emotional and behavioral disorders could interfere with proper treatment, Zito said.

"The problem is we have to speculate too much because we have inadequate information," Riddle said. "But the numbers do send up a red flag, and that's worrisome because it suggests here are a group of kids who may not be getting the medication they deserve."

LOAD-DATE: September 7, 2000

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General News;Ritalin

Copyright 2000 Chicago Sun-Times, Inc.
Chicago Sun-Times

September 03, 2000, SUNDAY, Late Sports Final Edition

SECTION: REAL LIFE; Pg. 11

LENGTH: 519 words

HEADLINE: Shyness becomes a disease

BYLINE: Michael Breen

BODY:

This year, don't forget those back-to-school essentials for your child: a new pencil case, a spiral notebook, a healthy breakfast and, of course, a dose of Paxil.

You remember Paxil -- it's the drug for shyness, and now it's not just for adults anymore.

That's your back-to-school message from the drug industry. I recently received a press release from the Anxiety Disorders Association of America. It said if your child is afraid of going back to school, maybe it's not normal, maybe your child needs drugs. The release says three children in every class have an anxiety disorder. The solution? Well, enclosed are details of a drug company-sponsored workshop showing the wonders of Paxil and similar drugs.

Pushing drugs to "anxious" children is the latest in a troubling trend. Millions of children already take drugs for depression and attention deficit disorder. Researchers say an unbelievable 10 percent of Virginia grade-schoolers take now **Ritalin**. Experts say that at most only half of those children have attention deficit disorder; the rest are kids who "act out." The use of Prozac also has skyrocketed.

Even more disturbing, 2 percent of preschoolers use **Ritalin** or antidepressants. Their numbers have at least tripled in recent years. This even though the FDA never approved **Ritalin** for children under 6.

Children have become the targets of a powerful foe. The New York Times recently described how Pfizer, the country's largest drug company, sells drugs the way Procter & Gamble sells Tide. From a drug's discovery, marketers position it, decide whom to pitch it to and plot an advertising campaign. Pfizer spends 40 percent of its revenue on marketing, twice what it spends on research and development.

Kids have opened up a whole new market for drug companies. Now shy kids may be the biggest gold mine yet. As the first step, turn a personality flaw into an illness: Turn shyness into "anxiety disorder." This is old hat for the drug industry.

My press release is a good example; it defines childhood anxiety as an "inability to separate from home" and "excessive worry about social situations." As a new school year begins, what child doesn't have those problems?

Next we'll be watching commercials in which miserable shy children are transformed into popular, smiling students. Parents will be asked to "talk to your doctor about what you can do for childhood anxiety disorder."

If we judge from the past, millions of concerned parents will take that advice. Why should that bother us? Partly because the drugs have side effects, partly because kids have no say in the matter, but mostly because of the message we send our children: They have to be perfect.

Many children benefit from psychoactive drugs. I know, they have their place. But experts say many others risk far more than they gain.

The drug companies have won. A child with the "blues" now has depression; one who "acts out" now has attention deficit disorder. And soon a child worried about going back to school will have a disorder all her own.

Dr. Michael Breen is the medical editor at WBBM-Channel 2.

LANGUAGE: English

LOAD-DATE: September 05, 2000

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General News;Ritalin

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Copyright 2000 Guardian Newspapers Limited
The Observer

September 3, 2000

SECTION: Observer News Pages, Pg. 1

LENGTH: 410 words

HEADLINE: **Ritalin** banned for under-fives

BYLINE: Gaby Hinsliff Chief Political Correspondent

BODY:

THE use of **Ritalin** for pre-school children is to be banned, in effect, in Britain amid growing fears over the increasing use of drugs to treat hyperactivity.

The controversial calming drug treatment for disturbed and aggressive children has been regarded by many parents as a lifeline since it was first prescribed in Britain.

Its use has grown rapidly, with the number of prescriptions tripling in the 1990s. Now the National Health Service's 'best practice' watchdog is to issue guidelines advising caution on its use for very young children.

There are concerns that the use of the medication can mask emotional or other causes of troubled behaviour. Psychiatrists have warned that toddler tantrums, for example, may be confused with more serious disorders.

Ritalin, methylphenidate, was referred by Health Secretary Alan Milburn to the National Institute for Clinical Excellence, the independent watchdog which rules on the appropriate use of drugs.

It recommends that **Ritalin** should not be given to under-fives. Although older children may continue to receive it, there will be clearer definitions of the conditions for which it can be beneficial as part of a specialist treatment programme.

A recent study found prescription of stimulants to American children under four, suffering from conditions including Attention Deficit Hyperactivity Disorder (ADHD), increased threefold between 1991 and 1995, with the trend still rising.

Gill Mead, of ADHD Support For Families, said parents of younger children would be 'disappointed' if they were refused medication. 'Most parents start coming to us when their children first enter social situations - nursery school. The touch-paper is ignited, the minute you put them into situations that trigger anxiety,' she said.

'Some parents are very anti-medication. I can recall a sad case of two headteachers with a son diagnosed with ADHD. They said, "We don't need medication and we don't need to pump our son full of drugs" - they came back to me and said they wished they had tried drug treatment because he is now up for GBH.'

Mead firmly believes that **Ritalin** works, 'not only for the child but for the parents, who are given enough of a breathing space from troubled behaviour to assist the family to maintain the love for that child'.

Ministers, manufacturers and patients have a few weeks to challenge the findings before they are officially released to doctors.

LANGUAGE: ENGLISH

LOAD-DATE: September 5, 2000

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General News;Ritalin

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Copyright 2000 Gannett Company, Inc.
USA TODAY

August 15, 2000, Tuesday, FINAL EDITION

SECTION: NEWS; Pg. 16A

LENGTH: 498 words

HEADLINE: Reading, writing and **Ritalin**

BODY:

Parents of children who act up in class have another worry to add to their list of back-to-school concerns: Some educators have accused couples of child abuse for refusing to treat their child's "attention deficit and hyperactivity disorder" with drugs such as **Ritalin**.

Proponents of the heavy-handed infringement on parental rights call the drugs "lifesaving" and argue that to intervene on behalf of a child who is denied **Ritalin** is similar to intervening on behalf of a child denied treatment for a life-threatening illness.

Their choice of words is significant: Child-protection authorities typically won't step in to overrule a parent's authority to make medical decisions for a child unless it can be proved that the child's life is at stake.

To be sure, **Ritalin** has proved useful in treating the symptoms of some children who are accurately diagnosed with attention deficit and hyperactivity disorder. But while children's use of **Ritalin** and other such drugs has more than quintupled in the past decade, the drugs' longer-term effects, whether beneficial or harmful, are not well understood.

Forcing parents to put a child on **Ritalin** in spite of such questions robs them of the right to refuse controversial and possibly dangerous medical care. Yet that's what happened in at least two cases reported by USA TODAY last week:

* An Albany, N.Y., couple agreed to put their 7-year-old son back on **Ritalin** after a family court told them in July that if they didn't, they could be deemed child abusers. A school counselor precipitated the case, the couple says.

* Another New York couple was visited by child protective services checking out anonymous allegations of medical neglect after they took their son off **Ritalin** and other drugs. Halting the drugs went against the advice of a school-recommended psychiatrist.

Drugs such as **Ritalin** are prescribed to help children with attention deficit disorder ignore distractions. Currently 3.8 million children are diagnosed with ADD/ADHD, according to the American Academy of Pediatrics; about 2 million are on **Ritalin**.

But with the disorder now the most common childhood diagnosis, the accuracy of the label is in question. In two school districts near Virginia Beach, for example, fully 20% of white boys in the fifth grade in 1995-96 were taking drugs for ADHD, shows a 1999 study by psychologist Gretchen LeFever.

And in the face of growing concern over schools that pressure parents to give their kids the drugs, Colorado's board of education last fall passed a resolution critical of local schools, calling on them to use in-classroom techniques to deal with children's difficulties.

Putting a child on a prescription drug is a medical decision, not an educational one. Absent evidence that the lives of children are at stake when they're not on **Ritalin**, no arm of the state should be ramming the drug treatment down parents' -- and children's -- throats.

LANGUAGE: ENGLISH

LOAD-DATE: August 15, 2000

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General News;Ritalin

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USA TODAY

August 15, 2000, Tuesday, FINAL EDITION

SECTION: LIFE; Pg. 1D

LENGTH: 603 words

HEADLINE: **Ritalin** kept him in school, but 'it stunned me emotionally'

BYLINE: Karen Thomas

BODY:

Ritalin. Does it work?

"I was medded up, way early," says David Cole, who was diagnosed with attention deficit hyperactivity disorder (ADHD) in first grade and was taking **Ritalin** before he entered second grade.

Whether it helped him beat the statistics to rank among the less than 1% of learning-disabled students who complete a four-year college depends on many factors, Cole says.

"If it was a foregone conclusion that I would stay in this school environment that was unsuited to me, then yes, it helped. I got thrown out of class less," he says.

"Without it, I would come home crying because I would have been punished all day long. That didn't happen as much with the **Ritalin**. However, I don't think I was learning very much either way."

Methylphenidate, or **Ritalin**, has been around for more than 50 years, and its use has risen more than 600% since 1993. In recent years, the drug market has grown significantly, and many other stimulants are being used to treat children diagnosed with ADHD, characterized by behaviors such as inattentiveness, impulsiveness and hyperactivity.

Scientific studies in recent years often point to improvement in ADHD children when medicated: the ability to complete tasks more quickly and pay attention more closely. A decade ago, scientists using new brain-scan technology found evidence of brain differences in children diagnosed with ADHD; similar studies are underway looking at the brains of ADHD children who had not been treated with stimulants.

Opponents fear drugs are being used liberally without any evidence about the long-term effects of children taking stimulants or the benefits of the knowledge learned while medicated. The controversy

burdens parental decisions on medication.

"I can't even imagine the position my mother was in. I just can't imagine," Cole says. "It's difficult for me to sit in judgment of any parents of these kids because it's so complex.

"We can remove ourselves intellectually -- if you had an 8-to-1 teacher ratio and plenty of exercise and a good diet and competent physicians and well-trained teachers. Yeah. No joke.

"I'm glad I'm not one of those parents now. I don't know what I'd do. I tell you, I would not send a child like me to public school. And I don't think private school is better."

Perhaps home-schooling, he says, is the option he will choose if he becomes the father of a child with learning disabilities. Evidence often points to a hereditary path for ADHD traits. Cole took himself off **Ritalin** when he was about 12 or 13. At Brown University, he tried **Ritalin** again and began taking other drugs used to treat ADHD and continues a regimen now.

Medications, he says, "can be a valid part of an educational plan. Medication is *not* an educational plan. It's being misused when it allows a child to participate in a fundamentally inaccessible education environment. That's how it was used with me."

As an adolescent, he says, "I began to develop an understanding of how it made me feel. It made me less present emotionally. I'm hesitant to talk about it; the reactions to medications are so incredibly personal."

His **Ritalin** experience at Brown mirrored his elementary school years: "It stunned me emotionally. I was two steps removed."

Without it, Cole is certain his educational destiny would have veered down a different path: "I would have been diagnosed with oppositional behavior disorder and put into a group home. A kid gets a lousy teacher, throws a chair out of total frustration. That kid goes to a group home."

GRAPHIC: PHOTO, Color, Chris Yarbrough, AP; Cole: He stopped taking **Ritalin** when he entered his teens, then tried it again at Brown.

LANGUAGE: ENGLISH

LOAD-DATE: August 15, 2000

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General News;Ritalin

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Copyright 2000 Gannett Company, Inc.
USA TODAY

August 16, 2000, Wednesday, FINAL EDITION

SECTION: NEWS; Pg. 18A

LENGTH: 594 words

HEADLINE: Forced **Ritalin** use sounds like '1984'

BODY:

USA TODAY's article on parents' being pressured to put kids on **Ritalin** sounded an alarm for anyone concerned about civil liberties and the integrity of the family unit ("Parents pressured to put kids on drugs," Life, Aug. 8).

If we want our families to be strong, we must hold dear the rights and responsibilities of parents to their children.

Any attempt by the government to force parents to drug their children not only breaches the integrity of the family unit, but also is downright horrifying. It sounds like George Orwell's **1984**.

Alexandra Hopkins

North Hollywood, Calif.

Form of drug addiction

There is a growing use of illicit drugs among schoolchildren ("Reading, writing and **Ritalin**," Our View, Attention deficit and hyperactivity disorder debate, Tuesday). On the one hand, we continue our futile but persistent "war against drugs" in which we try to tell kids that they can be happier without drug abuse. On the other hand, we still keep giving kids and their parents the ambiguous message that they will be happier taking drugs.

Ritalin, Prozac and all of the other mood-altering, mind-controlling drugs may seem to make kids more tractable and less trouble, but at what cost?

USA TODAY's article in Life contains this chilling statement: "The latest study shows that non-medicated ADHD kids are three times slower than their non-ADHD counterparts making quick decisions; the slowness vanished with methylphenidate (**Ritalin**)."

As a teacher myself, I know that we try to help our children develop

the ability to reason, use judgment, weigh alternatives and decide carefully based on as much data as possible rather than to make quick, snap decisions that are often faulty.

My assumption, knowing something about the effects of **Ritalin**, **would be that the Ritalin**-drugged students easily absorb and parrot back not only academic information, but also moral and ethical decisions as fed to them by authority -- *without* stopping to weigh and form their own conclusions. Very, very scary.

Rosalyn Newhouse

Tigard, Ore.

Diseases are 'complete fiction'

USA TODAY's article on **Ritalin** missed a very important point: The Diagnostic and Statistical Manual (DSM) -- the psychiatrists' reference on what diseases are out there and what drugs are used to treat them -- is complete fiction.

Psychiatric "diseases" are *voted* into existence by a panel, and when these "diseases" win the vote and are included in the next edition of the DSM, they become by that fact "real."

The way I see it, when little Johnny fidgets in his seat, folks, it's not attention deficit disorder (ADD) or any other combination of letters. It's that he's had too much sugar in his diet, or too much TV, or is simply the straw that breaks the back of the teacher who would rather not confront the idea of actually finding out what's going on in this kid's life.

So the teacher takes the easy way out and sends Johnny to the counselor's office. And after an interview, a diagnosis is made, a label applied and a drug administered. And little Johnny goes through the rest of his life damned by the ineradicable blot on his record caused, at root, by fidgeting in class.

What's arguably worse is that because of this sequence of events, little Johnny has to take powerful mind-altering drugs that do more to wreck his sanity than they do to cure anything at all -- much less a made-up "disease" that has no clinical basis whatsoever.

Dave Silberstein

Altadena, Calif.

LANGUAGE: ENGLISH

LOAD-DATE: August 16, 2000

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General News;Ritalin

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Sun-Sentinel (Fort Lauderdale, FL)

August 19, 2000, Saturday, Broward Metro EDITION

SECTION: EDITORIAL, Pg. 15A, THOMAS SOWELL CREATORS SYNDICATE

LENGTH: 735 words

HEADLINE: WAKE UP, PARENTS: YOUR RIGHTS ARE BEING ERODED;
IT IS DANGEROUS TO PUT DECISION-MAKING IN THE HANDS OF PEOPLE WHO PAY NO
PRICE;
FOR BEING WRONG.

BYLINE: THOMAS SOWELL CREATORS SYNDICATE

BODY:

One of the scariest stories in the news is receiving very little attention. According to USA Today, parents are being put under pressure by schools and by courts to have their children drugged with **Ritalin**. Some parents have been threatened with charges of child neglect or abuse -- and of having the child taken away by the authorities -- if they do not give their children **Ritalin**.

All it takes to have **Ritalin** prescribed is a label of "attention deficit hyperactivity disorder." And there are lots of little tin gods in the schools who are ready to put this label on children who are bored and fretful at the uninteresting and unchallenging material presented to them. Very bright children are particularly likely to be frustrated and acting out.

Some parents have seen almost miraculous improvements in their children's interest and behavior, just by finding a more interesting teacher or a more interesting school. But now that judges are willing to threaten to take children away unless parents knuckle under to school shrinks and social workers who want the child drugged, that option may not be available in time.

It is hard to imagine a more stupid or more dangerous way of making decisions than by putting those decisions in the hands of people who pay no price for being wrong. Know-it-alls in the school system do not lose one dime or one hour's sleep if their bright ideas turn out to be all wrong, or even disastrous, for the child. It is parents and children who pay the price.

There is not even a record kept as to how often the education bureaucrats have been wrong. How often are the schools' diagnoses of various conditions wrong? I could rattle off a dozen examples just from casual observation. There are kids who were put into classes for retarded children, who later turned out to have IQs way above the national average.

A professor of neurosciences at the University of Massachusetts has examined numerous diagnoses of children for numerous conditions. She says that three-quarters of the case histories she has seen have at least one diagnosis that is "completely off the mark."

What is even scarier than the error rate and the recklessness with which diagnoses are made in the school system -- often by people with neither an M.D. nor a Ph.D. -- are the sheep-like parents who simply go along with whatever the "experts" say. Now the law is threatening to come down hard on parents who refuse to be sheep.

This is not just an isolated problem. It is part of a widespread erosion of parents' rights to raise their own children. Moreover, there is a whole ideology favoring government takeovers of parents' role. This ideology has been promoted for decades by people like Hillary Rodham Clinton and organizations like the so-called Children's Defense Fund.

Schools have already taken over the decision as to when and in what manner your child will be introduced to sex education.

The question is not whether the decisions made by the schools are wise decisions. The more fundamental question is why they have a right to take over such decisions from parents in the first place. Still more basic is the question: Why do we let them get away with it?

This is still a democracy, after all. If parents started voting against politicians and judges who have been taking away their rights as parents, it would have to stop. If legislatures started impeaching judges who punish parents for refusing to drug their children, that would come to a halt as well.

There is no great mystery as to why people want more power over other people. There have always been despots, large and small, throughout thousands of years of recorded history. For at least the past two centuries, there have also been ideologies that argued for government takeovers of parents' role in the raising of children. There is nothing original in Hillary Clinton's notion that "it takes a village to raise a child" -- whether the parents want their child raised by a village or not.

Claims that "studies prove" the need for **Ritalin** are far less convincing when you realize how often studies have "proved" one thing, only to have later studies prove the opposite.

Parents and voters need to wake up to the dangerous extension of government despotism into the family.

Readers may write to Thomas Sowell at Creators Syndicate, 5777 W. Century Blvd., Suite 700, Los Angeles, CA 90045.

GRAPHIC: DRAWING, Drawing: Editorial cartoon

LOAD-DATE: August 23, 2000

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General News;Ritalin

Copyright 2000 Gannett Company, Inc.
USA TODAY

August 21, 2000, Monday, FINAL EDITION

SECTION: NEWS; Pg. 16A

LENGTH: 374 words

HEADLINE: Anti-**Ritalin** propaganda ignores success

BODY:

The letters from several USA TODAY readers regarding **Ritalin** were truly chilling ("Forced **Ritalin** use sounds like '1984', " "Form of drug addiction," "Diseases are 'complete fiction,' " Letters, Wednesday).

The ignorance and misinformation about attention deficit disorder (ADD) and doctor-prescribed **Ritalin** are baffling.

The opinions in the letters parrot the extreme right-wing political propaganda that there is no such thing as ADD and that public schools and pediatricians are part of a sinister cabal that forces parents to give their kids drugs.

Nothing could be further from the truth. ADD and attention deficit and hyperactivity disorder (ADHD) do not simply mean that a child fidgets in class, although this may be a symptom.

ADD-related learning disabilities are just that -- learning disabilities that affect the incoming-information processing of the brain.

Most kids with ADD/ADHD fidget because they are not getting it. They are not getting information in class that they can process and assimilate. **Ritalin** slows down a brain that is functioning at warp speed and allows a child to absorb information.

The academic life of our child was saved through the use of **Ritalin**. We had tried everything from summer school to tutoring, from threats to intimidation to psychological therapy. Finally, at wits' end, we tried **Ritalin** as a last resort. We were not coerced. We were not forced. Our pediatrician closely monitors the **Ritalin** use, and our child must have physical exams more often than average to be sure there are no side effects. **Ritalin** is a class-two drug and is regulated by the government, to the extreme.

Many people who denounce **Ritalin** and the existence of ADD and ADHD also do not believe in the more mainstream psychological disorders such as manic depression and schizophrenia.

They believe that praying, better nutrition and a return to Gestapo-like tactics in school will "cure" all of these imaginary disorders.

Ritalin scary? What's scary are the attitudes of those too ignorant to get the full story, and who would sanctimoniously narrow the choices of the rest of us to decide what is best for our families.

Lynn Highland

Morrison, Colo.

LANGUAGE: ENGLISH

LOAD-DATE: August 21, 2000

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General News;Ritalin

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Copyright 2000 Toronto Star Newspapers, Ltd.
The Toronto Star

August 21, 2000, Monday, Edition 1

SECTION: NEWS

LENGTH: 672 words

HEADLINE: ARE OUR CHILDREN HEALTHY - MENTALLY?

BYLINE: Valerie Lawton

BODY:

'As kids hit school age, parents become so busy and often children become so busy and we're losing contact, we're losing the connectedness between children and family.'

Many parents report signs
of emotional, behavioural disorders,
study reveals

OTTAWA - Large numbers of parents believe their children are suffering from symptoms of emotional and behavioural disorders, a major new report on the health of Canadian kids says.

Mental health is one of the most disturbing issues highlighted in the latest version of a profile of children in Canada, said Dawn Walker, executive director of the Canadian Institute of Child Health.

"Parents by a large majority are indicating that their perception of their children is that of a problem," she said.

The report highlights the findings from a study that surveyed parents of 4-to- 11-year-olds about their children's mental health. The study is part of a national survey conducted by Statistics Canada, which is following 23,700 children from birth on.

Many parents reported their kids are nervous, high strung, or tense (30 per cent of boys); that they cry a lot (28 per cent of girls); are stubborn, sullen or irritable (48 per cent of girls); can't sit still, and are restless or hyperactive (51 per cent of boys).

"It doesn't really indicate a happy picture of childhood," said Walker.

But it's not clear from the findings whether parents simply have unrealistic expectations and are overly concerned about normal kid behaviour, or whether many children are suffering from real problems.

The institute - a national non-profit organization dedicated to improving the over-all health and well-being of youth - launches its report, The Health of Canada's Children, tomorrow. The report is a compilation of data and research on a range of topics - from pregnancy and breastfeeding to childhood disease to social problems.

The report raises many red flags about the state of Canada's children, in particular in areas such as child

care, services for disabled children, nutrition and physical fitness and poverty.

Walker said mental health should also be a major concern.

"We're pretty good at understanding the stages of early child development in infancy - a lot of parents read a lot, there are a lot of support groups," Walker said.

"But as kids hit school age, parents become so busy and often children become so busy and we're losing contact, we're losing the connectedness between children and family."

Another problem, she said, is that parents are increasingly concerned about their children's ability to compete and succeed in life.

"They're looking for winners. They're looking for their kids to be the best, the best in all things. There's very little tolerance for normalcy."

The report also points to various studies that found:

Only 26 per cent of girls, and 35 per cent of boys in Grade 10 describe themselves as "very happy" about their lives.

The number of **Ritalin** pills dispensed in Canadian pharmacies hit 56.2 million in 1998, up from 26.8 million in 1994. **Ritalin** is the medication most commonly used to treat children with problems such as hyperactivity and attention deficit disorder.

Walker argues Canada needs to do a better job at tracking children's mental health issues, as well as funding programs to help children deal with problems.

"The mental health support programs that the school boards have been running have been cut dramatically."

An open letter at the end of the profile calls for Canada's economic and social policy to be revamped to better protect children and their families.

"Many children fall through the cracks due to bureaucracy and systems not designed to put the needs of children first," says the letter.

The federal government has plans for a national children's agenda, but its negotiations with the provinces have been bogged down by disagreements between the two levels of government over social transfer payments.

LANGUAGE: English

LOAD-DATE: August 21, 2000

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General News;Ritalin

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August 22, 2000, Tuesday, Final Edition

SECTION: HEALTH; Pg. Z07

LENGTH: 1322 words

HEADLINE: INTAKE

BODY:

More Than An Ounce Of Prevention

A national group of nurses wants women to leave their next medical appointment about a pound heavier--the weight of a 300-page glossy magazine.

The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) has begun giving away 500,000 copies of its first "Every Woman" handbook, which the group calls "The Essential Guide for Healthy Living."

"Nurses believe wholeheartedly in the power of every woman to make her own health care decisions," said Gail Kincaide, AWHONN's executive director of the 22,000-members nonprofit group. "On average, nurses spend more time talking with and listening to their patients than any primary health care provider," she said in a statement, adding that "'Every Woman' builds on the trusting relationship between nurses and the women for whom they provide care."

In addition to commissioning and editing articles on such topics as pregnancy, cancer, menopause, skin care and incontinence, the AWHONN staff vetted all the ads.

Because "we don't invest in tobacco or alcohol," said Karen Kelly Thomas, deputy executive director of AWHONN, the organization debated whether to accept an ad for O'Doul's low-alcohol malt drinks, which are made by Anheuser-Busch. After discussion, the ad was approved.

Likewise, Kelly Thomas said, AWHONN insisted that in ads for baby formula, "the copy had to indicate that breast [milk] is best." Indeed, an ad from Enfamil reads, "Remember, breast-feed as long as you can. . . ."

According to Howard Shaw, president of the publishing firm that partnered with AWHONN to produce the magazine, the advertising rates were \$ 56,000 for a page and \$ 90,000 for a two-page spread. Shaw declined to disclose the total revenue raised for the project by his firm, Profile Pursuit, which is based in London and New York.

To order a free copy of the magazine, contact AWHONN at www.awhonn.org or 800-673-8499, ext. 2401.

--Tom Graham

The Scoop on Soft Frozen Yogurt

As the dog days of summer arrive, go easy on soft frozen yogurt. While yogurt shops often tout this creamy treat as a dieter's delight, it could contain up to 50 percent more calories than consumers expect, according to registered dietitian Joanne Lichten.

Here's why: Nutritional information on soft frozen yogurt is often posted on the wall of yogurt shops. The number of calories per serving are calculated according to fluid ounces (eight to the cup). Yet the containers in which it's served are often labeled in weight ounces (16 to the pound). Since the two measures aren't interchangeable, that simple difference tacks on up to 50 percent more calories.

That means a serving of four ounces labeled as containing 130 calories actually contains about 185 calories. The numbers really add up for large sizes, says Lichten, author of "Dining Lean: How to Eat Healthy in Your Favorite Restaurants" (Nutrify Publishing). "Say you see the nutrition labeling and order the eight-ounce cup, thinking that it contains just 260 calories," she says. "You're actually getting 400 calories."

Add a cone or some candy toppings and the calories go even higher. "It's why consumers have to look and see how frozen yogurt is being advertised," advises Nadine Pazder, a registered dietitian at Morton Plant Hospital in Clearwater, Fla., and a national spokesperson for the American Dietetic Association. "The calories should be on the pricing board or menu."

But remember, Pazder says, "that fluid and weight ounces are two different things." And when in doubt, she advises, "ask more questions." Or go with the smaller size.

--Sally Squires

Readin' and Writin' and **Ritalin**; New Drug for ADHD Delivers a Dose That Lasts All Day

Imagine being required to march into your boss's office at a certain time every day to take your Prozac or your birth control pill--while the boss looks on.

Inconvenient? An invasion of privacy? Humiliating enough to make you avoid taking your medicine? All of the above?

Yet that's just what the millions of kids who take **Ritalin** or another brand of the drug methylphenidate endure every school day with trips to the nurse's office for medication to treat their attention deficit/hyperactive disorder (ADHD).

Things may improve for those youngsters, however, with the introduction this month of Concerta, a newly engineered form of methylphenidate that delivers the benefits of **Ritalin** while eliminating one of its biggest shortcomings: the need to take pills several times a day.

ALZA Corp., Concerta's manufacturer, has devised a time-release mechanism that feeds methylphenidate into the bloodstream throughout the day. Unlike other drug options such as **Ritalin** (and its generic equivalents, which account for 80 percent of the market), Concerta offers "Home to Homework" coverage: Once ingested in the morning, a single pill controls ADHD symptoms during the school day and into the early evening.

Ritalin has gained notoriety in recent years, playing a starring role in the controversy over whether America's children are over-medicated. But despite that controversy, methylphenidate remains the drug of choice for controlling the short attention span, hyperactivity and impulsive behavior that plague the estimated 3 percent to 5 percent of school-age children in America who suffer from ADHD and attention deficit disorder (ADD). But to maintain appropriate levels in the bloodstream, the drug generally must be administered three times a day. Most schools do not allow students to carry any prescription or over-the-counter drugs, thus the medication must be brought to the school so that the school nurse can give it to youngsters at the appropriate time. For some kids, it also means going straight home after school to dose up, instead of going to a friend's house or playing soccer.

A time-release version of **Ritalin** (called **Ritalin SR**) has been available since 1982, but it releases a steady stream of methylphenidate without taking into account variations in the body's tolerance for the drug. In short, the medication doesn't sustain its effects throughout the school day. (Novartis, **Ritalin's** manufacturer, is now developing a longer-acting formulation of **Ritalin**.)

"**Ritalin SR** helped give us the idea that a unique pattern of drug delivery was needed," says Sam Saks, a doctor and group vice president at ALZA Corp. Concerta, which received final FDA approval in early August, delivers its doses in waves, mimicking the effects achieved by taking a pill at breakfast, lunch and late afternoon.

Concerta relies on ALZA's time-release system, OROS, which has been used in other medications for nearly two decades. OROS orchestrates three phases of drug delivery, including the initial, immediate release of the drug contained in the pill's overcoating. Subsequent releases come from interior layers as they are dissolved and propelled to the surface of the pill by a "push layer" that swells up when stomach liquid enters through a hole drilled into the pill by a laser during manufacturing.

ALZA's clinical studies show Concerta's side effects (including headache and abdominal pain) to be similar to those associated with **Ritalin** and other methylphenidate products. At \$ 1.75 to \$ 1.85 per day, it is on the expensive end of the range of ADHD drugs (which Saks says runs from about \$.60 to about \$ 2.25).

"Concerta is a premium product that has high value," Saks says. With Concerta "there is no need for a child to take a controlled substance to school, no need for the child to remember to comply, and no need for the child to leave the classroom to take the medication."

"As far as we're concerned," Saks continues, "the decision to medicate a child is between the doctor, the child and the parents. Concerta makes possible the elimination of the school system's involvement" in treating students with ADHD.

--Jennifer Huget

GRAPHIC: ILL., ROBERT BARKIN

LANGUAGE: ENGLISH

LOAD-DATE: August 22, 2000

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Copyright 2000 The Detroit News, Inc.
The Detroit News

August 27, 2000, Sunday

SECTION: Metro; Pg. 1

LENGTH: 497 words

HEADLINE: Kids with attention disorder get special treatment

BYLINE: Pete Waldmeir; The Detroit NewsCOLLEGE; EXAMINATIONS; STUDENTS; DISEASE

BODY:

A Metro Detroit student I'll call Mary is starting her freshman year at the University of Notre Dame this fall. Her dad is a graduate, and that had something to do with her admission to a selective school.

But she also scored 33 on her ACT college admission test, just three points short of perfect and considerably above the national average, despite the fact that she been treated for years for Attention Deficit Disorder -- known as ADD.

Actually, you could say her high score really isn't "despite" having grown up as an ADD kid. Her testing success, her dad acknowledges, can be attributed directly to her long-term use of the controversial drug **Ritalin**.

Mary and her dad don't want their names used, of course. But their story is true.

And it will be repeated thousands of times as high school seniors struggle with PSAT, SAT and ACT college admissions tests in coming months.

Unlike the rest of the student population, you see, kids with ADD and ADHD (Attention Deficit Hyperactivity Disorder) can be classified as disabled under the Americans with Disabilities Act. That can make them eligible for Supplemental Social Security Income, and their schools get extra federal money to subsidize programs for them.

But there's one other little-known benefit that accompanies their treatment: ADD and ADHD kids can apply for unlimited time to take college entrance exams, a break that's frequently granted.

Mary, who was a normal student with normal grades, had a letter from her doctor, her dad said. In his view, she deserves a break because she has an illness that requires medicine.

There are those, of course, who will argue with that kind of logic. Particularly parents whose students have taken the tests over and over to score high enough to get into the college of their choice because they just didn't have enough time to read, digest and respond to the test materials.

Now before everybody gets all upset, nobody wants to further hobble kids with legitimate physical, psychological or other learning disabilities. They have enough problems.

It's just that the diagnosis and treatment of ADD and ADHD, and the widespread use of **Ritalin**, have become so controversial over the last few years that it makes you wonder where the line ought to be drawn.

Some 12 million Americans, about half of them school-age kids, use **Ritalin** each year to help improve concentration and shut out distractions. That number is up 500 percent over the last 10 years.

Michigan ranked third among states in **Ritalin** use, according to a 1998 Detroit News study.

Don't get me wrong. Millions of kids may need it.

But studies show thousands, maybe millions more, are given it merely to avoid longer, more extensive and expensive treatment without drugs.

And consider this: If long-term use of drugs like **Ritalin** is supposed to make a kid "normal," then why not treat users and nonusers equally when it comes to critical issues such as eliminating time limits on college exams?

GRAPHIC: Pete Waldmeir

LOAD-DATE: August 29, 2000

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Copyright 2000 Guardian Newspapers Limited
The Observer

September 3, 2000

SECTION: Observer News Pages, Pg. 1

LENGTH: 410 words

HEADLINE: **Ritalin** banned for under-fives

BYLINE: Gaby Hinsliff Chief Political Correspondent

BODY:

THE use of **Ritalin** for pre-school children is to be banned, in effect, in Britain amid growing fears over the increasing use of drugs to treat hyperactivity.

The controversial calming drug treatment for disturbed and aggressive children has been regarded by many parents as a lifeline since it was first prescribed in Britain.

Its use has grown rapidly, with the number of prescriptions tripling in the 1990s. Now the National Health Service's 'best practice' watchdog is to issue guidelines advising caution on its use for very young children.

There are concerns that the use of the medication can mask emotional or other causes of troubled behaviour. Psychiatrists have warned that toddler tantrums, for example, may be confused with more serious disorders.

Ritalin, methylphenidate, was referred by Health Secretary Alan Milburn to the National Institute for Clinical Excellence, the independent watchdog which rules on the appropriate use of drugs.

It recommends that **Ritalin** should not be given to under-fives. Although older children may continue to receive it, there will be clearer definitions of the conditions for which it can be beneficial as part of a specialist treatment programme.

A recent study found prescription of stimulants to American children under four, suffering from conditions including Attention Deficit Hyperactivity Disorder (ADHD), increased threefold between 1991 and 1995, with the trend still rising.

Gill Mead, of ADHD Support For Families, said parents of younger children would be 'disappointed' if they were refused medication. 'Most parents start coming to us when their children first enter social situations - nursery school. The touch-paper is ignited, the minute you put them into situations that trigger anxiety,' she said.

'Some parents are very anti-medication. I can recall a sad case of two headteachers with a son diagnosed with ADHD. They said, "We don't need medication and we don't need to pump our son full of drugs" - they came back to me and said they wished they had tried drug treatment because he is now up for GBH.'

Mead firmly believes that **Ritalin** works, 'not only for the child but for the parents, who are given enough of a breathing space from troubled behaviour to assist the family to maintain the love for that child'.

Ministers, manufacturers and patients have a few weeks to challenge the findings before they are officially released to doctors.

LANGUAGE: ENGLISH

LOAD-DATE: September 11, 2000

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