What is behind the alarming increase in Ritalin use among US children?

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In 1997, 5 million people, most of them school-aged children, were prescribed psychotropic drugs in the US. The vast majority were given the drug Ritalin for treatment of Attention Deficit Hyperactivity Disorder, or ADHD. The 1990s has witnessed a startling increase in the number of children diagnosed with ADHD and a corresponding increase in the use of Ritalin and similar drugs for its treatment. Ritalin use alone has gone up 700 percent since 1990.

ADHD is one of the most common childhood disorders. It is diagnosed in 3 to 5 percent of children, eight times more often in boys than girls. ADHD has been medically described since 1902. Before the 1940s children who had difficulty learning or concentrating were considered mentally retarded, emotionally disturbed or culturally disadvantaged.

Following initial research in the 1940s children who were hyperactive, distractible and impulsive were said to have Hyperkinetic Disorder of Childhood. In 1980 it was renamed Attention Deficit Disorder (ADD) to emphasize the attention problem. In 1987 the name was changed again, this time to Attention Deficit Hyperactivity Disorder to reflect the addition of hyperactivity/impulsively (HI) to the list of symptoms.

The change in terminology for this disorder, and our understanding of it, is one indicator of the very complex nature of the disorder. The cause of ADHD is unknown, and there is no single test for the condition. A child with ADHD displays a range of symptoms, such as distractibility and a short attention span, that are not developmentally appropriate for his mental age. Ideally diagnosis of a child would involve a visit with the child, reports on his schoolwork, examination of his home life, and discussions with parents and teachers to develop a profile of the child and his situation.

Since diagnosing ADHD is based on behavior that is to one degree or another present in all children, deciding when a child is affected by ADHD is a matter of judging degrees. Making the diagnosis even more difficult is the fact that ADHD frequently appears with other disorders, including Tourette Syndrome, lead poisoning, fetal alcohol syndrome and retardation. In addition, many other conditions--depression, manic depressive illness, substance abuse, anxiety and personality disorders--share similar symptoms.

Ritalin is the most often prescribed medication for ADHD. It is a stimulant that is closely related to amphetamine. Over 70 percent of all children diagnosed with ADHD are prescribed Ritalin. Another 20 percent are prescribed its generic equivalent, Methylphenidate (MPH), and another stimulant similar to Ritalin, Dexedrine.

It is not known exactly how Ritalin works on a child with ADHD or why a stimulant would help a hyperactive child have better concentration. What is known is that Ritalin is not a cure in the sense that an antibiotic might cure an ear infection. While Ritalin is in the blood stream it helps the child, but once blood levels of the drug are reduced the child's behavior returns to its previous state. Also, the use of Ritalin in children diagnosed with ADHD is not diagnostic. While other medications treat specific symptoms of the distinct disorder for which they are prescribed, Ritalin has the same effect on all people with or without ADHD. In other words, everyone who takes Ritalin is able to concentrate better, is less fidgety, is better able to focus, etc.

Many unknowns

ADHD has been perhaps the most studied of all childhood psychiatric conditions, and Ritalin is the most studied childhood psychotropic medication. However there is still much that is not known about ADHD and Ritalin.

There are no firm figures on how many children are taking the drug. In the 1980s it was estimated that between 200,000 and 500,000 children were receiving stimulants. In 1987 750,000 children were believed to be on the medication. Both of these figures were the result of extrapolation from regional studies. A study done by the University of California, Irvine, Child Development Center estimated that in 1993 3 million children were diagnosed with ADHD. Ninety percent of these children were on medication; 1.3 million receiving Ritalin. Researchers believe that the number of children on Ritalin has grown to 3.5 million with another 1.4 million taking other medications, most likely Dexedrine.

Production and use of Ritalin is expected to double by the year 2000, which would bring the number of children taking the medication to 7 million. Some estimate that ADHD affects 10 percent of all children. If this is so, it would mean that within a few years fully 10 million children could be on the drug.

No other nation comes close to the US in the production and use of Ritalin. Ninety percent of all Ritalin is produced and used in the United States. Only Australia is close to the US in per capita use. Canada has seen a comparable rise, although it is still at about one-fourth of per capita use as compared to the United States. Britain has had a policy of intervening with social support for children with ADHD and using Ritalin only as a last resort, although these measures are being attacked because of budget cuts. Sweden prohibits use of the drug.

There is a wide disparity in the prescription and use of Ritalin in the US. Virginia has the highest per capita use of the drug. It is six times higher than the state with the lowest usage, Hawaii. Within some states there is a 20-fold difference among communities. In Michigan 5 percent of pediatricians were prescribing 50 percent of the Ritalin. In

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Delaware, 9 of 135 providers (7 percent) wrote 26 percent of Ritalin prescriptions. These disparities imply that there are developing Ritalin mills, medical practices that become known for quickly diagnosing ADHD and prescribing Ritalin. Doctors and parents have reported that some school districts regularly inform parents that their child is possibly afflicted with ADHD and tell them which doctor to see.

Ritalin produces quick and noticeable changes in the child in reducing many of the symptoms associated with ADHD. In the short term it does, while in the blood stream, improve concentration. It will improve a child's test scores and make a child less combative and decrease aggression. However it cannot resolve more complex problems such as low reading comprehension, nor can it help children with learning disabilities, such as dyslexia.

Little is known about whether the temporary improvements continue once the child is removed from treatment. According to Dr. Diller Lawrence in his book *Running on Ritalin*, studies conducted in the 1960s show that drug treatment, isolated from behavioral modification and talk therapy, produces no long-term benefits for the child. In these studies researchers found that children treated only with Ritalin were just as likely as the ADHD population as a whole to suffer problems of unfinished education, drug addiction and problems with the law.

Despite the lack of scientific support, many experts in the field, such as Russell Barkley of the University of Massachusetts Medical School, now recommend prescribing Ritalin without any other form of treatment.

The majority of research into ADHD has centered on finding a biological cause for it. This emphasis has helped legitimize the use of medication. Likewise the general conception of describing the disorder as behavioral tends to place the blame upon the child's parents, caregivers or teachers.

In reality the relationship is much more complex. Biological and genetic factors, as well as behavioral training, undoubtedly have an impact. However, if the social conditions under which a child grows, including the stress on children caused by changes within society, are ignored then no real insight into the problem, nor its correct treatment, can be discovered.

Social issues behind the use of Ritalin

Since 1960 the number of children in families where both parents are working has gone up from 30 percent to 70 percent. Sixty percent of preschool children are now in some form of daycare. The number of children growing up in single parent households, mostly headed by women, has also gone up dramatically. The vast majority of these parents have to work. Parents from varied economic backgrounds--from poor single parents forced to enter the work force because of changes in welfare laws, to white collar and professional workers putting in a 50- or 60-hour workweek--have less and less time to spend with their children.

Moreover, because of the added pressure for academic achievement children are being forced to compete in school at younger and younger ages. There is very little time for evaluation and patient work to overcome learning problems. It is not uncommon now to find three and four year olds being brought in for ADHD evaluation and being prescribed Ritalin.

The educational crisis has exacerbated the problem. Schools are under greater pressure to have students diagnosed with ADHD and placed on Ritalin. Budget cuts have led to a dramatic increase class sizes. Classes of 30, 35 children and more preclude one-on-one treatment of behavioral problems and lead administrators and teachers to seek quick solutions. Furthermore, cuts in special education programs have reduced the amount of resources available for classroom aides, specialists, counselors and teachers to help troubled students. The full inclusion of special education students in regular classes has placed even greater responsibility on already over-taxed teachers.

There are many alternative treatments for ADHD that prove effective. Many educators, psychologists and psychiatrists point to how behavior management and changing the child's structure and environment can alleviate symptoms of ADHD. But such approaches and changes cost far more than the cost of a Ritalin prescription, and schools already dealing with massive budget cuts do not have the resources to develop additional programs.

Obvious measures to alleviate some of the factors that may lead to ADHD--such as better daycare provision, smaller classrooms, individual consistent attention and discussions with counselors and social workers--are precluded in an atmosphere of constant budget-cutting and belt-tightening.

Under these conditions many children who have symptoms similar to ADHD have been misdiagnosed and given Ritalin. One study found that when children diagnosed with ADHD were reevaluated with a standard test more than 25 percent were learning disabled and not ADHD.

In addition, the market-driven restructuring of the health care industry has also contributed to the increase in Ritalin usage. It is much cheaper for Health Maintenance Organizations (HMOs) to treat ADHD with drugs rather than psychiatric analysis and other behavioral therapies. A typical month-long prescription of Ritalin is $30 to $60. A typical psychiatric analysis is $1,500, or at least twice as much as the cost of Ritalin for a year. Most managed care plans limit psychiatric treatment or behavioral therapies to a time much too short to have any effect on ADHD.

In addition, HMO's, managed care and health insurance companies all pressure doctors to spend less time with patients. Few doctors have the time for the type of evaluation required to diagnose a child with ADHD: observing the child, discussing with the parents, teachers and other caregivers. Routine appointments in a clinic are placed 15 minutes apart and most doctors do not even spend that much time with the patient. Furthermore, the changes in diagnostic standards have meant that physicians are no longer required to witness symptoms, but can rely on reports from untrained school authorities and parents.

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