

Addressing the Latest Headlines About Treatment

Bryan Goodman, MA, with Brooke Molina, MD

THE MULTIMODAL TREATMENT STUDY ON AD/HD, OR MTA, has helped to shape the mental health community's view of how AD/HD should be treated. The federally funded study was released in the late 1990s, and since then, researchers have charted the success of its participants. Recently, information was released on the progress of these children six to eight years after the study began. We asked Brooke Molina, PhD, one of the MTA investigators, about her impressions from the latest findings. A member of CHADD's professional advisory board, Molina is associate professor of psychiatry and psychology at the University of Pittsburgh and director of the Youth and Family Research Program.



Brooke Molina, MD

What do the latest findings from the study tell us about the use of behavioral interventions and medication in treating AD/HD?

There are several take-home points from this complicated study. Perhaps the first, most easily digested piece of information for parents is that the teens in the MTA were still doing better on average than when they joined the study eight years ago as children. That is important because it suggests overall that benefits the children received from being treated appear to continue. On the other hand, they were on average not functioning quite as well as classmates who did not have AD/HD. The second major take-home point is that treatment decisions should probably be made after parents and their treating professional consider which type of treatment (behavior therapy or medication or both) they are most likely to use correctly and consistently.

This recommendation follows from our finding that although all children were doing better than when they joined the study, there were no differences by high school between children who received behavior therapy versus children who received medication either delivered by the study or by doctors in the community. We even found that children who stayed medicated by their community doctors up to eight years after joining the study were not functioning any better than children no longer medicated. This is a difficult finding to understand, because we were no longer controlling

the type or quality of treatment received. Families were selecting treatment themselves. Thus, there could be many reasons for this particular result.

There is one important practical implication, however: Parents and treating professionals should not assume that medication will continue to be effective or needed long-term for everyone, even if it was effective and needed in the beginning. The treatment needs to be individually, carefully, and



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regularly monitored to decide whether or not it is continuing to help. Another important practical implication is that parents and treating professionals may want to consider creative ways of implementing behavioral strategies that help to improve behavior and school performance as children age. There are not a lot of good studies yet on how best to treat adolescent AD/HD behaviorally, but that field is slowly growing.

The treatment became less intense for many people as the study ended and they returned to treatment in their communities. How can we ensure that people being treated in their communities have access to the best treatment available?

This is more a political and economic issue than scientific. Availability of good, evidence-based treatments varies from one geographic location to another. However, the professional organizations to which treating professionals belong have developed practice guidelines to help doctors provide the most effective treatments. Parents can help by asking their doctors about the methods they use to help children with AD/HD and whether they are using evidence-based methods and guidelines.

Let's say you're sitting next to a mother on an airplane who asks you about the implications of the findings for her child with AD/HD. What advice would you give this mother?

My advice would not just be based on the

findings in that one article, but more broadly based on all the literature and clinical common sense. The advice would include that she do as much as she can to learn effective parenting strategies that children with AD/HD need more than the average child,



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such as behavior charts for daily behavior and homework goals, and very consistent rules. This does not imply that she has been a bad parent, just that her child requires something beyond the ordinary parenting that would be adequate for most children. She should talk with the school to find out if there is a behavior specialist who can work with her. If she wants to consider medication because these strategies aren't enough, she should talk with her child's pediatrician or consult a child psychiatrist about whether the AD/HD is problematic enough to warrant medication and then proceed with careful monitoring and follow-up. She should ensure good nutrition with the doctor's advice because most of the AD/HD medications reduce appetite. Finally, she might find a support group to help her engage with other parents who have children with similar difficulties.

We're constantly bombarded by mixed messages in the media about medication treatment. How can parents sift through misinformation and be proactive in finding accurate information that will help them as they make important healthcare decisions?

This is a problem that we have for all kinds of health conditions and their treatment, and it is understandably frustrating. In the case of AD/HD, the problem is aggravated by the fact that medication treatment for children and for AD/HD is controversial. Consequently, people will interpret findings differently depending on what they feel is most important for children's well-being. For example, we found two years ago that the children newly treated with AD/HD medications did not grow as fast as the children not being treated with medications for AD/HD. Over the course of two years, they grew 2 cm (about $\frac{3}{4}$ inch) less than the children not treated. Well, how do you interpret that next to the finding that AD/HD medications effectively treated AD/HD symptoms during that same time? It depends upon how much importance you place on height relative to the behavioral, social, and academic performance benefit that your child might have. People vary in this, perhaps depending partly on whether the child is large or small for age. Parents can be most proactive by reading as much as they can about AD/HD and the most recent research findings. The discussion section (the last part) of the primary professional journal article about the study should be understandable to the average college graduate; it is usually far better balanced (having undergone peer review) than popular-media secondhand reports, which tend to focus on one side. Parents should also ask their treating professionals questions. They should

expect their treating professionals to provide balanced answers that give them the information they need to make an informed choice.

How can we improve on medication treatment and behavioral interventions?

The results of the study suggest that medication treatment should really be carefully monitored individually long-term, rather than being assumed to work forever. We just don't have evidence that it works for longer than two years, although many treating professionals have plenty of experiences with individuals who appear to benefit for years. Another implication is that dosage may be kept low for some children if behavioral strategies are used effectively. We've known that from earlier studies but this result was also found in the MTA. However, we also know that some families have a hard time implementing behavioral strategies for various reasons, such as when parents divorce and consistency becomes difficult when parents are not working together, or when school professionals have large classrooms of children and little time to do anything extra.

We can certainly improve by providing more behavioral expertise in the schools. There are a lot of opportunities there to boost creative problem solving by providing schools with more or better-trained staff who can train and consult with parents and teachers to work more effectively with children with AD/HD. Many of these skills could also be used for students who have behavior problems but not necessarily AD/HD, so the money would be well spent and would improve academic performance.

Would you like to add anything else?

Perhaps the most compelling finding from this study was the result that the teens in the MTA were, on average, still having quite a few difficulties in many different areas of life. Although this statement is just based on the averages, and there are no doubt children in the group who are doing just fine, we really need to appreciate the fact that AD/HD doesn't go away for many children. We have not yet fully come to grips with this problem and figured out how best to help these youth in high school and beyond. We hope to learn more from the teens who are doing well to figure out why their outcomes are good, but this research has yet to develop and to inform our interventions. At present, we know that many teens stop taking medication, and we have few studies that show us how to work behaviorally with teenage AD/HD. Thus, we need to shift some of our attention to this subgroup of youth to figure out how best to help them achieve their potential. ●