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Dear Dr. Block:

This letter is a response to the latest guidelines published by AAP with respect to lowering the age to 2 years old for physicians to screen for ADHD. Clearly, we believe that children of all ages should be screened for any number of potential problems that may be present. However, we also believe that children and parents would best be served if children were evaluated by a doctoral level behavioral health specialist when a behavioral problem is the focus of a screen. When behavioral problems are screened by a physician, the likelihood that this will lead to the inappropriate prescribing of psychostimulants and other psychotropic medications greatly increases. Psychotropic medications prescribed to children and adolescents are all too common. We do not believe that this is a good practice particularly when a child is only 2 years old.

NAPPP is concerned about the increased prescribing of psychotropic medication in the child and adolescent population. A very recent study new study from Rutgers University and Columbia University shows that prescriptions for antipsychotic medications to children aged 2 to 5 years doubled between the years 1999-2001 and 2007. The top-selling medicines in 2010 were anti-psychotics for schizophrenia and bipolar disorder with \$15 billion in sales. The studied group was a population of privately insured children. Moreover, the age of children being medicated with psychotropic drugs is getting younger and the number of children being medicated increasing every year. These same researchers produced a previous study in a population of children enrolled in a government Medicaid program. They concluded that children seen by physicians insured under Medicaid are about four times as likely to be prescribed an anti-psychotic medication as those covered with private insurance.

What is more problematic about this growing practice is there appears to be little evidence, if any, that these drugs are effective in this population of patients. Physicians, on the other hand, seem unconcerned about the lack of evidence or effectiveness of these drugs. It is common knowledge, however, that children are not part of the population included in clinical trials, so why the rush to prescribe wholesale these potentially dangerous medications to such a vulnerable population? This is an important question.

Given the lack of data, can we rationally infer there is a greater likelihood that danger extends to children? We believe we can.

Does ADD/ADHD Qualify As A Real Diagnosis?

Before even considering ADD/ADHD as a medical problem, it seems to us that the current use of psychostimulants also should be scrutinized as a treatment option. Many of the children being treated for ADD/ADHD have long-standing but undiscovered sleep disorders. Not surprisingly, psychostimulants do produce gains in performance with these children. One would expect these results if a sleep disorder were present. For too long, many have accepted that ADD/ADHD are established conditions that need medical as opposed to behavioral treatment.

To date, not a solitary cause has yet been identified for ADHD. ADHD will likely prove to be an umbrella term for a number of behavioral and/or neurologically based disorders. Furthermore, there hasn't been any identified cause specific to ADD, leaving open the likelihood that ADD may be a catchall condition. The National Institutes of Health Consensus Development Conference and your own organization agree that there is no known biological basis for ADHD. The more one reviews the literature on hyperactivity or ADD, the less certain we are about what it is, or whether it really exists as a stand-alone disorder. So, at issue is not only the question of drugs for the treatment for attention-deficit problems, but also the question of why physicians prescribe these medications for children when other factors may be the cause of the problems.

In May 2010, The American Medical Association issued a news release on this specific issue, detailing the numerous co-morbidity conditions found along side ADD/ADHD. In that release, several researchers made the following statement: "Among children and adolescents with attention-deficit/ hyperactivity disorder, more than 80 percent had a diagnosis of at least one other psychiatric disorder, most commonly oppositional defiant disorder and conduct disorder, according to new research presented at the American Psychiatric Association's Annual meeting in May of 2010.

It is important to note that the conditions specified in the news release are behavioral disorders. Moreover, the issue is whether the condition labeled ADD/ADHD is a primary diagnosis or a symptom related to other, established behavioral disorders. It appears that the latter is the case, and raises to the question of why these children are being treated with drugs when they more than likely are experiencing a behavioral disorder amenable to non-drug treatment.

Children Diagnosed With Attention Deficit Problems

In 2007, the FDA issued an administrative order that requires that all makers of ADHD medications to develop and provide patients with Medication Guides. The guides must contain and warn patients, in clearly readable language, to possible heart and psychiatric problems related to ADHD medicine. The FDA took this action because of complaints and the increasing data that concluded ADHD patients with heart conditions had a higher risk of strokes, heart attacks, and sudden death when using these medications. The psychological symptoms associated with these drugs include hearing voices, having

hallucinations, becoming suspicious for no reason, or becoming manic. The FDA found that these symptoms occurred in patients who had no history of behavioral disorders. Ritalin is a psychostimulant medication prescribed primarily to children.

In addition to Ritalin and other psychostimulants, the non-amphetamine-based medication prescribed to children with ADHD is Strattera. The FDA warns that children and teenagers who use Strattera are more likely to have suicidal thoughts than children and teenagers with ADHD who do not use this medication. Children who use Strattera must be supervised and their behavior carefully monitored. Symptoms may develop suddenly and they are a serious threat to the child.

These medications have become ubiquitous in schoolyards across America. In 2001, the average total annual expected cost per patient was \$1,631 for Concerta, and \$2,080 for Ritalin. Adderall, another widely used psychostimulant cost \$2,232 per patient. In 2003, psychostimulants had sales of \$2.4 billion. By 2008, sales of Adderall reached \$1.1 billion while sales of Strattera were \$479 million. Clearly, these medications are big profit-producers for the drug companies, but are dangerous when prescribed to children. The FDA has been derelict in its duties and too industry-friendly. The FDA appears unwilling to challenge the drug companies, no matter how demonstrable the research on the dangers and ineffectiveness of these medications.

The FDA, as well as every pediatric physician group, is aware of the effectiveness of non-drug treatment for attention-deficit problems. They also are aware of the problems with the long-term use of psychostimulants. These medications can change brain structure and inhibit growth in children. Moreover, these drugs are sold on school grounds as a "drug of choice" because they are so easy to get.

An important study by Cummings and Wiggins published in 2001 looking at children and adolescents diagnosed with ADD/ADHD and on psychotropic medications when entering treatment, showed a dramatic reduction in the use and amount of medications at the conclusion of treatment when these patients were provided with behavioral interventions. Cummings and Wiggins advocated for a collaborative model between primary care physicians and psychologists to bring about a rapid stabilization of the patient's condition while at the same time reducing or eliminating medications. This was not a small study. The records of 168,113 episodes of children and adolescents over a four-year period, who received behavioral intervention while on medication, was reviewed for the study. At the conclusion of treatment, only 13% of the children remained on medications contrasted with about 67% of children and adolescents who were on medication when they first entered behavioral treatment. More importantly, 95% of the 5 to 6 year olds and 92% of the 1 to 17 year olds did not need any medication at the end of treatment. This success was achieved with an average of only six sessions of behavioral intervention. The implications for cost control are obvious. However, the rapid stabilization of symptoms without medication and over such a short time is impressive and important.

Contrast these results with the meager clinical trials reported by the drug manufacturers of psychostimulants. Although this data comprises a large number of data points, both the number of prescriptions for psychostimulants continues to increase along with the costs for these medications. In the same time period, behavioral intervention has significantly been diminished. But even as the use of psychostimulants is questionable, some psychiatrists have called for adding marijuana to be used in treating attention deficit symptoms.

Recently, an article appeared in the New York Times reporting on the use of marijuana for treating children with ADD/ADHD. The Times article is just one of several that have been popping up since medical marijuana initiatives have been passed a handful of states. Initially, the use of marijuana to treat pain and suffering related to the side effects of chemotherapy and to increase appetite in HIV patients were used as the rationale for the medical marijuana initiatives. Right now, however, a patient can get a prescription for almost any type of complaint. Anxiety, depression and other behavioral disorders are now at the top of the complaint list. Thus, it is not surprising that more disorders are being added to the list. How safe can a drug be when some psychiatrists are advocating that these patients would be better off with marijuana?

Frequently, parents have no place to turn to get appropriate information when their child's behavior appears different. Many articles on attentional disorders available on the Internet imply that a simple pill prescribed by a psychiatrist will make everything better. What these articles do not tell parents, or anyone else for that matter, is that the physician most likely has received many "incentives" for prescribing medications as opposed to ordering an evaluation to find out if the child really does have ADHD or other disorder. Thus, getting labeled with an attentional disorder diagnosis has increasingly becoming part and parcel of medical practice.

In those infrequent cases in which a psychologist is consulted, we become the referral source for psychiatrists and we lose the patient. I am not suggesting we lose the patient because psychologists cannot prescribe medications. We lose the patient because psychologists typically are not part of the treatment process. The ability to prescribe not only gives one control over the treatment process but also the ability NOT to prescribe. Many physicians and parents simply do not understand this, as they want relief for their children and are not provided with the information that physicians often withhold. As a consequence, patients are not able to evaluate alternative diagnoses or alternatives to medications. Medications gain, patients lose. It is not uncommon for patients and parents to hear, "You must take this pill for the rest of your life."

Psychologists can provide a proper and appropriate diagnosis that can spare parents and their children a lifetime of misery. We are specialists at looking at differential diagnoses. As to cost-effectiveness, having an appropriate diagnosis is key to controlling healthcare costs.

NAPPP believes that doctoral level behavioral specialists need to be part of the treatment process. To get this, we need to have the ability to question medications as being the first, and many times only, consideration in a treatment plan. There are just too many psychotropic medications being prescribed for our children and for the wrong reasons. Organized Medicine seems reluctant to admit to this. We need to change this process. Medicating without a thorough, professional diagnosis is not only wrong, but also abusive to the patient. Medications may be necessary for some patients, but their irresponsible overuse is a serious problem.

A solution, among many that NAPPP endorses, is to regulate when and how some of these medications are used. We advocate eliminating ads for prescription drugs from television and magazines. We did this for alcohol because, as a society, we recognize that advertising is directly related to substance abuse. Also, physicians should be empowered and mandated to better inform parents of the possible harms many drugs can cause their children, and that no medications will be prescribed unless there is a thorough evaluation by a qualified, doctoral-level psychologist. Physicians need to be trained and directed to shift more of their concentration on the underlying causes of behavioral disorders in children. Today's society can be very difficult for many people. Stress can produce many symptoms that can lead to many problems. Learning to manage stress is a long-term solution. Medications are short-term, at best. Medicating a child without a substantial evaluation should never be equated with good medical treatment, counseling and professional guidance.

In conclusion, we call upon AAP to adopt and publish guidelines that no child or adolescent suspected of having a behavioral problem will be prescribed a psychotropic medication before being evaluated and diagnosed by a doctoral level behavioral health specialist. At the end of this letter I have attached some references for your use. I thank you for your consideration as I am sure that AAP is as concerned about these patients as we are. I wait your response.

Very truly your,

[John Caccavale](#)

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