Drugs to Treat A.D.H.D. Reach the Preschool Set
By Roni Caryn Rabin
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Ruth Grau was first told her son had attention deficit hyperactivity disorder when he was 3. The idea of medicating him was anathema to her, so she and her husband tried an alternative approach: exercise, occupational therapy and a diet free of junk food — no sweets, no dairy, no processed food.

When the boy was 4, they started a behavior modification program with the help of a psychiatrist. But when their son started kindergarten, he still “wouldn’t sit down, would fidget, wouldn’t be on task, wouldn’t stop talking, wanted to go outside and play,” said Ms. Grau, 46, who with her husband owns Springboard Vacations, a travel company in Redondo Beach, Calif. “He had a wonderful teacher, but he was falling further and further behind.”

When the child was 5, the psychiatrist started him on medication, and though Ms. Grau had not shared that information with his teacher, the teacher sensed a difference right away.

“She rang us the same day and said, ‘I don’t know what you’ve done, but he was so much better in class today,’ ” Ms. Grau said. Of the decision to put her son on medication, she said, “I don’t regret it for a minute.”

Although methylphenidate, a stimulant used to treat A.D.H.D. and sold under brand names like Concerta and Ritalin, is not approved for use in children under age 6, physicians may prescribe it to them. And they may be doing so more often. Last week, the American Academy of Pediatrics revised its A.D.H.D. treatment guidelines, giving doctors a green light to prescribe drugs even to preschoolers with A.D.H.D. if behavioral efforts fail.

But the new guidelines raise tough questions for parents. While some children may well benefit from drug therapy, many critics say Americans generally are too quick to embrace medication instead of discipline or lifestyle changes for treatment of A.D.H.D.

According to a recent study by the National Institutes of Health and the Agency for Healthcare Research and Quality, the number of children ages 6 to 12 taking stimulants for A.D.H.D. has increased steadily in recent years, to 5.1 percent of all children in 2008, up from 4.2 percent in 1996.

Behavioral psychologists who work with young children say it can often be difficult to tell the difference between a healthy, active 4- or 5-year-old and one with A.D.H.D.

“You’re trying to differentiate what may be normative, somewhat disorganized, active, distractible behavior in a 4-year-old, that to an adult may look difficult to control, from something that would qualify as a diagnosis of A.D.H.D.,” said Rahil Briggs, a psychologist and director of the Health Steps Program at Children’s Hospital at Montefiore Medical Center in the Bronx.
And A.D.H.D. “is a really powerful diagnosis that can lead to a host of interventions that may just be inappropriate, or may even be quite harmful,” she added.

The new guidelines issued by the pediatrics academy endorse off-label use of methylphenidate — that is, for a purpose not expressly approved by the Food and Drug Administration. And evidence of its safety and effectiveness in children younger than 6 is limited.

Nearly a dozen small studies have been done of very young children taking the drug, but only one long-term large multisite randomized clinical trial of children ages 3 to 5 has been completed. In that trial, the Preschool A.D.H.D. Treatment Study, conducted under the auspices of the National Institute of Mental Health, all 303 preschoolers and their parents participated in a 10-week behavioral therapy and training course beforehand. Nearly one-third of the children who completed the behavioral modification program did not proceed to the medication phase of the trial, many of them because their behavior had improved so much they did not need further treatment.

While preschoolers’ A.D.H.D. symptoms were reduced while on medication, the trial also found, the younger children did not benefit as much as older children do, and in one phase of the trial their improvement was not significantly better than with a placebo. Younger children also were more sensitive to adverse side effects.

Many children lost weight and stopped growing. Others suffered insomnia, loss of appetite, moodiness and nervousness, and skin-picking behavior. One in 10 of the children dropped out of the study because the side effects were intolerable.

Dr. Mark Wolraich, who was chairman of the A.A.P. subcommittee on A.D.H.D., emphasized that the new guidelines for prescribing medication to younger children are very conservative. “We’re saying they should be going through a behavioral intervention first and should have moderate to severe symptoms, not just mild symptoms, before medication is considered,” Dr. Wolraich said. “We’re describing much more pervasive symptoms that are stricter than we do with older children.”

Dr. Wolraich, chief of the section on developmental and behavioral pediatrics at University of Oklahoma Health Sciences Center in Oklahoma City, acknowledged that he is an occasional paid consultant to four drug companies that sell A.D.H.D. drugs, including Eli Lilly and Shire Pharmaceuticals. He said he was compensated for providing expert advice on how the medications could be improved for children’s use.

Dr. Lawrence Diller, a behavioral developmental pediatrician in Walnut Creek, Calif., who has long worried about the overuse of drugs like methylphenidate, said behavioral interventions should always be attempted before medication is used.

“I’m really heartened that they’re promoting behavioral intervention for the little kids,” Dr. Diller said. But the new guidelines also raise the age for prescribing A.D.H.D. medication to 18, up from 12.
“My question is, why aren’t they promoting behavioral modification first for the older kids too?” he said. “Behavioral intervention has been shown in older kids to either obviate the need for medication, or decrease the amount they’re taking.”