Are we overprescribing for ADHD?

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A recent report by the Care Quality Commission (CQC) drew attention to the 50 per cent increase in prescription of methylphenidate for ADHD over the preceding six years. The upward prescribing trend has also been noted in Scotland. The report did not suggest the findings represented any change in prescribing and attributed the rise to the ongoing increase in diagnosis of ADHD.

Media coverage in the wake of the CQC report focussed both on broad worries such as that the UK might be moving towards rates of diagnosis in the USA (The New York Times reported recently that up to 20 per cent of school-age boys were said to be on medication for ADHD) and more specific concerns, for example that stimulants have potential risks and do not reduce the long-term problems associated with ADHD.

There has been a steady increase in recognition and diagnosis of ADHD in children and adolescents over the past 20 years and a more recent recognition of adult ADHD. Despite this, rates of diagnosis in the UK remain low compared with what might be expected; the worldwide prevalence rate is estimated to be 5 per cent of school-age children, with 1.5 per cent having the most severe form of ADHD, hyperkinetic disorder. Rates of diagnosis are around 1.5 per cent in England and less than 1 per cent in Scotland. These figures do not support a view that ADHD is being overdiagnosed in the UK.

UK guidelines

Current UK guidelines recommend a multimodal approach to the management of ADHD, incorporating psychological interventions, educational strategies and medication. Stimulant medication such as methylphenidate is recommended for school-age children with more severe ADHD or moderate ADHD with co-morbid anxiety or oppositional defiant disorder. Parental behaviour management strategies are recommended as first line for children with less marked difficulty, with medication being added if symptoms do not respond sufficiently to psychological treatment alone.

A NICE technology appraisal of the most commonly used medications in ADHD (including methylphenidate) concluded that they were effective in controlling the symptoms of ADHD compared to no medication. A review of new evidence by NICE in 2013 did not lead to any change in the 2008 ADHD guideline recommendations but did highlight areas of ‘new evidence uncertainty’ including long-term effects of both pharmacological and nonpharmacological treatment.

Benefit of treatment

Anecdotally, parents have some awareness of the longer-term problems of medication and are willing to trade the potential risk of, for example, reduced growth for what they perceive as benefits to their child’s academic and social functioning.

Children and adolescents with ADHD are at increased risk of low self-esteem, academic underachievement, poor peer relationships, disrupted family relationships, accidents, antisocial behaviour, later substance misuse, depression and anxiety. Around 60–70 per cent will have partial continuation of symptoms into adulthood.

A recent review and analysis of research into long-term outcomes of ADHD reported that although treatment (of any kind) did not generally result in normal function, areas such as self-esteem, social function, academic outcome and drug misuse did show some benefit of treatment. The eight-year follow-up of the Multimodal Treatment of ADHD (MTA) study also found that those with ADHD fared worse than normal controls but that children with behavioural and sociodemographic advantage, with the best response to treatment, had the best long-term prognosis. So, although treatment may offer some protection against secondary impairments, those with the most severe disorder at the outset are the most vulnerable to poor outcomes in later years.

Conclusion

Stimulant medication such as methylphenidate is broadly effective in treating symptoms and reducing impairment in ADHD and therefore continues to be a mainstay of treatment, but there is little evidence currently to help the clinician weigh up the risks vs benefits for the individual in the longer term. The issue is therefore less about stemming the rising tide of methylphenidate prescription but more about encouraging the research that will help to answer these questions.

References

5. NICE. Methylphenidate, atomoxetine and dexamfetamine for attention deficit hyperactivity disorder (ADHD) in children and adolescents. TA98. March 2006.

Declaration of interests

None to declare.

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