

ALASKA LEGISLATURE COMMITTEE FILES 2001-2002 0072

10554 SENATE HEALTH EDUCATION & SOCIAL SERVICES

7. Carey WB. NIH Consensus Conference on ADHD (transcript).
November 16-18, 1998. Bethesda, MD.

Home

E-Mail

Vol. 15, No. 37 -- October 4-11, 1999

Published Date September 10, 1999, in Washington, D.C. www.insightmag.com

Copyright © 1999 News World Communications, Inc.

Q: Should schools use behavioral screening to find 'at risk' children?

Yes: Kids with serious emotional problems need to be identified early on and helped.

By James M. Kauffman
[\(click here to go to Bev's rebuttable\)](#)

"Behavioral screening" means selecting students who are at highest risk for behaving in a socially unacceptable manner. Such behavior degrades schools and short-circuits students' future.

Unlike psychological testing, behavioral screening does not delve into the student's mental life or psychological processes. It is merely a process of identifying students who are most likely to cause trouble to others and themselves. Public schools should use behavioral screening, but only if they follow it with actions shown to reduce the likelihood of problem behavior. By "problem behavior" I mean behavior that is very likely to be judged unacceptable or maladaptive -- fighting, intimidating others, mean-spirited teasing, disobedience to adults, disrespectful conduct, extreme social withdrawal and other ways of demonstrating a lack of social awareness or congeniality.

Some public schools have become places where obstreperous, mean, disrespectful, intimidating behavior is treated as "okay" and "normal." Properly implemented behavioral screening identifies students whose behavior is unacceptable, even if they are just starting to exhibit such bad conduct. And, if it is followed by best behavior-management practices,

behavioral screening allows teachers to nip these problems in the bud -- to prevent them from escalating into something worse.

Most teachers know which students probably are headed for trouble. However, most problem students aren't formally identified until they are about 15 years old and their problems are longstanding and severe -- way too late for prevention. Teachers do better in identifying high-risk youngsters of any age when they have a systematic way of describing kids' behavior and know just what to look for. The most accurate and reliable behavioral screening methods rely on teacher judgments guided by rating and observation instruments that have been field-tested. The best such instruments are the SSBD (Systematic Screening for Behavior Disorders) and the ESP (Early Screening Project), created and field-tested by educational researcher Hill M. Walker and his associates at the University of Oregon. Some school districts have purchased these instruments or adopted behavioral-screening policies. However, I do not know -- and I doubt anyone does -- which districts or states have attempted to implement behavioral screening and related preventive practices as field-tested and recommended by Walker and his colleagues or other prominent scientists.

Here's the essential question you have to ask when you weigh the pros and cons of behavioral screening: Would I rather let problems become intolerable before doing something about them or, alternatively, identify problems when they're not so bad and prevent them from getting worse? The simple fact is that you can't prevent something after it happens. Either you prevent it or you let it happen and then bemoan it.

The only reason to use behavioral screening in schools is prevention. School personnel and the general public increasingly call for the prevention of school shootings and other outrageous acts of violence. Preventing such incidents would save a lot of money, not to mention lives and misery. But ignorance and politics stand in the way. So we wait for catastrophe, then ask why it happened. Here are some arguments people trot out to defeat prevention, even while saying they want it. I discuss these in detail in "How We Prevent the Prevention of Emotional and Behavioral Disorders" in the journal *Exceptional Children* (Summer 1999).

We don't want to label and stigmatize kids. You can't prevent what you can't talk about, and you can't talk about something without a label for it. Furthermore, there is no credible evidence that labels and stigma are the problem. Kids behave badly, then get labeled -- not the other way around. And those who feel no guilt, those who experience no stigma attached to unacceptable behavior, are more likely headed for bigger trouble than those who do.

We don't want to "medicalize" or "psychologize" the problem. We haven't. We have made it a legal problem. False accusation, privacy, due process and other legal matters are the objections people tend to raise.

False positives are unacceptable. Every screening device produces some errors: false positives and false negatives. A false positive means the screening identifies someone it shouldn't have; a false negative means someone who should have been identified was overlooked. Which kind of error is more dangerous? It depends on the consequences. False positives -- for example, false convictions -- are what judges and juries try hardest to avoid. False negatives, which involve overlooking illnesses, are the dangers

CORRECTION

THE FOLLOWING DOCUMENT(S)
HAVE BEEN REFILMED TO
ASSURE LEGIBILITY OR PAGINATION



Central Microfilm Services
Department of Education & Early Development
State of Alaska

behavioral screening allows teachers to nip these problems in the bud -- to prevent them from escalating into something worse.

Most teachers know which students probably are headed for trouble. However, most problem students aren't formally identified until they are about 15 years old and their problems are longstanding and severe -- way too late for prevention. Teachers do better in identifying high-risk youngsters of any age when they have a systematic way of describing kids' behavior and know just what to look for. The most accurate and reliable behavioral screening methods rely on teacher judgments guided by rating and observation instruments that have been field-tested. The best such instruments are the SSBD (Systematic Screening for Behavior Disorders) and the ESP (Early Screening Project), created and field-tested by educational researcher Hill M. Walker and his associates at the University of Oregon. Some school districts have purchased these instruments or adopted behavioral-screening policies. However, I do not know -- and I doubt anyone does -- which districts or states have attempted to implement behavioral screening and related preventive practices as field-tested and recommended by Walker and his colleagues or other prominent scientists.

Here's the essential question you have to ask when you weigh the pros and cons of behavioral screening: Would I rather let problems become intolerable before doing something about them or, alternatively, identify problems when they're not so bad and prevent them from getting worse? The simple fact is that you can't prevent something after it happens. Either you prevent it or you let it happen and then bemoan it.

The only reason to use behavioral screening in schools is prevention. School personnel and the general public increasingly call for the prevention of school shootings and other outrageous acts of violence. Preventing such incidents would save a lot of money, not to mention lives and misery. But ignorance and politics stand in the way. So we wait for catastrophe, then ask why it happened. Here are some arguments people trot out to defeat prevention, even while saying they want it. I discuss these in detail in "How We Prevent the Prevention of Emotional and Behavioral Disorders" in the journal *Exceptional Children* (Summer 1999).

We don't want to label and stigmatize kids. You can't prevent what you can't talk about, and you can't talk about something without a label for it. Furthermore, there is no credible evidence that labels and stigma are the problem. Kids behave badly, then get labeled -- not the other way around. And those who feel no guilt, those who experience no stigma attached to unacceptable behavior, are more likely headed for bigger trouble than those who do.

We don't want to "medicalize" or "psychologize" the problem. We haven't. We have made it a legal problem. False accusation, privacy, due process and other legal matters are the objections people tend to raise.

False positives are unacceptable. Every screening device produces some errors: false positives and false negatives. A false positive means the screening identifies someone it shouldn't have; a false negative means someone who should have been identified was overlooked. Which kind of error is more dangerous? It depends on the consequences. False positives -- for example, false convictions -- are what judges and juries try hardest to avoid. False negatives, which involve overlooking illnesses, are the dangers

doctors worry about most. Legally, we worry most about personal rights; medically, we worry most about health and safety. Educators, like physicians, should choose to be safe rather than sorry. In *Consilience: The Unity of Knowledge*, Edward O. Wilson puts it this way: "In ecology, as in medicine, a false positive diagnosis is an inconvenience, but a false negative diagnosis can be catastrophic. That is why ecologists and doctors don't like to gamble at all, and if they must, it is always on the side of caution. It is a mistake to dismiss a worried ecologist or a worried doctor as an alarmist." It is also a mistake to dismiss a worried teacher as an alarmist. Too often, educators' worries are dismissed until the problem is severe. Then, of course, it is too late for prevention, and the action demanded by the public and the law is suspension, expulsion or imprisonment.

Special education and related interventions don't work. Screening may result in special education or related services, such as counseling. Special education can and often does work well in preventing the catastrophic consequences of academic failure and unchecked misbehavior. Of course anything can be poorly implemented, producing bad results. But when special education and related programs are conducted well, identifying the students who need them and providing the services do more good than harm. False positives aren't as dangerous as false negatives.

We don't want to place any student in a restrictive environment. Every place is restrictive of some things and not of others. Schools should restrict bad behavior in an effective and humane way. Students should be placed in classes and schools where their unacceptable behavior and academic failure are restricted and their desirable conduct and academic learning effectively are encouraged.

We don't want to identify more students for special services; we already serve too many. If you want to prevent problems, then you have to identify more kids -- address problems earlier, which inevitably means identifying more students than we do now, when we wait for the problems to get out of hand.

Special education and related services cost too much. You have to spend more now on screening and prevention to save money in the long run. Prevention isn't free any way you cut it, but it's cheaper than the alternative. Most Americans, including elected representatives, don't take the long view. They'd rather have low taxes now or even tax cuts and ostensible legal protections than spend money on prevention that would save dollars down the road and make schools safer. Whose fault? We elect our representatives.

Don't worry, this kid will grow out of it. Such "developmental optimism" isn't often warranted in the case of aggressive, disruptive, disobedient, intimidating, can't-pay-attention behavior. All the evidence indicates this kind of behavior is poison for a child's future -- likely to get worse without appropriate management.

Too many minority kids get identified. Too few kids of every ethnic group are identified. The evidence is overwhelming that any observed disproportion in identification is not a result of overidentification of minority students but underidentification of others.

Diversity is to be welcomed, and deviance is in the eye of the beholder. Difference is not necessarily deviance. But some kinds of diversity are not okay, especially the disruption, aggression, academic failure, inattention,

disobedience and disrespect that are the primary targets of behavioral screening. Deviance is behavior that leads to unacceptable later outcomes, and we can define it away or deal with it as a reality.

But, let's suppose that a school, district or state decides to do behavioral screening, using a field-tested instrument such as the SSBD or ESP to guide the selection of kids at risk for worsening problems. Let's suppose they stay faithfully with the user's manual so that false positives and false negatives are minimized and the vast majority of the students identified by the screening really are headed for bigger trouble if we don't do something now. What should we do?

The popular view is that punishment is the key. Hammer them early with humiliation if not corporal punishment. Wrong. This is not smart for the long term. The real key is a highly structured program, instruction that lets kids know what's okay and what is not, that provides consistent positive and negative consequences for behavior. But, like anything else, if it's done poorly, it'll turn out badly.

If you want behavioral screening and prevention to work, then you have to follow screening with two ideas and implement them well. First, you need a good schoolwide discipline plan, one in which behavioral expectations are clear and consistent for all students. All teachers must carefully monitor students' behavior and follow through consistently and calmly with consequences for what they see. The emphasis must be on praise and recognition for desired behavior, not on punishment for transgression (although nonphysical, consistent, reasonable punishment for misbehavior is important). Second, you need good alternatives for the 5 or 6 percent who still misbehave. The plan must involve teaching appropriate conduct, much as one teaches anything else -- through direct instruction, guided practice, feedback and praise for making progress. Sometimes, but not always, this can be administered in the context of a regular school and classroom. Sometimes, such instruction needs to be done in a special class or school where the teaching can be more intensive and sustained.

Behavioral screening? Absolutely -- but only if we do it right and practice prevention. We can't prevent all problems, but we can improve the odds a lot.

No: Don't give educational experts another tool to 'psychologize' the school curriculum.

By B.K. Eakman

Now that much of America is resigned to high-schoolers blowing away their classmates, kindergartners kicking and biting their teachers and 8-year-olds playing sex instead of jump rope, the mental-health industry believes it finally has our attention. Psychologists are calling loudly for

mandatory, universal behavioral screening. Give them a license to inspect every 5-year-old, and they claim they can identify those at risk of becoming mentally unstable, antisocial and even violent. And if they can just intervene soon enough, without parental interference, they say they can turn these youngsters around.

Education experts Hill Walker and Herbert Severson of the Institute on Violence and Destructive Behavior at the University of Oregon's College of Education are but two among a large cottage industry of child experts pitching universal screening instruments to local school districts and state and federal agencies. The concept goes like this: Teachers are taught to match the classroom and playground conduct of pupils against a list of behavioral patterns. Certain markers (or "red flags") signal a child's need for professional help. These youngsters are referred to a school psychologist, counselor or other behavioral specialist, who determines what triggers troubled children's outbursts and teaches alternative ("adaptive") behaviors. Parents are enlisted to reinforce these alternatives while experts continue to monitor (track) each child's progress through observation and additional psychological testing.

The technical difference between "screening" and "psychological testing" is that the former concentrates on behavior patterns and the latter focuses on personality traits. In other words, a person can demonstrate abnormal behavior and still possess a "normal" personality. People often do extraordinary things, for example, in high-stress situations, but this isn't necessarily indicative of a subject's underlying personality traits.

If you find that distinction difficult to follow, imagine the dilemma of an average teacher faced with referring students for psychological counseling based on a list of red-flag signals for abnormality. An inexperienced teacher may check off the red-flag term "loner" for a child who is merely "reserved." If the youth is referred for counseling, the ensuing psychological tests and counseling may reveal that his parents practice modesty and private, as opposed to public, displays of emotion. Psychology tends to interpret this as "withholding affection," "rigidity," "intolerance," even "inhibition," in which case the counselor may teach the child adaptive behaviors designed to promulgate perverse ideas about tolerance. Moreover, psychological referral will have long-term ramifications for the child.

In a 1996 case, Allegheny County Parents Coalition vs. Western Psychiatric Institute and Clinic, a clinical screening instrument was developed under the auspices of the National Institute of Mental Health, apparently recast for school consumption under the name School-Wide Intervention Model, or SWIM. The program utilized, among other things, a diagnostic tool called the Disruptive Behaviors Disorders, or DBD, Rating Scale. The DBD was given to teachers to rate their students -- without the informed consent of parents. SWIM's ostensible purpose was to locate children with Attention-Deficit and/or Hyperactivity Disorder, or ADD/ADHD. The shocker came when parents in Pittsburgh's Gateway School District learned that ADD and ADHD were being used as markers (red flags) for schizophrenia -- and that, furthermore, responses would not be shared with parents but, rather, would go into a computer database. Despite legal intervention, parents still haven't seen their own youngsters' answers and, worse, parents cannot verify that school officials have erased the data as

promised.

The fact is, children have been exposed to screening mechanisms for years, surreptitiously and overtly. Inevitably, the line between personality testing and behavioral screening becomes blurred. Even standardized tests, which supposedly measure only academic knowledge, are rife with psycho-behavioral fishing expeditions. These run the gamut of self-reports, open-ended "prompts" and what-would-you-do-if queries. The testers assert that the primary goal is to screen for "maladjustment." The fact is that this involves probing the child's belief system as well as the attitudes of family members. Take, for example, Pennsylvania's infamous (and now renamed) Educational Quality Assessment, or EQA, in the 1980s. Sixty-one percent of the questions were similar to this: "There is a secret club at school called the Midnight Artists. They go out late at night and paint funny sayings and pictures on buildings. I would JOIN THE CLUB when I knew ... [a] my best friend had asked me to join; [b] Most of the popular students in school were in the club; [c] my parents would ground me if they found out I joined. The question above is typical of the "fishing probe: It is assumed that the child will join the club under some circumstance, including the desire to provoke parents.

The interpretive literature to such assessments contain the details laypeople don't see. The EQA's creators were looking for: "the child's locus of control," "willingness to receive stimuli," "amenability to change" and propensity for "conform[ing] to group goals." In English this means: Where is the child coming from? Is he easily influenced and gullible? Are his views firm or easy to change? Will he submit to group-think and go along to get along?

At the time of the uproar over EQA, both the test's developers and the government agencies that paid for its dissemination lied about its nature and purpose. It took alert parents four years and the intervention of congressional representatives to get an admission that the test's chief purpose was psychological screening.

Obviously, universal mandatory tests would eliminate the necessity for such obfuscation. With the recent spate of school shootings, today's dominating behavioral-psychology wing of the education establishment feels confident it can convince legislators to do away with pesky parental-consent forms and mandate its larger agenda: mass psychological testing, treatment and tracking.

Which brings us to the things behavioral experts aren't mentioning: the extent to which intimate and personal data already are collected and shared via computer; the technological inability to prove when or if computerized data are purged (destroyed); the long-term nature of psychological tracking; the planned level of family intervention; the poor track record of existing assessments and therapies; and the ulterior purposes to which collected personal data can be applied, such as modifying politically incorrect beliefs and worldviews. In other words, "psychologized education" can serve as a stealth version of politically correct propaganda.

Five-year-olds are easy to entrap. The way they respond to any given question (the so-called "prompt" will depend a lot on what happened that morning. If Johnny got into trouble for missing the school bus, he may insist his parents hate him. If he got a birthday cake, his parents love him.

Youngsters also misinterpret events. Yet, psychologists use such questionable data to make predictions about how students will react to future "stimuli".

The at-risk label, accurate or not, triggers intervention by psychologists and social-service agencies. When a child is referred for counseling, that fact becomes part of his permanent record. This is not a paper document in a manila folder, but an electronic portfolio.

The rapidly accelerating capability of computers coupled with the demand by government for state-federal compatibility ("cross-referenceability") means this information is slowly making its way into the child's future financial, employment and medical records. Loopholes in privacy laws make it difficult to stop a child's file from eventually landing on the desktops of executives, security officers or anybody with an ax to grind.

Counseling also triggers what is called an IEP (individual education plan), implying a "tailored" (or individualized) curriculum. Few parents realize that by giving schools permission to run an IEP for their child, they are giving officials permission to supersede the parent in a range of educational decisions. An educational Website, teachersfirst.com, describes the IEP as a working document that goes with the student from year to year and beyond, as he leaves high school and goes on to postsecondary training or the work environment. In other words, IEP involves tracking.

So, what do we do about wacko kids and prisonlike schools? First of all, we should reject 35 years of bad parenting advice. Psychologized education and parenting have resulted in adults transferring guidance and leadership to the child's peer group under the assumption that the children are being "socialized." Every parent used to know it wasn't in the best interests of young children to spend too much time with each other. The emphasis on socialization and group think has turned the old school cliques into Lord-of-the-Flies subcultures that indulge in brutal territorial exercises.

Second, reinstate concepts about right and wrong and shame and guilt. They are not the emotional cripples mainstream psychologists claim. Dissenting experts point out that guilt, for example, is a civilizing influence, implying personal responsibility. Guilt is harmful only if one takes responsibility for that which one can't control. But psychologists have convinced parents and policymakers that all behavior is outside one's control.

This is why psychotropic drugs are increasingly prescribed for bored, daydreaming and ants-in-the-pants conduct. But sleep centers around the country are discovering a horrifying side-effect: Kids on antidepressants frequently don't enter deep, Stage 4 sleep. Severe sleep deprivation results in heightened irritability, impaired judgment and uncontrollable rage.

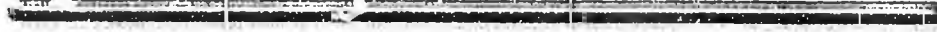
Given the pervasiveness of psychology in policymaking, parenting and teacher training, it is imperative that dissenting organizations and individuals of means launch massive numbers of private schools, franchise them, flood the nation with them, and refuse to accept one dime of federal or state money. The approach to education -- open or structured -- doesn't matter. Parents and market forces will decide which work and which don't.

Finally, fed-up teachers must redirect the focus of their unions. Instead of lobbying for gay rights, they should push for expulsion of students who

continually disrupt their classes, for training in diagnosing real learning problems and for backup by administrators.

The time for Band-Aid remedies is over. Education needs a transfusion.

•



[Home](#)

[E-Mail](#)

Senate Bill 230

Psychotropic Drugs For Children

Articles For Use of Psychotropic Drugs

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

PSYCHIATRIC MEDICATION FOR CHILDREN AND ADOLESCENTS PART I: HOW MEDICATIONS ARE USED

No. 21

(11/99)

Medication can be an effective part of the treatment for several psychiatric disorders of childhood and adolescence. A doctor's recommendation to use medication often raises many concerns and questions in both the parents and the youngster. The physician who recommends medication should be experienced in treating psychiatric illnesses in children and adolescents. He or she should fully explain the reasons for medication use, what benefits the medication should provide, as well as unwanted side-effects or dangers and other treatment alternatives.

Psychiatric medication should not be used alone. As undertaking a medication trial may mean adjusting doses of medicine over time and/or the use of additional medications to meet an individual youngster's needs, the use of medication should be part of a comprehensive treatment plan, usually including psychotherapy, as well as parent guidance sessions.

Before recommending any medication, the child and adolescent psychiatrist interviews the youngster and makes a thorough diagnostic evaluation. In some cases, the evaluation may include a physical exam, psychological testing, laboratory tests, other medical tests such as an electrocardiogram (EKG) or electroencephalogram (EEG), and consultation with other medical specialists.

Child and adolescent psychiatrists stress that medications which have beneficial effects also have unwanted side effects, ranging from just annoying to very serious. As each youngster is different and may have individual reactions to medication, close contact with the treating physician is recommended. Do not stop or change a medication without speaking to the doctor. Psychiatric medication should be used as part of a comprehensive plan of treatment, with ongoing *medical assessment* and, in most cases, *individual and/or family psychotherapy*. **When prescribed appropriately by a psychiatrist (preferably a child and adolescent psychiatrist), and taken as prescribed, medication may reduce or eliminate troubling symptoms and improve the daily functioning of children and adolescents with psychiatric disorders.**

Medication may be prescribed for psychiatric symptoms and disorders, including, but not limited to:

1. **Bedwetting**-if it persists regularly after age 5 and causes serious problems in low self-esteem and social interaction.
2. **Anxiety** (school refusal, phobias, separation or social fears, generalized anxiety, or posttraumatic stress disorders)-if it keeps the youngster from normal daily activities.

3. **Attention deficit hyperactivity disorder**-marked by a short attention span, trouble concentrating and restlessness. The child is easily upset and frustrated, often has problems getting along with family and friends, and usually has trouble in school.
4. **Obsessive-compulsive disorder**-recurring obsessions (troublesome and intrusive thoughts) and/or compulsions (repetitive behaviors or rituals such as handwashing, counting, checking to see if doors are locked) which are often seen as senseless but which interfere with a youngster's daily functioning.
5. **Depressive disorder**-lasting feelings of sadness, helplessness, hopelessness, unworthiness and guilt, inability to feel pleasure, a decline in school work and changes in sleeping and eating habits.
6. **Eating disorder**-either self-starvation (anorexia nervosa) or binge eating and vomiting (bulimia), or a combination of the two.
7. **Bipolar (manic-depressive) disorder**-periods of depression alternating with manic periods, which may include irritability, "high" or happy mood, excessive energy, behavior problems, staying up late at night, and grand plans.
8. **Psychosis**-symptoms include irrational beliefs, paranoia, hallucinations (seeing things or hearing sounds that don't exist) social withdrawal, clinging, strange behavior, extreme stubbornness, persistent rituals, and deterioration of personal habits. May be seen in developmental disorders, severe depression, schizoaffective disorder, schizophrenia, and some forms of substance abuse.
9. **Autism**-(or other pervasive developmental disorder such as Asperger's Syndrome)-characterized by severe deficits in social interactions, language, and/or thinking or ability to learn, and usually diagnosed in early childhood.
10. **Severe aggression**-which may include assaultiveness, excessive property damage, or prolonged self-abuse, such as head-banging or cutting.
11. **Sleep problems**-symptoms can include insomnia, night terrors, sleep walking, fear of separation, anxiety.

For additional information about psychiatric medications see Facts for Families:

#29 Psychiatric Medication for Children and Adolescents: Part II-Types of Medications, and

#51 Psychiatric Medications for Children and Adolescents: Part III-Questions to Ask.

For additional information see Facts for Families:

#00 Definition of a Child and Adolescent Psychiatrist,

#25 Know Where to Seek Help for Your Child, and

#52 Comprehensive Psychiatric Evaluation.

See also: *Your Child* (1998 Harper Collins)/*Your Adolescent* (1999 Harper Collins).

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 6,900 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

Facts for Families® is developed and distributed by the American Academy of Child and Adolescent Psychiatry (AACAP). *Facts* sheets may be reproduced for personal or educational use without written permission, but cannot be included in material presented for sale. To order full sets of FFF, contact **Public Information, 1.800.333.7636**.

Free distribution of individual *Facts* sheets is a public service of the AACAP **Special Friends of Children Fund**. Please make a tax deductible contribution to the AACAP Special Friends of Children Fund and support this important public outreach. (AACAP, Special Friends of Children Fund, P.O. Box 96106, Washington, D.C. 20090).

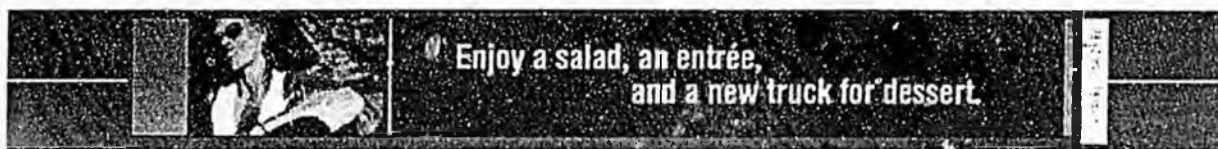
**For more information
about "Your Child"**

Copyright © 1997 by the American Academy of Child and Adolescent Psychiatry. Please read this disclaimer.

[[Facts For Families Main Menu](#)] [[Spanish](#)] [[Deutsch](#)] [[French](#)]

About AACAP | What's New? | Members Only | Facts for Families
Press Releases | Legislation | Meetings | Journal and Publications | Award Opportunities
Clinical Practice | Research | Training | Regional Organizations
Membership | JobSource | Resource Links

.6



drkoop[®].com Attention Deficit Disorder

To print: Select File and then Print from your browser's menu.

[Close Window](#)

Treatment of Attention Deficit Disorders

Attention Deficit Disorder

ADHD can take quite a toll. It is tough for the individual who must cope with daily frustrations. It is rough on family members whose lives are regularly disrupted by outbursts, temper tantrums or other misbehavior.

It's normal for parents to feel helpless and confused about the best ways to handle their child in these situations. Because kids with ADHD do not purposely decide to act up or not pay attention, traditional discipline -- like spanking, yelling at, or calmly trying to reason with your son or daughter -- usually does not work. Fortunately there are treatment options that can help alleviate the symptoms of ADHD and arm families with the tools needed to better handle problem behaviors when they arise.

These interventions include:
psychosocial interventions
medication
a combination of these two approaches

Psychosocial interventions

Research has shown that medication alone is not always sufficient. For more than two decades, psychosocial interventions such as parent training and behavioral modifications have been used for children with ADHD. A key goal is to teach parents and educators methods that equip them to better handle problems when they arise. In this approach they learn how to reward a child for positive behaviors and how to discourage negative behaviors. This therapy also seeks to teach a child techniques that can be used to control inattention and impulsive behaviors.

Preliminary research has shown that behavior modification is also effective for children with severe oppositional problems. Such an approach may lower the number or severity of oppositional behaviors, although the underlying condition -- ADHD -- remains.

Medications

Used properly, medicines such as methylphenidate hydrochloride (Ritalin) and other stimulants help suppress and regulate impulsive behavior. They squelch hyperactivity, improve social interactions and help people with ADHD concentrate, enabling them to perform better in school and at work.

These medications also may help children with co-existing disorders control

destructive behaviors. When used with proper medical supervision, they are considered generally safe and free of major unwanted side effects. (Some children may experience insomnia, stomachache or headache.) They rarely make children feel high or, on the flip side, overly sleepy or out of it. Although not known to be a significant problem, height and weight should be monitored with long-term use of these medications. These medications are not considered addictive in children. However, they should be carefully monitored in teen-agers and adults because they can be misused.

It is important to understand that these medications are not a cure-all, but they can be highly effective when used appropriately in the right dosage for each individual. In fact, as many as nine out of 10 children do better when they are taking one of the most commonly used stimulants. However, in combination with other techniques such as behavior modification or counseling, symptoms may improve even more. Researchers are currently evaluating the effectiveness of medications in combination with these other approaches to determine the best route to take.

Individuals taking any of the medications listed below should see their doctor regularly for a check-up to review the types and timing of ADHD symptoms. The benefits and potential risks of using these medications also should be discussed before the first prescription is filled.

The most commonly used stimulants are:

- methylphenidate hydrochloride (Ritalin)
- dextroamphetamine sulfate (Dexedrine or Dextrostat)
- a dextroamphetamine/amphetamine formulation (Adderall)

When these front-line medications are not effective, physicians sometimes opt to use one of the following:

- bupropion hydrochloride (Wellbutrin) -- an antidepressant that has been shown to decrease hyperactivity, aggression and conduct problems.
- imipramine (Tofranil) or nortriptyline (Pamelor) -- these antidepressants can improve hyperactivity and inattentiveness. They can be especially helpful in children experiencing depression or anxiety.
- clonidine hydrochloride, (Catapres) -- used to treat high blood pressure, clonidine also can help manage ADHD and treat conduct disorder, sleep disturbances or a tic disorder. Research has shown it decreases hyperactivity, impulsivity and distractibility, and improves interactions with peers and adults.
- guanfacine, (Tenex) -- this antihypertensive decreases fidgeting and restlessness and increases attention and a child's ability to tolerate frustration. A study of children who also have Tourette syndrome showed the medication improved vocal and motor tics as well.
- Pemoline (Cylert) -- is no longer considered a first- or second-line treatment due to concerns about the risk of liver dysfunction.

Other treatments

Some people with ADHD benefit from emotional counseling or psychotherapy. In this approach, counselors help patients deal with their emotions and learn ways to cope with their thoughts and feelings in a more general sense.

Group therapy and parenting education can help many children and their

families master valuable skills or new behaviors. The goal is to help parents learn about the particular problems their children with ADHD have, and give them ways to handle those problems when they arise. Likewise, children can be taught social skills and gain exposure to the same techniques the parents are learning, easing the way for those methods to be incorporated at home.

Support groups link families or adults who share similar concerns.

Therapies that have not been scientifically proved to be helpful in the treatment of ADHD include:

- herbal products
- restrictive or supplemental diets
- allergy treatments
- megavitamins
- chiropractic adjustment
- biofeedback
- perceptual motor training
- medications for inner ear problems
- yeast infection treatments
- pet therapy
- play therapy
- eye training
- colored glasses

Dartmouth Medical School
Date Published: 1/2/01
Date Reviewed: 3/31/01

[Close Window](#)

MAKING HISTORY
The New York Times
ON THE WEB

January 4, 2001

Report Seeks Mental Help for Children

By REUTERS

WASHINGTON, Jan. 3 — One in 10 American children suffers from some sort of mental health problem, but only 20 percent are being treated for it, Surgeon General David Satcher said in a report today.

"We are talking about depression, which is probably the most common, but also attention deficit hyperactivity disorder and obsessive-compulsive disorder," Dr. Satcher said in a telephone interview.

The report called for an overhaul of children's mental health programs, including training teachers and doctors to recognize problems and doing more research.

"We need a system in place that helps us recognize problems early," Dr. Satcher said.

An overhaul would cost money, Dr. Satcher acknowledged, but he said society was already paying a high price for the lack of treatment.

"When we don't respond, children are dumped into the juvenile justice system in many cases," he said, adding that others ended up in special education classes or on welfare.

"The burden of suffering experienced by children with mental health needs and their families has created a health crisis in this country," Dr. Satcher wrote in the report.

The report called for promoting public awareness of children's mental health issues, reducing the stigma associated with mental illness and improving the assessment and recognition of mental health needs in children.

Dr. Satcher said the issue of treating mental illness in children had been muddied by such debates as whether too many or too few children were being treated with drugs for attention deficit hyperactivity disorder. "We believe there are children being inappropriately treated," he said. "But we also believe there are a lot of children who have not been diagnosed and who could benefit from treatment."

Advertisement

TECHNO SCOUT
 Your search ends here
TECHNOLOGY UPDATES

If the world was flat, just about any antenna would do!

A floor lamp that spreads sunshine all over a room

The most important new auto technology is 125 miles high

Why wake up to an annoying buzzer?

Why spend hundreds on a bigger monitor enlarge the one you have

Penetrating gel emulsifies fat on contact

Alert animals that your vehicle is approaching

Your webcam, digital camera and video camera into one convenient, compact unit.

Click for the complete story
 Advertisement



For Immediate Release
February 13, 2002

Contact: Peg Nichols
301-306-7070 ext.102

**CHADD CONCERNED ABOUT LEGISLATIVE EFFORTS DESIGNED TO RESTRICT
PHYSICIAN & TEACHER ROLE IN TREATMENT OF AD/HD**

California Hearing Latest in Series of Hearings Throughout Country

Landover, MD—CHADD, the nation's leading advocacy organization serving those with Attention-Deficit/Hyperactivity Disorder (AD/HD), is deeply concerned about growing legislative efforts designed to restrict the role that physicians and teachers can play in advising families about the use of medication for the treatment of AD/HD. California is the latest of several state legislatures to consider such a proposal.

California SB 119, addressed today in a California State Senate public hearing, would criminalize physicians if statutory procedures were not followed when a physician prescribes a psychiatric medication to a legal minor. The legislation makes it a crime for a physician to prescribe a psychiatric medication to a legal minor until the physician has received a physical exam report from a pediatrician and had all physical conditions treated prior to prescribing the medication; the physician has fully explained all possible side effects to the parents; and has obtained written informed consent from the parents.

"CHADD believes that all families should have access to the best, evidence-based science in the diagnosis and treatment of AD/HD. We are therefore concerned when legislation is proposed which undermines this critical access," said E. Clarke Ross, Chief Executive Officer of CHADD. "While many of these proposals are designed to ensure more appropriate prescribing and dispensing of psychiatric medications, others are designed to discourage the administration of psychotropic medications in schools. Consequently, while some of the proposals are resulting in improved medical-practitioner-educator-family communication, others are replacing the science underlying the diagnosis and treatment of AD/HD with unproven theories and concepts."

The Surgeon General of the United States and the National Institute of Mental Health¹, as well as leading medical societies such as the American Academy of Pediatrics (AAP), American Psychiatric Association (APA), and the American Academy of Child and Adolescent Psychiatry (AACAP), recognize that medication, under the prescription of a treating medical professional and when taken as prescribed—along with other non-medication interventions—provides an effective foundation for the treatment of AD/HD. This is called multi-modal treatment.

Multi-modal treatment is a long-term management plan that combines medication with a variety of other treatment interventions designed to produce the best results. Such interventions include individualized education plans, special education resources when needed, behavioral therapy, family training and counseling. CHADD endorses a multi-modal approach to the treatment of AD/HD.

-more-

¹ United States Surgeon General of the United States. Report on Mental Health. Washington, DC: Department of Health and Human Services, December 1999.

CHADD's Position on Legislative Efforts Designed to Restrict Physicians' Roles

CHADD believes that legislation must not limit or undermine the ability of a medical professional, within their scope of practice, from treating AD/HD based on the most widely accepted evidence-based medicine. CHADD encourages all families and physicians to follow best practice assessment and treatment guidelines being uniformly implemented throughout the nation. Using the force of law and agencies of government—particularly criminal penalties—to monitor and enforce best practice treatment guidelines is an ineffective approach at best and disastrous approach at worst. Instead, ongoing training and education in the diagnosis and treatment of AD/HD should be encouraged among all physicians.

CHADD's Position on Teacher Involvement in Recognizing AD/HD

The above principles also apply to teachers, given the critical role they play in assisting children and their families when AD/HD is suspected. Teachers are frequently the first to recognize learning, functioning, and behavioral problems in the school setting and therefore should be able to advise parents of such observations. CHADD believes that professionals should act within their professional scope of practice; thus, school personnel should not recommend the use of medication. Medication assessment and prescription is the role of physician. However, teachers should be able to recommend a comprehensive and complete medical assessment by persons licensed to perform such evaluations. Because students spend a significant portion of their day in the classroom, the vital role teachers play in providing observations to the diagnosing professionals cannot be underestimated. Effective communication between teachers, professionals and parents is essential and strongly encouraged.

With over 22,000 members and 200 affiliates nationwide, CHADD works to improve the lives of people affected by AD/HD through collaborative leadership, advocacy, research, education and support: CHADD CARES. For additional information about AD/HD or CHADD, please contact the CHADD National Call Center at 1-800-233-4050, or visit the CHADD website at www.chadd.org

For Further Information on this Issue: Members of the media should contact Peg Nichols, Director of Communications and Media Relations, at 301-306-7070, extension 102. Legislative staff should contact Stephen Spector, Director of Public Policy, at 301-306-7070, extension 109.

#

International Consensus Statement on ADHD

January 2002

We, the undersigned consortium of international scientists, are deeply concerned about the periodic inaccurate portrayal of attention deficit hyperactivity disorder (ADHD) in media reports. This is a disorder with which we are all very familiar and toward which many of us have dedicated scientific studies if not entire careers. We fear that inaccurate stories rendering ADHD as myth, fraud, or benign condition may cause thousands of sufferers not to seek treatment for their disorder. It also leaves the public with a general sense that this disorder is not valid or real or consists of a rather trivial affliction.

We have created this consensus statement on ADHD as a reference on the status of the scientific findings concerning this disorder, its validity, and its adverse impact on the lives of those diagnosed with the disorder as of this writing (January 2002).

Occasional coverage of the disorder casts the story in the form of a sporting event with evenly matched competitors. The views of a handful of non-expert doctors that ADHD does not exist are contrasted against mainstream scientific views that it does, as if both views had equal merit. Such attempts at balance give the public the impression that there is substantial scientific disagreement over whether ADHD is a real medical condition. In fact, there is no such disagreement --at least no more so than there is over whether smoking causes cancer, for example, or whether a virus causes HIV/AIDS.

The U.S. Surgeon General, the American Medical Association (AMA), the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry (AACAP), the American Psychological Association, and the American Academy of Pediatrics (AAP), among others, all recognize ADHD as a valid disorder. While some of these organizations have issued guidelines for evaluation and management of the disorder for their membership, this is the first consensus statement issued by an independent consortium of leading scientists concerning the status of the disorder. Among scientists who have devoted years, if not entire careers, to the study of this disorder there is no controversy regarding its existence.

ADHD and Science

We cannot over emphasize the point that, as a matter of science, the notion that ADHD does not exist is simply wrong. All of the major medical associations and government health agencies recognize ADHD as a genuine disorder because the scientific evidence indicating it is so is overwhelming.

Various approaches have been used to establish whether a condition rises to the level of a valid medical or psychiatric disorder. A very useful one stipulates that there must be scientifically established evidence that those suffering the condition have a serious deficiency in or failure of a physical or psychological mechanism that is universal to humans. That is, all humans normally would be expected, regardless of culture, to have developed that mental ability.

And there must be equally incontrovertible scientific evidence that this serious deficiency leads to harm to the individual. Harm is established through evidence of increased mortality, morbidity, or impairment in the major life activities required of one's developmental stage in life. Major life activities are those domains of functioning such as education, social relationships, family functioning, independence and self-sufficiency, and occupational functioning that all humans of that developmental level are expected to perform.

As attested to by the numerous scientists signing this document, there is no question among the world's leading clinical researchers that ADHD involves a serious deficiency in a set of psychological abilities and that these deficiencies pose serious harm to most individuals possessing the disorder. Current evidence indicates that deficits in behavioral inhibition and sustained attention are central to this disorder -- facts demonstrated through hundreds of scientific studies. And there is no doubt that ADHD leads to impairments in major life activities, including social relations, education, family functioning, occupational functioning, self-sufficiency, and adherence to social rules, norms, and laws. Evidence also indicates that those with ADHD are more prone to physical injury and accidental poisonings. This is why no professional medical, psychological, or scientific organization doubts the existence of ADHD as a legitimate disorder.

The central psychological deficits in those with ADHD have now been linked through numerous studies using various scientific methods to several specific brain regions (the frontal lobe, its connections to the basal ganglia, and their relationship to the central aspects of the cerebellum). Most neurological studies find that as a group those with ADHD have less brain electrical activity and show less reactivity to stimulation in one or more of these regions. And neuro-imaging studies of groups of those with ADHD also demonstrate relatively smaller areas of brain matter and less metabolic activity of this brain matter than is the case in control groups used in these studies.

These same psychological deficits in inhibition and attention have been found in numerous studies of identical and fraternal twins conducted across various countries (US, Great Britain, Norway, Australia, etc.) to be primarily inherited. The genetic contribution to these traits is routinely found to be among the highest for any psychiatric disorder (70-95% of trait variation in the population), nearly approaching the genetic contribution to human height. One gene has recently been reliably demonstrated to be associated with this disorder and the search for more is underway by more than 12 different scientific teams worldwide at this time.

Numerous studies of twins demonstrate that family environment makes no significant separate contribution to these traits. This is not to say that the home environment, parental management abilities, stressful life events, or deviant peer relationships are unimportant or have no influence on individuals having this disorder, as they certainly do. Genetic tendencies are expressed in interaction with the environment. Also, those having ADHD often have other associated disorders and problems, some of

which are clearly related to their social environments. But it is to say that the underlying psychological deficits that comprise ADHD itself are not solely or primarily the result of these environmental factors.

This is why leading international scientists, such as the signers below, recognize the mounting evidence of neurological and genetic contributions to this disorder. This evidence, coupled with countless studies on the harm posed by the disorder and hundreds of studies on the effectiveness of medication, buttresses the need in many, though by no means all, cases for management of the disorder with multiple therapies. These include medication combined with educational, family, and other social accommodations. This is in striking contrast to the wholly unscientific views of some social critics in periodic media accounts that ADHD constitutes a fraud, that medicating those afflicted is questionable if not reprehensible, and that any behavior problems associated with ADHD are merely the result of problems in the home, excessive viewing of TV or playing of video games, diet, lack of love and attention, or teacher/school intolerance.

ADHD is not a benign disorder. For those it afflicts, ADHD can cause devastating problems. Follow-up studies of clinical samples suggest that sufferers are far more likely than normal people to drop out of school (32-40%), to rarely complete college (5-10%), to have few or no friends (50-70%), to under perform at work (70-80%), to engage in antisocial activities (40-50%), and to use tobacco or illicit drugs more than normal. Moreover, children growing up with ADHD are more likely to experience teen pregnancy (40%) and sexually transmitted diseases (16%), to speed excessively and have multiple car accidents, to experience depression (20-30%) and personality disorders (18-25%) as adults, and in hundreds of other ways mismanage and endanger their lives.

Yet despite these serious consequences, studies indicate that less than half of those with the disorder are receiving treatment. The media can help substantially to improve these circumstances. It can do so by portraying ADHD and the science about it as accurately and responsibly as possible while not purveying the propaganda of some social critics and fringe doctors whose political agenda would have you and the public believe there is no real disorder here. To publish stories that ADHD is a fictitious disorder or merely a conflict between today's Huckleberry Finns and their caregivers is tantamount to declaring the earth flat, the laws of gravity debatable, and the periodic table in chemistry a fraud. ADHD should be depicted in the media as realistically and accurately as it is depicted in science -- as a valid disorder having varied and substantial adverse impact on those who may suffer from it through no fault of their own or their parents and teachers.

Sincerely,

Russell A. Barkley, Ph.D.
Professor
Depts. Of Psychiatry and Neurology
University of Massachusetts Medical School
55 Lake Avenue North
Worcester, MA 01655,

Edwin H. Cook, Jr., M.D.
Professor
Departments of Psychiatry and Pediatrics
University of Chicago
5841 S. Maryland Ave.
Chicago, IL

Mina Dulcan, M.D.
Professor
Department of Child and Adolescent Psychiatry
2300 Children's Plaza #10
Children's Memorial Hospital
Chicago, IL 60614

Susan Campbell, Ph.D.
Professor
Department of Psychology
4015 O'Hara Street
University of Pittsburgh
Pittsburgh, PA 15260

Margot Prior, Ph.D.
Professor
Department of Psychology
Royal Children's Hospital
Parkville, 3052 VIC
Australia

Marc Atkins, Ph.D.
Associate Professor
University of Illinois at Chicago
Institute for Juvenile Research
Department of Psychiatry
840 South Wood Street, Suite 130
Chicago, IL 60612-7347

Christopher Gillberg, M.D.
Professor
Department of Child and Adolescent Psychiatry
University of Gothenburg
Gothenburg, Sweden

Mary Solanto-Gardner, Ph.D.
Associate Professor
Division of Child and Adolescent Psychiatry

The Mt. Sinai Medical Center
One Gustave L. Levy Place
New York, NY 10029-6574

Jeffrey Halperin, Ph.D.
Professor,
Department of Psychology
Queens College, CUNY
65-30 Kissena Ave.
Flushing, NY 11367

Jose J. Bauermeister, Ph.D.
Professor,
Department of Psychology
University of Puerto Rico
San Juan, PR 00927

Steven R. Pliszka, M.D.
Associate Professor and Chief
Division of Child and Adolescent Psychiatry
University of Texas Health Sciences Center
7703 Floyd Curl Drive
San Antonio, TX 78229-3900

Mark A. Stein, Ph.D.
Chair of Psychology
Children's National Medical Center and
Professor of Psychiatry & Pediatrics
George Washington Univ. Med. School
111 Michigan Ave. NW
Washington, DC 20010

John S. Werry, M.D.
Professor Emeritus
Department of Psychiatry
University of Auckland
Auckland, New Zealand

Joseph Sergeant, Ph.D.
Chair of Clinical Neuropsychology
Free University
Van der Boecharst Straat 1
De Boelenlaan 1109
1018 BT Amsterdam
The Netherlands

Ronald T. Brown, Ph.D.
Associate Dean, College of Health Professions
Professor of Pediatrics
Medical University of South Carolina
19 Hagood Avenue
P. O. Box 250822
Charleston, SC 29425

Alan Zametkin, M.D.
Child Psychiatrist
Kensington, MD

Arthur D. Anastopoulos, Ph.D.
Professor, Co-Director of Clinical Training
Department of Psychology
University of North Carolina at Greensboro
P. O. Box 26164
Greensboro, NC 27402-6164

James J. McGough, M.D.
Associate Professor of Clinical Psychiatry
UCLA School of Medicine
760 Westwood Plaza
Los Angeles, CA 90024

George J. DuPaul, Ph.D.
Professor of School Psychology
Lehigh University
111 Research Drive, Hilltop Campus
Bethlehem, PA 18015

Stephen V. Faraone, Ph.D.
Associate Professor of Psychology
Harvard University
750 Washington St., Suite 255
South Easton, MA 02375

Florence Levy, M.D.
Associate Professor
School of Psychiatry
University of New South Wales
Avoca Clinic
Joynton Avenue
Zetland, NSW, 2017, Australia

Mariellen Fischer, Ph.D.

Professor,
Department of Neurology
Medical College of Wisconsin
9200 W. Wisconsin Avenue
Milwaukee, WI 53226

Joseph Biederman, M.D.
Professor and Chief
Joint Program in Pediatric Psychopharmacology
Massachusetts General Hospital and
Harvard Medical School
15 Parkman St., WACC725
Boston, MA 02114

Cynthia Hartung, Ph.D.
Assistant Professor
Oklahoma State University
215 North Murray
Stillwater, OK 74078

Stephen Houghton, Ph.D.
Professor of Psychology
Director, Centre for Attention & Related Disorders
The University of Western Australia
Perth, Australia

Gabrielle Carlson, M.D.
Professor and Director,
Division of Child and Adolescent Psychiatry
State University of New York at Stony Brook. Putnam Hall
Stony Brook, NY 11794

Charlotte Johnston, Ph.D.
Professor
Department of Psychology
University of British Columbia
2136 West Mall
Vancouver, BC, Canada V6T 1Z4

Thomas Spencer, M.D.
Associate Professor and Assistant Director, Pediatric Psychopharmacology
Harvard Medical School and
Massachusetts General Hospital
15 Parkman St., WACC725
Boston, MA 02114

Thomas Joiner, Ph.D.
The Bright-Burton Professor of Psychology
Florida State University
Tallahassee, FL 32306-1270

Rosemary Tannock, Ph.D.
Professor of Psychiatry,
Brain and Behavior Research
Hospital for Sick Children
55 University Avenue
Toronto, Ontario, Canada M5G 1X8

Adele Diamond, Ph.D.
Professor of Psychiatry
Director, Center for Developmental Cognitive Neuroscience
University of Massachusetts Medical School
Shriver Center
Trapelo Rd.
Waltham, MA

Carol Whalen, Ph.D.
Professor
Department of Psychology and Social Behavior
University of California at Irvine
3340 Social Ecology II
Irvine, CA 02215

Stephen P. Hinshaw, Ph.D.
Professor,
Department of Psychology #1650
University of California at Berkeley
3210 Tolman Hall
Berkeley, CA 94720-1650

Herbert Quay, Ph.D.
Professor Emeritus
University of Miami
2525 Gulf of Mexico Drive, #5C
Long Boat Key, FL 34228

John Piacentini, Ph.D.
Associate Professor
Department of Psychiatry
UCLA Neuropsychiatric Institute
760 Westwood Plaza
Los Angeles, CA 90024-1759

Philip Firestone, Ph.D.
Professor
Departments of Psychology & Psychiatry
University of Ottawa
120 University Priv.
Ottawa, Canada K1N 6N5

Salvatore Mannuzza, M.D.
Research Professor of Psychiatry
New York University School of Medicine
550 First Avenue
New York, NY 10016

Howard Abikoff, Ph.D.
Pevaroff Cohn Professor of Child and Adolescent Psychiatry
NYU School of Medicine
Director of Research
NYU Child Study Center
550 First Avenue
New York, NY 10016

Keith McBurnett, Ph.D.
Associate Professor
Department of Psychiatry
University of California at San Francisco
Children's Center at Langley Porter
401 Parnassus Avenue, Box 0984
San Francisco, CA 94143

Linda Pfiffner, Ph.D.
Associate Professor
Department of Psychiatry
University of California at San Francisco
Children's Center at Langley Porter
401 Parnassus Avenue, Box 0984
San Francisco, CA 94143

Oscar Bukstein, M.D.
Associate Professor
Department of Psychiatry
Western Psychiatric Institute and Clinic
3811 O'Hara Street
Pittsburgh, PA 15213

Ken C. Winters, Ph.D.
Associate Professor
Director, Center for Adolescent
Substance Abuse Research
Department of Psychiatry
University of Minnesota
F282/2A West, 2450 Riverside Ave.
Minneapolis, MN 55454

Michelle DeKlyen, Ph.D.
Office of Population Research
Princeton University
286 Wallace
Princeton, NJ 08544

Lily Hechtman M.D. F.R.C.P.
Professor of Psychiatry and Pediatrics,
Director of Research,
Division of Child Psychiatry,
McGill University, and
Montreal Childrens Hospital.
4018 St. Catherine St. West.,
Montreal, Quebec, Canada. H3Z-1P2

Caryn Carlson, Ph.D.
Professor
Department of Psychology
University of Texas at Austin
Mezes 330
Austin, TX 78712

Donald R. Lynam, Ph.D.
Associate Professor
University of Kentucky
Department of Psychology
125 Kastle Hall
Lexington, KY 40506-0044

Patrick H. Tolan Ph.D.
Director, Institute for Juvenile Research
Professor, Department of Psychiatry
University of Illinois at Chicago
840 S. Wood Street
Chicago, IL 60612

Jan Loney, Ph.D.
Professor Emeritus

State University of New York at Stony Brook
Lodge Associates (Box 9)
Mayslick, KY 41055

Harold S. Koplewicz, M.D.
Arnold and Debbie Simon Professor of Child and Adolescent
Psychiatry and Director of the NYU Child Study Center
New York, NY

Richard Milich, Ph.D.
Professor of Psychology
Department of Psychology
University of Kentucky
Lexington, KY 40506-0044

Laurence Greenhill, M.D.
Professor of Clinical Psychiatry
Columbia University
Director, Research Unit on Pediatric Psychopharmacology
New York State Psychiatric Institute
1051 Riverside Drive
New York, NY 10032

Eric J. Mash, Ph.D.
Professor
Department of Psychology
University of Calgary
2500 University Drive N.W.
Calgary, Alberta T2N 1N4

Russell Schachar, M.D.
Professor of Psychiatry
Hospital for Sick Children
555 University Avenue
Toronto, Ontario
Canada M5G 1X8

Eric Taylor
Professor of Psychiatry
Institute of Psychiatry
London, England

Betsy Hoza, Ph.D.
Associate Professor
Department of Psychology, #1364
Purdue University

West Lafayette, IN 47907-1364

Mark. D. Rapport, Ph.D.
Professor and Director of Clinical Training
Department of Psychology
P.O. Box 161390
University of Central Florida
Orlando, Florida 32816-1390

Bruce Pennington, Ph.D.
Professor
Department of Psychology
University of Denver
2155 south Race Street
Denver, CO 80208

Anita Thapar MB BCh, MRCPsych, PhD
Professor,
Child and Adolescent Psychiatry Section
Dept of Psychological Medicine
University of Wales College of Medicine
Heath Park, Cardiff
CF14 4XN United Kingdom

Ann Teeter, Ed.D.
Director of Training, School Psychology
University of Wisconsin – Milwaukee
Milwaukee, WI 53201

Stephen Shapiro, Ph.D.
Department of Psychology
Auburn University
226 Thach
Auburn, AL 36849-5214

Avi Sadeh, D.Sc
Director, Clinical Child Psychology Graduate Program
Director, The Laboratory for Children's Sleep Disorders
Department of Psychology
Tel-Aviv University
Ramat Aviv, Tel Aviv 69978
ISRAEL

Bennett L. Leventhal, M.D.
Irving B. Harris Professor of Child and Adolescent Psychiatry
Director, Child & Adolescent Psychiatry

Vice Chairman, Dept. of Psychiatry
The University of Chicago
5841 S. Maryland Ave.
Chicago, IL 60637

Hector R. Bird, M.D.
Professor of Clinical Psychiatry
Columbia University
College of Physicians and Surgeons
1051 Riverside Drive (Unit 78)
New York, NY 10032

Carl E. Paternite, Ph.D.
Professor of Psychology
Miami University
Oxford, OH 45056

Mary A. Fristad, PhD, ABPP
Professor, Psychiatry & Psychology
Director, Research & Psychological Services
Division of Child & Adolescent Psychiatry
The Ohio State University
1670 Upham Drive Suite 460G
Columbus, OH 43210-1250

Brooke Molina, Ph.D.
Assistant Professor of Psychiatry and Psychology
Western Psychiatric Institute and Clinic
University of Pittsburgh School of Medicine
3811 O'Hara Street
Pittsburgh, PA 15213

Sheila Eyberg, PhD, ABPP
Professor of Clinical & Health Psychology
Box 100165
1600 SW Archer Blvd.
University of Florida
Gainesville, FL 32610

Rob McGee, PhD
Associate Professor,
Department of Preventive & Social Medicine,
University of Otago Medical School,
Box 913 Dunedin,
New Zealand.

Terri L. Shelton, Ph.D.
Director
Center for the Study of Social Issues
University of North Carolina – Greensboro
Greensboro, NC 27402

Steven W. Evans, Ph.D.
Associate Professor of Psychology
MSC 1902
James Madison University
Harrisonburg, VA 22807

Sandra K. Loo, Ph.D.
Research Psychologist
University of California, Los Angeles
Neuropsychiatric Institute
760 Westwood Plaza, Rm 47-406
Los Angeles, CA 90024

William Pelham, Jr., Ph.D.
Professor of Psychology
Center Children and Families
State University of New York at Buffalo
318 Diefendorf Hall
3435 Main Street, Building 20
Buffalo, NY 14214

J. Bart Hodgens, Ph.D.
Clinical Assistant Professor
of Psychology and Pediatrics
Civitan International Research Center
University of Alabama at Birmingham
Birmingham, AL 35914

Terje Sagvolden, Ph.D.
Professor
Department of Physiology
University of Oslo
N-0316 Oslo, Norway

Thomas E. Brown, Ph.D.
Asst. Professor
Dept. of Psychiatry
Yale University School of Medicine
New Haven, CT

Daniel F. Connor, M.D.
Associate Professor
Department of Psychiatry
University of Massachusetts Medical School
55 Lake Avenue North
Worcester, MA 01655

Daniel A. Waschbusch, Ph.D.
Assistant Professor of Psychology
Director, Child Behaviour Program
Department of Psychology
Dalhousie University
Halifax, NS B3H 4R1 CANADA

Kevin R. Murphy, Ph.D.
Assistant Professor
Dept. of Psychiatry
University of Massachusetts Medical School
55 Lake Avenue North
Worcester, MA 01655

Michael Aman, Ph.D.
Professor of Psychology and Psychiatry
The Nisonger Center
Ohio State University
1581 Dodd Drive
Columbus, Ohio, U.S.A.

Blythe Corbett, Ph.D.
M.I.N.D. Institute
University of California, Davis
4860 Y Street, Suite 3020
Sacramento, CA 95817

Deborah L. Anderson, Ph.D.
Assistant Professor
Department Pediatrics
Medical University of South Carolina
Charleston, SC 29425

Lisa L. Weyandt, Ph.D.
Professor, Dept. of Psychology
Central Washington University
400 East 8th Avenue
Ellensburg, WA 98926-7575

Michael Gordon, Ph.D.
Professor of Psychiatry
Director, Child & Adolescent Psychiatric Services, & Director, ADHD Program
SUNY Upstate Medical University
750 East Adams Street
Syracuse, NY 13210

Lawrence Lewandowski, Ph.D.
Meredith Professor of Teaching Excellence
Department of Psychology
Syracuse University
Syracuse, NY

Erik Willcutt, Ph.D.
Assistant Professor
Department of Psychology
Muenzinger Hall D-338
345 UCB
University of Colorado
Boulder, CO 80309

Senate Bill 230

Psychotropic Drugs For Children

Informational Articles On Use of Psychotropic Drugs

Original article:
<http://my.webmd.com/content/article/1728.84235>

Do Laws Limiting School Involvement in ADHD Do More Harm Than Good?

Experts Say Schools Have Role to Play in Management of Mental Disorder

By *Steve Mitchell*

WebMD Medical News

July 18, 2001 (Washington) -- In response to reports of parents being pressured by school officials to place their children on Ritalin or similar drugs to treat attention deficit hyperactivity disorder, or ADHD, several state legislatures are enacting or considering legislation that may discourage schools from playing doctor.

But these laws may do more harm than good, because schools can play vital roles in diagnosing ADHD as well as treating the condition, experts say.

According to the National Institute of Mental Health, approximately 4.1% of children between the ages of 9 and 17 have ADHD, which includes the symptoms of an inability to stay focused or finish tasks. Children with this condition may also have depressive and anxiety disorders or engage in drug abuse.

Connecticut recently became the first state to enact legislation that specifically prohibits school officials from recommending psychotropic drugs -- the class of drug that Ritalin belongs to -- to parents for their children. Under the Connecticut law, school personnel can, however, recommend that children be evaluated by a doctor.

Colorado's Board of Education enacted a resolution in 1999 to encourage the use of classroom management modifications to deal with behavioral problems rather than prescription medications.

Other states, including Washington, North Carolina, Hawaii, and Georgia, have passed legislation that calls for a closer look at the use of Ritalin and other ADHD drugs in children and their effect on learning.

"It's not the role of school psychologists or personnel to recommend medication," says Clarke Ross, DPA, CEO of the patient advocacy group Children and Adults with Attention-Deficit/Hyperactivity Disorder, or CHADD, which is supportive of the type of legislation that Connecticut enacted. School officials' role is "to identify learning problems of children and to encourage medical evaluation," he tells WebMD.

But Daniel Lieberman, MD, a psychiatrist and director of outpatient psychiatry at George Washington University in Washington, takes a different view. He agrees that "it's totally inappropriate for school officials to press a parent to place a child on medication." However, he doesn't believe that legislation is an appropriate response to this situation.

He fears that legislation may discourage teachers from taking action when they know there's a problem for fear of being punished under the law. Then "parents would never hear about what's happening in school [with their children]."

In some cases, a child with ADHD could go undiagnosed, Lieberman says. This is because the condition can sometimes only become apparent "in highly structured situations," such as school, and the parents may not pick up on the symptoms at home.

And when it comes to diagnosing the condition, even doctors can have difficulty. Some doctors are not familiar with proper guidelines for diagnosing ADHD and hence some underdiagnose the condition and others overdiagnose it, according to the National Institute of Mental Health.

Citing a 1999 report from the U.S. Surgeon General, Ross says that a proper diagnosis of ADHD requires a comprehensive and complete examination by a trained professional. "This is not something you do in one session," he says, noting that the doctor needs to be able to identify a pattern of behaviors that are repeated over time to accurately diagnose ADHD.

The American Academy of Pediatrics shares Lieberman's views that teachers may have a role to play in the management of ADHD. The AAP plans to release guidelines in October helping doctors determine the best way to treat ADHD, and one component of the guidelines will point out the importance of "teachers working with parents not only to diagnose the condition but to help treat it," a source at AAP tells WebMD.

This is because appropriate treatment of this condition should involve not only medication, such as the commonly prescribed Ritalin or Adderall, but behavioral and educational therapy. So schools can play a role in ensuring that ADHD children receive appropriate educational intervention, the AAP source says.

Another issue is whether schools pushing Ritalin is a widespread problem or a matter of a few isolated cases. Despite reports in the media of parents being pressed by school officials to place their children on ADHD medication, no formal surveys have ever been done to assess the extent of the problem. So "whether we have a few cases or a lot remains to be seen," Lieberman says.

But Lieberman says he has not had any of his patients complain about it, and Ross says no incidence like this has been reported by CHADD members. Ross, whose son has ADHD, adds that he doesn't really believe it's a problem across the country.

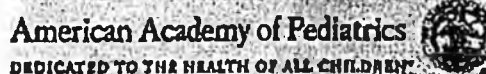
Even the Connecticut law was based on anecdotal evidence of parents complaining that schools were pressuring them, says David Wilkins, spokesman for Rep. Lenny Wilkins, who authored the legislation. No formal, scientific evaluations of the problem were ever done, Wilkins tells WebMD.

Ross notes that similar legislation has not been proposed at the federal level, and he doubts that it ever will be. This is because the federal government funds less than 10% of elementary and secondary schools, so the issue of ADHD drugs in these schools remains largely the purview of state and local governments, he says.

Medically Reviewed

By Dr. Charlotte Grayson

© 2001 WebMD Corporation. All rights reserved.



Members Only Channel | Search | Site Map | BookStore | Contact Us | Guestbook | Home



Press Release

AAP RELEASES NEW GUIDELINES FOR TREATMENT OF ATTENTION-DEFICIT/HYPERACTIVITY DISORDER

Below is a news release on a treatment guideline published in the October issue of *Pediatrics*, the peer-reviewed scientific journal of the American Academy of Pediatrics (AAP).

For Release: October 1, 2001, 12:01 a.m. (ET)

CHICAGO - The American Academy of Pediatrics (AAP) released new recommendations today for treating school-age children with attention-deficit/hyperactivity disorder (ADHD). This guideline is intended for primary care physicians who have already accurately established an ADHD diagnosis. Last year the AAP released guidelines for diagnosing ADHD.

ADHD is a condition of the brain that makes it difficult for children to control their behavior in school and social settings. It is one of the most common chronic conditions of childhood and affects between 4 and 12 percent of all school-age children. About 3 times more boys than girls are diagnosed with ADHD.

Children with ADHD may experience significant functional problems such as school difficulties, academic underachievement, troublesome relationships with family members and peers, and behavioral problems. Different children have different symptoms or problems with ADHD.

The new standardized AAP guidelines were developed by a panel of medical, mental health and educational experts. The AAP partnered with The Agency for Healthcare Research and Quality, and the Evidence-based Practice Center at McMaster University in Canada to develop the evidence base of literature on the topic. The recommendations were based on scientific studies that carefully evaluated treatments of school-age children with ADHD.

The new guidelines include the following recommendations:

- Primary care clinicians should establish a treatment program that recognizes ADHD as a chronic condition. This implies the need for education about the condition, and a sustained monitoring system to track the effects of treatment and developmental changes in behavior.
- The treating clinician, parents, and child, in collaboration with school personnel, should specify appropriate goals to guide management. Goals should relate to the specific problems of the individual child, e.g., school performance, difficulty finishing tasks, problems with interactions with schoolmates.
- If appropriate, the clinician should recommend behavior therapy and/or stimulant medication to improve specific symptoms in children with ADHD. The guideline provides a review of the scientific evidence for recommending medication and behavior therapy.
- When the treatment for a child with ADHD has not met its goals, clinicians should re-evaluate the original diagnosis, all appropriate treatments, adherence to the treatment

plan, and coexisting conditions, including learning disabilities and mental health conditions.

- The clinician should provide a periodic and systematic follow-up for the child with ADHD. Monitoring should be directed to the child's individual goals, and any adverse effects of treatment, with information gathered from parents, teachers and the child. The guidelines recommend areas for future research in treatment options, long-term outcomes and other areas in the management of children with ADHD.

Already one of the most common and most studied conditions of childhood, ADHD treatment has increased in recent years. Treatments, both medications and behavior therapy, improve the functioning of most children with ADHD. Long-term management of ADHD requires active teamwork among clinicians, parents and teachers to help assure the best outcomes. While there is no proven cure for ADHD at this time, and the cause is unclear, research is ongoing to learn more about the role of the brain in ADHD and the best ways to treat the disorder.

The American Academy of Pediatrics is an organization of 55,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists dedicated to the health, safety and well-being of infants, children, adolescents and young adults.

© 2002 - American Academy of Pediatrics



This information is based on the American Academy of Pediatrics' policy statements *Diagnosis and Evaluation of the Child with Attention-Deficit/Hyperactivity Disorder*, published in the May 2000 issue of *Pediatrics*, and *Treatment of the School-Aged Child with Attention-Deficit/Hyperactivity Disorder*, published in the October 2001 issue of *Pediatrics*. *Parent Pages* offer parents relevant facts that explain current policies about children's health.

ADHD and Your School-Aged Child

Attention-deficit/hyperactivity disorder (ADHD) is a condition of the brain that makes it hard for children to control their behavior. It is one of the most common chronic conditions of childhood. All children have behavior problems at times. Children with ADHD have frequent, severe problems that interfere with their ability to live normal lives.

A child with ADHD may have one or more of the following behavior symptoms:

- **Inattention** - Has a hard time paying attention, day-dreams, is easily distracted, is disorganized, loses a lot of things.
- **Hyperactivity** - Seems to be in constant motion, has difficulty staying seated, squirms, talks too much.
- **Impulsivity** - Acts and speaks without thinking, unable to wait, interrupts others.

How can I tell if my child has ADHD?

Your pediatrician will assess whether your child has ADHD using standard guidelines developed by the American Academy of Pediatrics. Keep in mind the following:

- These guidelines are for children 6 to 12 years of age. It is difficult to diagnose ADHD in children who are younger than this age group.
- The diagnosis is a process that involves several steps. It requires information about your child's behavior from you, your child's school, and/or other caregivers.
- Your pediatrician also will look for other conditions that have the same types of symptoms as ADHD. Some children have ADHD and another (coexisting) condition, e.g., conduct disorder, depression, anxiety, or a learning disability.
- There is no proven test for ADHD at this time.

If your child has ADHD, the symptoms will

- Occur in more than one setting, such as home, school, and social settings.
- Be more severe than in other children the same age.
- Start before your child reaches 7 years of age.
- Continue for more than six months.
- Make it difficult to function at school, at home, and/or in social settings.

What does treatment for ADHD involve?

As with other chronic conditions, families must manage the treatment of ADHD on an ongoing basis. In most cases, treatment for ADHD includes the following:

1. **A long-term management plan.** This will have:
 - **Target outcomes** (behavior goals, e.g., better school work)
 - **Follow-up activities** (e.g., medication, making changes that affect behavior at school and at home)
 - **Monitoring** (checking the child's progress with the target outcomes)
2. **Medication.** For most children, stimulant medications are a safe and effective way to relieve ADHD symptoms.
3. **Behavior Therapy.** This focuses on changing the child's environment to help improve behavior.
4. **Parent Training.** Training can give parents specific skills to deal with ADHD behaviors in a positive way.
5. **Education.** All involved need to understand what ADHD is.
6. **Teamwork.** Treatment works best when doctors, parents, teachers, caregivers, other health care professionals, and the child work together.

It may take some time to tailor your child's treatment plan to meet his needs. Treatment may not fully eliminate the ADHD-type behaviors. However, most school-aged children with ADHD respond well when their treatment plan includes both stimulant medications and behavior therapy.

Is there a cure for ADHD?

There is no proven cure for ADHD at this time. The cause of ADHD is unclear. Research is ongoing to learn more about the role of the brain in ADHD and the best ways to treat the disorder. Many good treatment options are available. The outlook for children who receive treatment for ADHD is encouraging.

As a parent, you play a very important part in providing effective treatment for your child.

For further information ask your pediatrician about "Understanding ADHD: Information for Parents About Attention-Deficit/Hyperactivity Disorder," a new booklet from the American Academy of Pediatrics.

The information contained in this publication should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances.

©Copyright October 2001 American Academy of Pediatrics

This page may be freely reproduced with acknowledgement of the American Academy of Pediatrics.

FOR LOCAL LEADERSHIP OF PUBLIC EDUCATION



SCHOOL BOARD NEWS

FRONT PAGE ABOUT ARCHIVE NATIONAL AFFILIATE NSBA

Schools caught in the middle of Ritalin controversies

By Craig Colgan

12/5/00 – Controversy over the prescription drug Ritalin has heated up recently, and school officials find themselves, once again, caught in the middle.

The Texas State Board of Education approved a resolution in November urging local school boards to seek non-drug solutions to student behavior problems. The resolution quoted a federal panel that concluded the use of Ritalin results in "little improvement in academic or social skills."

The resolution, which carries no legal authority, is supported by anti-Ritalin activists who pushed for a similar resolution passed by the state board in Colorado. The activists claim Ritalin and other drugs associated with attention deficit hyperactivity disorder (ADHD) and attention deficit disorder (ADD) are routinely overprescribed and are increasingly abused.

There have been a growing number of confrontations nationwide pitting parents of children with attention deficits against school officials.

Albany, N.Y., school officials "turned in" two families to local child protective services after parents decided to take their children off medication prescribed for ADHD. Parents of one student pulled him out of school, while another decided to put their child back on medication.

And some accuse drug companies of marketing the drugs too aggressively.

Class action lawsuits were filed in September in California and in New Jersey alleging Novartis Pharmaceuticals, the manufacturer of Ritalin, and the American Psychiatric Association had illegally conspired to expand the market for the drug. Another suit against Novartis was filed in Texas.

Ritalin use soaring

Since 1990, Ritalin production is up 700 percent, and nearly 15 percent of America's school-age children are using psychiatric prescription drugs.

In February, researchers reported in *The Journal of the American Medical Association* on what they view as an acute increase in the number of preschoolers taking psychotropic drugs, particularly stimulants such as Ritalin and antidepressants such as Prozac.

Response from the federal government was swift. The Drug Enforcement Agency will

produce brochures this year discussing abuse of prescription drugs by parents and students. The National Institute of Mental Health said it would spend \$6 million over the next five years to study whether Ritalin is safe and effective for children under 6.

ADHD was recognized as a condition entitling children to special education services in 1997 when the Individuals with Disabilities Education Act was reauthorized.

The American Academy of Pediatrics, for the first time earlier this year, issued guidelines for diagnosing ADHD. The academy said it is unclear whether the disorder was being overdiagnosed, because of such wide variations in how doctors defined and treated it.

Under the new guidelines, to be diagnosed with ADHD, a child must exhibit symptoms in at least two settings, such as at home and at school, and the symptoms must persist for at least six months.

Mixed results

Meanwhile, research results on the long-term effectiveness of Ritalin have been mixed.

In a study published in August in the journal *Pediatrics*, researchers reported on evidence that showed children diagnosed with ADHD who are treated with Ritalin are significantly less likely to abuse drugs and alcohol as teenagers. And there are even some who say ADHD is underdiagnosed, such as James J. Crist, author of *ADHD—A Teenager's Guide*.

Dr. Lawrence Diller, a behavioral pediatrician, says, "The discussion gets polarized and there is plenty of hyperbole, because it is cheaper and faster to medicate than to address core interactional problems here."

Diller, the author of *Running on Ritalin: A Physician Reflects on Children, Society, and Performance in a Pill*, is a frequent public critic of what he sees as America's increasing dependence on Ritalin, though he does not oppose the drug if used properly.

"I have no doubt Ritalin works in the short term, but I don't see it as a moral equivalent or substitute for better parenting and schools," he says.

And that's just what some of the drug's critics are charging.

The Texas state board's resolution is filled with dire pronouncements about "documented incidences of highly negative consequences in which psychiatric prescription drugs have been utilized for what are essentially problems of discipline which may be related to lack of academic success."

The resolution then urges school districts to implement policies dealing with storage of drugs, require that all medications be dispensed by a "medical practitioner," and calls for greater communication and education on the issue.

The resolution came about at the urging of Texans for Safe Education, a group that opposes "the ever-increasing role of psychiatry and psychiatric drugs in schools," says John Breeding, a psychologist and the group's president.

Charges of abuse

Breeding, as do many of Ritalin's harsher critics, challenges the medical definition of ADHD, calling it, among other things, a construct of a profit-hungry pharmaceutical industry. He claims a million children are using Ritalin and other psychiatric drugs in Texas.

"This is about medicalizing behavior problems in children," Breeding says. "It is also a fact that some people die using these drugs. That is not radical. Reliance on Ritalin is a distraction of attention and resources away from doing the things that need to be done for children in need."

Breeding says he is in touch with allies in other states, and he hopes to convince the U.S. Attorney General to weigh in on preventing schools from requiring use of Ritalin and other medications for children with attention problems.

Shellie Hoffman, director of legal services for the Texas Association of School Boards, says the Texas state board's resolution accomplishes little.

"First, most school districts already have policies dealing with prescription medications that fully comply with state law," Hoffman says. "And while school districts certainly appreciate the encouragement to be cautious about the effects of these drugs, this is not an area that the state board has rule-making authority in. And, in fact, whether a child uses these types of drugs is very often not a decision school districts have any authority over."

Hoffman says the Texas State Board of Education was stripped of much of its authority in 1995, but continues to offer opinions on an array of controversial issues. (It recently approved a resolution encouraging districts to create policies for neutral "forums" before school events at which students may speak on issues of their choosing. Hoffman calls such forums a not-so-subtle invitation to prayer, a topic that has produced much rancor in Texas since the Supreme Court last spring outlawed student-led prayers before football games.)

Schools unfairly blamed

"I think there is a lot of confusion out there and misinformation in the perception that schools are pressing families and physicians to medicate children," says Ted Feinberg, assistant executive director of the National Association of School Psychologists. "I am sure there are some schools that are quick to judgment at times for some children having difficulty, but schools are not the perpetrators of Ritalin as a major answer to so many issues for children today."

What might be happening with various anti-Ritalin movements today may just be part of a cycle, he suggests. At the start of the ADD and Ritalin boom a decade ago, many parents and physicians were pushing for more children to be identified as having ADD, Feinberg points out.

"I think today the pendulum has just swung in the opposite direction," he says. "We need more research on this."

Feinberg believes it is unfair for schools "to be whipping posts for this issue. Parents need help and support, and need to be informed about alternative strategies before medication."

But the bottom line on Ritalin is that, "for many children, it often works."

[Top of Page](#)

Reproduced with permission from the Dec. 5, 2000, issue of School Board News. Copyright © 2000, National School Boards Association. Opinions expressed in this newspaper do not necessarily reflect positions of NSBA. This article may be printed out and photocopied for individual or educational use, provided this copyright notice appears on each copy. This article may not be otherwise transmitted or reproduced in print or electronic form without the consent of the Publisher. For more information, call (703) 838-6789.

[Front Page](#) | [About](#) | [Archive](#) | [National Affiliate](#) | [NSBA](#)

<p>LIBRARY</p> <p>HOW TO USE THIS SITE</p>	<p>JOURNAL OF THE AMA</p> <p>REGISTER</p> <p>SITE MAP</p> <p>SEARCH</p> <p>FORUMS</p> <p>CONTACT</p> <p>ADVERTISING</p>
<p>Vol. 283 No. 8, February 23, 2000</p>	<p>JAMA</p> <p>Editorial</p> <p>CURRENT ISSUE</p> <p>INDEXES</p> <p>PAST ISSUES</p>
<p>PDF OF THIS ARTICLE</p> <p>See Related: Articles Authors' Articles</p>	<p>Psychotropic Drug Use in Very Young Children</p> <p><i>J</i> Joseph T. Coyle, MD</p>
<p>Return to Table of Contents</p>	<p>The study by Zito and colleagues¹ in this issue of THE JOURNAL on the use of psychotropic medications in very young children in 2 Medicaid programs and a managed care organization suggests that 1% to 1.5% of all children 2 to 4 years old enrolled in these programs currently are receiving stimulants, antidepressants, or antipsychotic medications. The authors also report that the prevalence of neuropsychopharmacologic interventions in this age group increased substantially during the last decade.</p>
<p>INTRODUCTION</p>	<p>This reported increased use of psychotropic drugs in very young children raises important questions. Are the findings aberrant? Are they consistent with evidence-based medicine? Is there a reason to be concerned about this new prescribing pattern?</p>
<p>AUTHOR/ARTICLE INFORMATION</p>	<p>Several recent studies provide additional evidence that the prescription of psychotropic drugs to very young children has increased during the last decade. In a review of information from the Intercontinental Medical Statistics Study, Minde² described a 3-fold increase in methylphenidate prescriptions in Canada and a 10-fold increase in the prescription of selective serotonin reuptake inhibitors in the United States for children 5 years old and younger between 1993 and 1997. This article also summarized findings from Strasbourg, France, showing that 12% of children beginning school were receiving psychotropic medications, primarily phenothiazines, and that 76% of these commenced treatment by their fourth year of life.</p>
<p>REFERENCES</p>	<p>In an analysis of Michigan Medicaid claims, Rappley et al³ identified 223 children aged 3 years or younger who received the diagnosis of attention-deficit/hyperactivity disorder, the majority of whom had significant comorbid conditions. While only a quarter of these children received psychological services, nearly 60% received psychotropic medications, and almost half of these were prescribed 2 or more psychotropic medications. Thus, the findings of Zito et al¹ and Rappley et al³ appear to identify an important change in psychotropic drug prescribing practices for very young children. As 3 of the 4 data sets are derived from Medicaid populations, the findings suggest that poor children are experiencing these changes in drug prescribing practices, but additional investigation in other populations is required.</p>
<p>INTRODUCTION</p>	<p>It should be emphasized that most of the drugs prescribed involve off-label use because efficacy of psychotropic drugs has not been demonstrated in very young children. As noted by Greenhill,⁴ methylphenidate, the most commonly prescribed drug in these studies, carries a warning against its use in children younger than 6 years. Furthermore, the validity and reliability of the diagnosis of</p>
<p>AUTHOR/ARTICLE</p>	

INFORMATIONREFERENCES

years. Furthermore, the validity and reliability of the diagnoses of attention-deficit/hyperactivity disorder, mood disorders, and schizophrenia in very young children have not been demonstrated.

To ascertain whether the prescribing practices documented by these recent reports represent informed practice, I surveyed the editorial board (48 physicians) of the *Journal of Child and Adolescent Psychopharmacology* by facsimile about their prescribing of stimulants, clonidine, antidepressants, and antipsychotics for 2- to 4-year-old children (unpublished data, November 24, 1999). The board consists of expert clinicians and clinical researchers who are likely to treat the most difficult cases. Seventy-two percent of the physician board members responded. Most (28 of 35) reported either no use or very rare prescribing of these medications in this age group, and only 3 reported prescribing clonidine on rare occasions. The few positive responses generally were associated with the description of use of these drugs for severe, intractable cases such as the management of children with severe self-injurious behavior. The rarity of the use of psychotropic medications in very young children reported by experts in pediatric psychopharmacology suggests that they are much more reticent than the physicians treating the children in these studies.

Since there is virtually no clinical research on the consequences of pharmacologic treatment of behavioral disturbances of very young children, is there a basis for concern about these prescribing practices? Early childhood is a time of tremendous change for the human brain. Visual processing, language, and motor skills are acquired during this sensitive period.⁵ The cortical synaptic density reaches its maximum at the age of 3 years and is substantially modified by pruning during the next 7 years.⁶ At the same time, the cerebral metabolic rate peaks between 3 and 4 years of age.⁷

Studies in experimental animals indicate that the aminergic systems that are the target of action of these psychotropic medications play an important role in neurogenesis, neuron migration, axonal outgrowth, and synaptogenesis.⁸ In this regard, it has been shown that depletion of serotonin in the preweanling rat results in a persistent decrease in cortical synaptic density and in memory deficits in adulthood.⁹ Perinatal treatment of rats with an antipsychotic drug results in a long-standing abnormality in dopamine receptor function and altered levels of dopamine and norepinephrine in adulthood.¹⁰ Thus, it would seem prudent to carry out much more extensive studies to determine the long-term consequences of the use of psychotropic drugs at this early stage of childhood.

Given that there is no empirical evidence to support psychotropic drug treatment in very young children and that there are valid concerns that such treatment could have deleterious effects on the developing brain, the reasons for these troubling changes in practice need to be identified. Unfortunately, the study by Zito et al¹ does not provide the diagnoses of the children or the professional identities or specialties of the prescribers, which could shed some light on the reason for these prescribing patterns. One possible contributing factor is the way mental health services are provided to children. For example, many state Medicaid programs now provide quite limited reimbursement for the evaluation of behavioral disorders in children and preclude more than 1 type of clinical evaluator per day. Thus, the multidisciplinary clinics of the past that brought together pediatric, psychiatric, behavioral, and family dynamic expertise for difficult cases have largely ceased to exist. As a consequence, it

INTRODUCTIONAUTHOR/ARTICLE
INFORMATIONREFERENCES

appears that behaviorally disturbed children are now increasingly subjected to quick and inexpensive pharmacologic fixes as opposed to informed, multimodal therapy associated with optimal outcomes.¹¹ These disturbing prescription practices suggest a growing crisis in mental health services to children and demand more thorough investigation.

Author/Article Information

Author Affiliation: Departments of Psychiatry and Neuroscience, Harvard Medical School, Boston, Mass.

Corresponding Author and Reprints: Joseph T. Coyle, MD, Department of Psychiatry, Harvard Medical School, 115 Mill St, Belmont, MA 02478 (e-mail: joseph_coyle@hms.harvard.edu).

Editorials represent the opinions of the authors and THE JOURNAL and not those of the American Medical Association.

REFERENCES

1. Zito JM, Safer DJ, dosReis S, Gardner JF, Boles M, Lynch F. Trends in the prescribing of psychotropic medications to preschoolers. *JAMA*. 2000;283:1025-1030. [ABSTRACT](#) | [FULL TEXT](#) | [PDF](#) | [MEDLINE](#)
2. Minde K. The use of psychotropic medications in preschoolers: some recent developments. *Can J Psychiatry*. 1998;43:571-575. [MEDLINE](#)
3. Rappley MD, Mullan PB, Alvarez FJ, Eneli IU, Wang J, Gardner JC. Diagnosis of attention-deficit/hyperactivity disorder and use of psychotropic medication in very young children. *Arch Pediatr Adolesc Med*. 1999;153:1039-1045. [ABSTRACT](#) | [FULL TEXT](#) | [PDF](#) | [MEDLINE](#)
4. Greenhill LL. The use of psychotropic medication in preschoolers: indications, safety, and efficacy. *Can J Psychiatry*. 1998;43:576-581. [MEDLINE](#)
- 5.

[INTRODUCTION](#)

[AUTHOR/ARTICLE INFORMATION](#)

[REFERENCES](#)

[INTRODUCTION](#)

[AUTHOR/ARTICLE INFORMATION](#)

[REFERENCES](#)

Harris JW.
Developmental Neuropsychiatry.
Vol 1. New York, NY: Oxford University Press; 1995.

6.
Huttenlocher PR.
Morphometric study of human cerebral cortex development.
Neuropsychologia.
1990;28:517-527.
[MEDLINE](#)

7.
Chugarii HT, Phelps ME, Mazziotta JC.
Positron emission tomography study of human brain functional development.
Ann Neurol.
1987;22:487-497.
[MEDLINE](#)

8.
Coyle JT.
Biochemical development of the brain: neurotransmitters and child psychiatry.
In: Popper C, ed. *Psychiatric Pharmacosciences of Children and Adolescents*. Washington, DC: American Psychiatric Press; 1997:3-25.

9.
Mazer C, Muneyyirci J, Tahney K, Raio N, Borella A, Whitaker-Azmitia P.
Serotonin depletion during synaptogenesis leads to decreased synaptic density and learning deficits in the adult rat: a possible model of neurodevelopmental disorders with cognitive deficits.
Brain Res.
1997;760:68-73.
[MEDLINE](#)

▲
[INTRODUCTION](#)

[AUTHOR/ARTICLE INFORMATION](#)

[REFERENCES](#)
▼

10.
Rosengarten H, Friedhoff AJ.
Enduring changes in dopamine receptor cells of pups from drug administration to pregnant and nursing rats.
Science.
1979;203:1133-1135.
[MEDLINE](#)

11.
The MTA Cooperative Group.
A 14-month randomized clinical trial of treatment strategies for attention-deficit/hyperactivity disorder.
Arch Gen Psychiatry.
1999;56:1073-1086.
[ABSTRACT](#) | [FULL TEXT](#) | [PDF](#) | [MEDLINE](#)

© 2000 American Medical Association. All rights reserved.



JAMA

SHORT CUT:

Choose Journal



**Changing Lives - One Child at a Time
Building Bridges Between Families and Schools**

Home Page	Special Education Rules	IEP Issues	Early Intervention	Home Schooling
About CAUSE	PAC/SEAC News	Disability Topics	School Climate	Charter & Private
Workshop Calendar	Ask the Advocate	Legal Research	Cultural Issues	College Info
Request a Workshop	Book/Video Reviews	Section 504	Community Living	Kids & Teens
Conference Calendar	Inspiring Stories	Juvenile Justice	Science News	Summer Camp
State & National Links	Shop Online	New Legislation	Wraparound	Prof. Development
General Ed Reform	Online Surveys	Contact Your Legislator	Child Care	Contests/Job Listings
Parenting/Adoption Support	Statistics	Medicare/Medicaid/SSI/FSS	Insurance	Child Protective Svcs.

Last Updated 02/24/02

[Contact Us](#) - [Daily Updates](#) - [Search](#)

Translate [汉语](#) - [ترجم](#) - [العربية](#) - [فارسی](#) - [हिन्दी](#) - [فارسی](#) - Traducen

[Subscribe me to the CAUSE News Digest!](#)

Article of Interest - Medication

Take me to...

"Ritalin Bill is response to pressure on parents"
Some say it'll inhibit teachers from discussing child concerns
by Julie Ross, Detroit Free Press, December 24, 2001

It wasn't the mention of her son's fidgeting that surprised Jody Daniels so much.

She expected the teacher at his kindergarten screening test last year to note his squirming and repetitive kicking. Daniels already suspected her son might have attention deficit disorder, and because his birthday was so near the kindergarten registration cutoff date, she had held him back a year so he could mature.

During that year, Daniels researched the disorder and its most commonly prescribed medication -- Ritalin -- and decided not to have her son tested or medicated.

What shocked the Wyandotte resident was the teacher's reaction to her decision.

"She asked, 'What do you mean you're not going to do it?' " Daniels said recently. "I felt this pressure. I left there in tears."

According to several Michigan legislators, it's a common occurrence.

That's why state Rep. Susan Tabor, R-Lansing, introduced legislation last summer that's become known as the Ritalin Bill. It would ban teachers from recommending psychotropic drugs -- essentially Ritalin -- to parents. Connecticut and Minnesota passed similar laws this year.

"There have been situations where teachers have said, 'We think your daughter has ADD and should be on Ritalin,' " Tabor said. "They shouldn't be making that call."

Tabor's measure is part of a four-bill package that passed the House last month and awaits consideration by the Senate's Education Committee, possibly in January.

Originally, the bill went so far as to restrict teachers from discussing a child's behavior with the parent.

"That would have made parent-teacher conferences real interesting," said Louise Somalski, a Lansing-based legislative coordinator with the Michigan Federation of Teachers.

As the bill stands now, teachers would be allowed to discuss behavior and to recommend that a child visit a physician. Teachers would not, however, be able to specifically say a child has ADD or that the child should be on Ritalin.

The teachers federation is neutral about the bill, Somalski said.

But some legislators say it may prevent teachers from having open discussions with parents.

"I just think that the bill will tie the hands of teachers," said Rep. Irma Clark, D-Detroit, a former president of the Detroit Board of Education who voted against the House bill. "It says teachers cannot even discuss with parents the fact that the child might need Ritalin. I don't want our teachers being so strapped to where they'd be afraid to even talk to parents."

Another portion of the Ritalin package would create a 15-member advisory council to investigate psychotropic drugs and recommend policies regarding their use by children.

The council would include members of the Department of Community Health, the Department of Consumer and Industry Services and the Department of Education. It also would include a physician, a psychologist, a psychiatrist, a special education teacher, a general education teacher, a school principal, a school counselor, a school psychologist, a school nurse, a social worker and two parents.

The council would hold public hearings and compile a report.

Another portion of the legislative package would require the Department of Community Health to distribute information about psychotropic drugs.

Somalski said the teachers group supports both of those bills.

"We're always looking for professional development opportunities," she said. Because Ritalin "is so prevalent, it's always good to have our members aware of what behaviors to look for and what to do."

Sherry Feldman, who teaches fourth grade at Brooklands Elementary School in Rochester Hills, has heard stories of teachers recommending Ritalin to parents, but said the key for teachers is knowing what to say.

"My policy is there is very special language you can use without mentioning drugs," she

said. "I don't believe we should be recommending that. But there are ways to say to a parent, 'I would suggest you see a doctor.' "

Daniels said it wasn't the words her son's would-be teacher used that upset her as much as the pressure to put him on medication. She was so distraught after the initial kindergarten assessment that she didn't enroll him in their neighborhood Wyandotte school. Instead, she drives 40 minutes daily to shuttle him to a charter school in Flat Rock.

Daniels said she fears teachers who would prefer to have a quiet, orderly class would have labeled him with attention deficit disorder from the onset and been more strict about his behavior.

"He may be ADD or ADHD, but I think he's MCTTSA -- more creative than the system will allow," she said.

Contact JULIE ROSS at 313-223-4534 or ross@freepress.com.

Visit CAUSE online for Special Education News, Disability Information and Updates at <http://www.causeonline.org> or receive a weekly summary of updates by subscribing to the CAUSE news digest by visiting <http://www.causeonline.org/CAUSEnewsSubscribe.htm>.

CAUSE reprints articles of interest for our members and others. CAUSE does not necessarily endorse the views expressed. We welcome your comments.



DONATE NOW through

CAUSE, 2365 Woodlake Drive, Ste. 100, Okemos, Michigan 48864

Contact Us Phone: 517/706-CAUSE (2287) Toll Free: 800/221-9105 Fax: 517/347-1004

This project is generously funded through grants from the United States Department of Education (#H029M970018), the Michigan State Department of Education, the Skillman Foundation, and other private and public sources. Opinions expressed herein do not necessarily reflect the opinions of our funders. CAUSE is a 501(c)(3) organization and contributions to it are tax deductible. Disclaimer



ATTENTION DEFICIT DISORDER: A DUBIOUS DIAGNOSIS?

- [Purchase this program](#) | [Transcript](#)
- [CHADD \(Children and Adults with Attention Deficit Disorder\)](#)
- [An interview with: Stanley Greenspan, M.D.](#)
- ["Ritalin Ain't the Answer" by Matt Scherbel](#)
- [Books/Organizations](#)

Strong evidence indicates that the epidemic of Attention Deficit Disorder affecting mostly white, middle class boys is to a large extent man-made, one result of a long-term, unpublicized financial relationship between the company that makes the most widely known A.D.D. medication and the nation's largest "A.D.D. Support Group." That case is made in our documentary, "A.D.D.-A Dubious Diagnosis?"

No question that A.D.D. is spreading, along with the use of powerful psychostimulants. The number of children being medicated-now an estimated 2,000,000-seems to be doubling every two years.

In preparing our documentary, we heard time and again that Ritalin is "all over the schools." Recovering drug addicts told us that Ritalin was becoming what's called a "gateway drug," the first drug a child tries. And addicts told us that some teenagers snort Ritalin for a quick, cheap (but dangerous) high.

**Quick? Yes, because Ritalin is a stimulant.
Cheap? Yes, because parents pay the bill.**

Dangerous? Yes, powerful enough to kill. The federal Drug Enforcement Administration reports that a Virginia teenager died from snorting Ritalin. We hope our documentary and this guide will help parents and educators find alternatives to unnecessary labels and powerful drugs-like smaller classes, more interesting curricula, and more personal attention at home and in school.

-John Merrow

CHADD (Children and Adults with Attention Deficit Disorder)

Thousands of parents turn to A.D.D. "support groups" for information and help. They expect that the information will be accurate, unbiased and complete. The largest of these support groups is CHADD, Children and Adults with Attention Deficit Disorder.

As we report in "Attention Deficit Disorder: A Dubious Diagnosis?", many parents do not know that CHADD has for years been receiving large sums of money from the maker of Ritalin, Ciba-Geigy.

Here is some of what CHADD's literature tells parents, along with information it doesn't present.

CHADD SAYS:

"Psychostimulant medications are not addictive."

WHAT'S NOT SAID:

Methylphenidate and Ritalin are nearly identical to amphetamine- otherwise known as "speed". The federal Drug Enforcement Administration puts methylphenidate in the same class of drugs as morphine and codeine- drugs with legitimate medical application, but a high potential for abuse. Withdrawal effects (agitation, marked anxiety, and tension) from psychostimulants are common, and many doctors recommend tapering the dosage before discontinuing medication.

CHADD SAYS:

"The most likely cause of A.D.D. is a chemical imbalance or deficiency in certain chemicals in the brain that are located in the area responsible for attention and activity."

WHAT'S NOT SAID:

CHADD bases this claim on a 1990 study by Dr. Alan Zametkin of the National Institutes of Health (NIH), which found slightly lower levels of glucose metabolism in the brains of adults diagnosed with hyperactivity. Not mentioned by CHADD are the succeeding attempts* to replicate those results in children. Dr. Zametkin's later studies found "no

statistically significant differences" between the brains of normal children and children diagnosed with A.D.H.D. The root cause of the disorder remains unknown.

*Brain Metabolism in Teenagers With ADHD" (Arch. Gen. Psychiatry, Vol. 50, May 1993) and "Reduced Brain Metabolism in Hyperactive Girls" (J. Am. Acad. Child Adolesc. Psychiatry, 33: 6, July/August 1994)

CHADD SAYS:

"Emotional difficulties, including substance abuse, are more likely to occur when a child with A.D.D. is not treated."

WHAT'S NOT SAID:

There are no conclusive studies showing that treatment of A.D.D. reduces the risk of drug abuse. Even Ciba-Geigy's chief physician declined to support CHADD's assertion.

CHADD SAYS:

"Medication is not used to control behavior-medication is used to improve the symptoms of A.D.D."

WHAT'S NOT SAID:

The symptoms of A.D.D. outlined by the American Psychiatric Association (fidgets with hands or feet or squirms in seat, has difficulty remaining seated when required to do so, is easily distracted by extraneous stimuli, etc.) are all behavioral. Medication is used to help control these symptoms. Controlling behavior and improving the symptoms of A.D.D. are one and the same.

CHADD SAYS:

"Between 70-80% of children respond positively to these (psycho-stimulant) medications."

WHAT'S NOT SAID:

Research suggests that medication may not be so effective a treatment. Dr. James Swanson, Director of the Child Development Center at the University of California, has written: "...the short term effects of stimulants on academic performance are minimal compared to the effects on

behavior, and there is no evidence of beneficial effects on learning or academic achievement."*

*"Treatment of A.D.D.: Beyond Medication" (Beyond Behavior, Fall 1992/Vol. 4 No,1)

CHADD SAYS:

"Hundreds of studies on thousands of children have been conducted regarding the effects of psycho-stimulant medications. Relatively few long term side effects have been identified."

WHAT'S NOT SAID:

Hundreds of studies on stimulant medications have been conducted, but few have looked at long term side effects. Measuring the long term effects of pediatric medications is prohibitive because of legal and ethical dilemmas surrounding the use of children as test subjects. The federal Food and Drug Administration labeling for Ritalin includes the specific warning "Sufficient data on the safety and efficacy of long term use of Ritalin in children are not yet available."

The Experts

An interview with: **Stanley Greenspan, M.D.**

In the process of putting together "Attention Deficit Disorder: A Dubious Diagnosis?," we spoke with Dr. Stanley Greenspan, the child psychiatrist and author of *The Challenging Child*. Greenspan writes that many attention problems result from the way children process visual, auditory, motor, and spatial information, but these are often misdiagnosed as A.D.D.

DR. GREENSPAN: Many children who come in with attention problems in a general sense are actually having attention difficulties in one area but not another area. One little boy came in with mommy and daddy saying he never pays attention in school, but it turned out it was mostly during writing assignments. Talking to him one on one, he was very attentive. When he was examining things visually he was very attentive. It was only when he had to write things that he became inattentive. There were a lot of writing assignments in school, so he looked inattentive during a good deal of the day. Once we found out the primary challenge, we worked on

his being able to write more effectively...and that helped him out

Q- Is medication the only approach to treatment?

DR. GREENSPAN: There are many ways to help a child with attention problems. One is to shore up the area that's vulnerable; like writing skills or looking skills or listening skills, or the way the child reacts to sensations by getting overloaded. Another approach is using medication along with therapy to help the child cope better and deal with the challenges they face, but if you don't diagnose the particular problem you're not going to know which approach is the most effective for the child.

Q- How can parents tell if they're getting a proper diagnosis?

DR. GREENSPAN: Ideally, the parents come in first and talk to the clinician about what their concerns are, what they worry about, what's going on at school, what's going on at home, and what their main worries about the child are. Then the clinician should do a careful review of the child's functioning in all areas. There should be a careful developmental history, tracing that child's development from infancy, including the pregnancy and delivery up through the current age.

Q-Is that what usually happens?

DR. GREENSPAN: Sometimes children aren't seen for long enough periods of time on their own. Instead of being seen for a whole 45 minute session they are seen for 10 or 15 minutes. Instead of being observed interacting with their parents, sometimes young children are just provided with a standardized battery of tests. Sometimes family function isn't gone into in as much depth as it should. So it doesn't always occur the way it ought to occur.

Q- What's the cost of misdiagnosis and mistreatment?

DR. GREENSPAN: If you don't formulate the proper intervention, then the child's psychological coping capacity won't develop as optimally as it could. As the child gets along in life, he won't function- either as a parent rearing children, as a worker out on the job, or as a citizen. We are robbing our country of the kind of wisdom it's going to need in the future.

"Ritalin Ain't the Answer"

by Matt Scherbel

Matt Scherbel was 14 and in the eighth grade at Thomas Pyle Middle School in Bethesda, MD, when he wrote this for his school newspaper, "The Pyle Print."

The system wasn't and still isn't made for the extremists. The perfect student isn't a genius; he only takes extra care and concern. A stupid kid obviously doesn't fit; he needs more time to learn to learn and special attention that the system doesn't like. No, the perfect student is a schmo. He only hands in what is asked of him, therefore no special praise. He's quiet and speaks not a word of his own mind.

Schools don't like extremists who like to think and question. They are the dreamers. That doesn't mean that they are wrong. They just don't fit the norm, so they are labeled and damned, labeled as A.D.D. (Attention Deficit Disorder).

So the doctors dope us up with Ritalin and control our minds with low doses of speed. The teachers pay us no mind until our minds are under control. It screws up our train of thought and makes us one-dimensional. We get headaches and almost depressed getting on and off it. It takes away extra imagination and flow of the mind, hence destroying the true, purest ideas of my mind. I can't think right, and for six hours of the day, I'm not me. I'm what the system would like me to be.

The schools should shape our education around our idiosyncratic minds, our quaint minds, our quirky minds, our crackpot minds, our curious minds. Where would we be without eccentric people? We need them. The system should not shape our minds with dope and low doses of speed; the system should be shaped around us.

Ritalin does not help me learn; it simply lowers my mind down between the selected lines in which we are taught. Who's going to get further in life, the schmo with the same textbook answers and ideas, or the "A.D.D. kid" who can offer ideas that have never been thought of or a new perspective on something?

I truly look forward to the day when Ritalin isn't an answer. To the day when every student is labeled "learner."

BOOKS:

The U.S. Department of Education publishes a list of books about A.D.D. Copies of "Where do I turn?: A resource directory of materials about Attention Deficit Disorder" can be ordered through Eric Document Reproduction service (1.800.443.ERIC) Document #ED-370333.

In *The Challenging Child*, (New York, Addison Wesley, 1995) Psychiatrist Stanley Greenspan outlines numerous kinds of attention problems that stem from the way children process information. Greenspan believes a proper diagnosis is the first step to finding the correct treatment.

The War Against Children (New York, St. Martin's Press, 1994) by Dr. Peter Breggin and Ginger Ross Breggin takes a critical look at Ritalin and A.D.D. Other books by Dr. Breggin include *Toxic Psychiatry* and *Talking Back to Prozac.*, also published by St. Martin's Press.

In *The Myth of the ADD Child*, (New York, Dutton Press, 1995) Dr. Thomas Armstrong outlines 50 ways to improve a child's attention span without drugs or labels.

The Physician's Desk Reference, published by Medical Economic Data in Montevale, NJ. contains FDA- approved labeling information for Ritalin and other prescription drugs. The PDR can be found in most public libraries.

Dr. James Swanson Ph.D has published many scientific studies on stimulant medication for children. To learn what to expect from medication, read "Effect of Stimulant Medication on Children with Attention Deficit Disorder: A Review of Reviews", *Exceptional Children*, Vol. 60, no. 2, pp 154-162.

ORGANIZATIONS:**Children and Adults with Attention Deficit Disorder
(CHADD)**

CHADD
499 Northwest 70th Avenue, Suite 109
Plantation, FL. 33317

The nation's largest A.D.D. support group, CHADD publishes newsletters, fact sheets and educators' manuals. CHADD

presents itself as an impartial source of information for parents; only after we began our investigation did CHADD tell its members-in very general terms-about its financial support from Ciba-Geigy, Abbott Labs and Burroughs Wellcome, the makers of Ritalin, Cylert, and Dexedrine respectively.

The Center for The Study of Psychiatry

4628 Chestnut Street
Bethesda, MD 20814

Founded by Dr. Peter Breggin, the center describes itself as a research and educational network devoted to reform in psychiatry and to offering independent analyses of current psychiatric theories and practice. The center publishes newsletters and holds annual meetings for members.

The Feingold Association of the United States

PO Box 6550
Alexandria, VA 22306

Founded by Dr. Benjamin Feingold, this organization is committed to the belief that ADHD symptoms arise from artificial food additives and preservatives. It endorses a diet designed to lessen reactions that may create ADHD symptoms.

[[Home](#) | [Television](#) | [Radio](#) | [Sales info](#) | [Archives](#) | [About us](#) | [Feedback](#) | [PBS Online](#)]

Senate Bill 230

Psychotropic Drugs For Children

Sectional Analysis

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148



Session: (Jan. - May)
State Capitol, Suite 504
Juneau, AK 99801-1182
Phone: (907) 465-3822
Fax: (907) 465-3756
Toll free: (800) 770-3822

Senator Bettye Davis@legis.state.ak.us
<http://www.akdemocrats.org>

Senator Bettye Davis

Sectional Analysis Senate Bill 230

Section 1. Requires school boards to adopt policies restricting school personnel from recommending that a student be given psychotropic drugs.

Section 2. Technical amendment to accommodate the addition of AS 47.10.019(b) in sec. 3 of this bill.

Section 2. Prohibits a child from being considered to be a child in need of aid simply based on the refusal of the child's custodian to give psychotropic drugs to the child.

Senate Bill 230

Psychotropic Drugs For Children

Similar Legislation

Subject: Tomorrow's testimony on SB 230

Date: Mon, 4 Mar 2002 00:39:15 EST

From: WindWarner@aol.com

To: Senator_Lyda_Green@legis.state.ak.us

March 4, 2002

Testimony before the Alaska Health, Education, and Social Services Committee in support of Senate Bill 230, "An Act relating to recommending or refusing psychotropic drugs as a treatment for children and to the evaluation and treatment of children with behavioral or psychological problems."

From: Richard Warner, President
Citizens Commission on Human Rights of Seattle

This legislation represents a first step toward establishing clear limitations on the ability of state agencies to force parents to give normal children mind-altering drugs. The decision to give or not give a child such drugs must come only from the parent or guardian.

The drugging of children with psychotropic drugs is skyrocketing. Keep in mind, these psychiatric drugs have never been approved for use on children. The only exceptions are Ritalin and Paxil and they are not approved for children under six years old. And yet what do we find?

In November 1999, the U.S. Drug Enforcement Administration (DEA) warned about a record six-fold increase in Ritalin production between 1990 and 1995. The United States uses approximately 90% of the world's Ritalin.

A February 23, 2000 study in the Journal of the American Medical Association (JAMA) warned about the rapidly escalating psychiatric drugging of children. According to the study, "Stimulant treatment in preschoolers [2 - 4 years old] increased approximately 3-fold during the early 1990's." A survey by IMS Health, a company that measures drug usage for the pharmaceutical industry, found that the use of newer antidepressants like Prozac, Zoloft, Paxil, and Luvox on children less than 6 increased 580% between 1995 and 1999.

According to the Alaska Dept. of Education figures, the number of children in the disability category which includes ADD and ADHD (Other Health Impaired) increased by nearly 200% between December 1995 and December 2000. During that period total school enrollment increased approximately 7%.

According to the Drug Enforcement Agency, in the year 2000, methylphenidate (Ritalin) prescriptions in Alaska totaled 2,645 grams per 100,000 people. That's 529,000, 5 mg Ritalin tablets. And that is just one of many drugs being given to children.

Many states are responding to the escalating drugging of children by passing laws and regulations designed to control the labeling and drugging of children and to prevent state agencies from intimidating parents into putting their children on psychotropic drugs.

Last year both Connecticut and Minnesota passed laws barring schools from telling parents they must put their children on drugs and Minnesota and Utah passed laws preventing Child Protective Services from finding a parent guilty of neglect for refusing to drug their child. Arizona, California, Colorado, Iowa, Kentucky, Missouri, Michigan, New York, New Jersey, Utah, Washington, Wisconsin and Vermont have also introduced similar legislation.

A Utah bill which we support passed out of the House last week (66-4) and has been sent directly to the floor of the Senate for a vote. It will very

likely be passed this week. This bill prohibits teachers from recommending or requiring psychotropic drugs for a child or recommending psychiatric treatment or evaluation for a child.

The Utah bill also provides that the Division of Child and Family Services may not remove a child from his or her parents because the parents refuse to drug their child.

It is reasonable to suggest, and courts have ruled, that the state should not intervene in parents' decisions regarding medical treatment for their children when there is no clear consensus regarding the effectiveness and risks of a proposed treatment.

When the risks have been proven to be serious, as is the case with psychotropic drugs, and the diagnosis itself is in question, there is even more reason to clearly state the limits of state intervention.

Adverse reactions to these drugs listed in the Physician's Desk Reference include anorexia, nausea, dizziness, rapid heartbeat, cardiac arrhythmia, abdominal pain, and weight loss. Adverse reactions reported to the Food and Drug Administration include physiological problems such as liver disorders, blood disorders, and convulsions, including grand mal seizures, and mental and emotional reactions such as agitation, hostility, abnormal thinking, hallucinations, psychosis and personality disorders. There have been brain changes reported in various studies, including a 20-30% decrease in blood flow to all parts of the brain and cerebral atrophy - brain shrinkage.

The very diagnosis itself is apparently baseless. In 1998 the National Institutes of Health held the "NIH Consensus Development Conference on Diagnosis and Treatment of Attention Deficit Hyperactivity Disorder [ADHD]" to decide if there was a legitimate scientific basis for the diagnosis. The Conference's Consensus Statement stated, "we don't have an independent, valid test for ADHD; there are no data to indicate that ADHD is due to a brain malfunction; and finally after years of clinical research and experience with ADHD, our knowledge about the cause or causes of ADHD remains speculative."

In June 2000, the United States Supreme Court upheld a decision by the Washington State Supreme Court that hinged on parental rights. In the case, *Troxel v. Granville*, the court ruled,

Accordingly, so long as a parent adequately cares for his or her children (i.e., is fit), there will normally be no reason for the State to inject itself into the private realm of the family to further question the ability of that parent to make the best decisions concerning the rearing of that parent's children.

the Due Process Clause does not permit a State to infringe on the fundamental right of parents to make childrearing decisions simply because a state judge believes a "better" decision could be made.

This bill is an important step toward protecting parents and children. We do feel that this bill can be made much stronger and would suggest the Utah bill (House Bill 123) as a model.

Sincerely,

Richard Warner, President
Citizens Commission on Human Rights of Seattle
300 Lenora St., #B252
Seattle, WA 98121
(206) 283-1099 (office)
(206) 527-3501 (home)
email: windwarner@aol.com

Subject: SB 230 re psychotropic drugging of children

Date: Mon, 4 Mar 2002 00:07:36 EST

From: WindWarner@aol.com

To: Senator_Lyda_Green@legis.state.ak.us

Dear Senator Green,

I will be testifying tomorrow (Mar. 4) on a bill sponsored by Senator Bettye Davis, SB 230. This legislation relates to the drugging of children with psychotropic drugs for alleged behavioral disorders. I thought you should know that such legislation has been offered in many states and it is usually sponsored and pushed forward by Republicans. I am attaching a copy of a bill which just passed the House (66-4) in Utah (HB 123) and will go directly to the Senate floor to be voted on. It will most likely be passed by the Senate this week. It is a Republican bill and represents the efforts of a number of stakeholders including the schools, psychiatrists, medical board, representatives of the disability community, the National Alliance for the Mentally Ill, and the Utah Protection and Advocacy System. My testimony for tomorrow will follow in a separate email.

Sincerely,

Richard Warner, President
Citizens Commission on Human Rights of Seattle
300 Lenora St., # B252
Seattle, WA 98115
(206) 283-1099 (office)
(206) 527-3501 (home)
email: windwarner@aol.com

- 26 (ii) 20 U.S.C. Sec. 7101 et seq.;
 27 (iii) 29 U.S.C. Sec. 794; and
 28 (iv) 42 U.S.C. Sec. 12101 et seq.
 29 (2) Except as provided in Subsection (4) or (5), school personnel may not:
 30 (a) recommend to a parent or guardian that a child ~~h~~ [must] ~~h~~ take or ~~h~~ [must] ~~h~~ continue
 to
 30a take a
 31 psychotropic drug as a condition for attending school;
 32 (b) require that a child take or continue to take a psychotropic drug as a condition for
 33 attending school;
 34 (c) recommend that a parent or guardian seek or use any of the following:
 35 (i) the administration of any psychotropic medication to a child;
 36 (ii) a psychiatric ~~h~~ [] OR ~~h~~ psychological ~~h~~ [] or behavioral ~~h~~ treatment for a child; or
 37 (iii) a psychiatric ~~h~~ [] or behavioral health ~~h~~ evaluation of a child;
 38 (d) conduct a psychiatric or behavioral health evaluation of a child;
 39 (e) recommend a ~~h~~ [private] SPECIFIC ~~h~~ licensed physician, psychologist, or any other
 39a health specialist
 40 to a parent or guardian for a child; or
 41 (f) make a child abuse or neglect report to authorities, including the Division of Child and
 42 Family Services, solely on the basis that a parent or guardian refuses to consent to:
 43 (a) the administration of a psychotropic drug to a child;
 44 (b) a psychiatric, psychological, or behavioral treatment for a child; or
 45 (c) a psychiatric or behavioral health evaluation of a child.
 46 (3) Nothing in this section may be construed to restrict school personnel from:
 47 (a) communicating information between school personnel regarding a child; ~~h~~ [or] ~~h~~
 48 (b) informing a child's parent or guardian of a perceived behavioral problem of the child,
 49 provided that:
 50 (i) an assertion or recommendation is not made in violation of Subsection (2); and
 51 (ii) an attempt is not made to denigrate, criticize, or punish a parent, guardian, or child for
 52 a decision made by the parent or guardian for the child to take, not take, or discontinue to take a
 53 psychotropic drug ~~h~~ [] ; OR ~~h~~
 53a ~~h~~ [~~h~~ (c) EXERCISING THEIR AUTHORITY RELATING TO THE READMISSION OF A CHILD
 53b ~~WHO HAS BEEN SUSPENDED OR EXPELLED FOR A VIOLATION OF SECTION 53A-11-964, ~~h~~]~~
 53c (c) EXERCISING THEIR AUTHORITY RELATING TO THE PLACEMENT WITHIN THE SCHOOL
 53d OR READMISSION OF A CHILD WHO MAY BE OR HAS BEEN SUSPENDED OR EXPELLED FOR A

02-26-02 11:48 AM

4th Sub. (Green) H.B. 123

53e VIOLATION OF SECTION 53A-11-904. h

54 (4) Notwithstanding Subsections (2)(c) and (d), a ~~licensed mental health professional~~
55 ~~employed by a school~~ MENTAL HEALTH PROFESSIONAL ACTING IN ACCORDANCE WITH TITLE 58,
55a CHAPTER 60. MENTAL HEALTH PROFESSIONAL PRACTICE ACT. WORKING WITHIN THE SCHOOL
55b SYSTEM ~~h~~ may, for the sole purpose of complying with federal education law:
56 (a) recommend, but not require, a psychiatric or behavioral health evaluation of a child;

57 (b) recommend, but not require, psychiatric, psychological, or behavioral treatment for a
58 child; and

59 (c) conduct a psychiatric or behavioral health evaluation of a child with the consent of the
60 child's parent or guardian.

61 (5) Notwithstanding Subsection (2)(e), a school district may make available to an
62 interested parent or guardian a list of community resources, which may include mental health
63 services, provided that the list conspicuously states the following:

64 "This list is provided as a resource to you. The school neither recommends nor requires
65 that you use this list or any of the services provided in it. It is for you to decide what services, if
66 any, to access and from whom you wish to obtain them."

67 (6) A local school board shall adopt a policy that indicates that a violation of this section
68 is cause for disciplinary action under Section 53A-8-104.

69 Section 2. Section 78-3a-301 (Subsection (1)(m) is repealed 07/01/02) is amended to
70 read:

71 **78-3a-301 (Subsection (1)(m) is repealed 07/01/02). Removing a child from his home**
72 **-- Grounds for removal -- Exigent circumstances.**

73 (1) The Division of Child and Family Services may not remove a child from the custody
74 of his natural parent unless the division complies with the provisions of Title 62A, Chapter 4a,
75 Child and Family Services, including Subsections 62A-4a-103(2)(b) and 62A-4a-201(3), and
76 unless there is substantial cause to believe that any one of the following exist:

77 (a) there is a substantial danger to the physical health or safety of the minor and the minor's
78 physical health or safety may not be protected without removing him from his parent's custody.
79 If a minor has previously been adjudicated as abused, neglected, or dependent, and a subsequent
80 incident of abuse, neglect, or dependency has occurred involving the same alleged abuser or under
81 similar circumstance as the previous abuse, that fact constitutes prima facie evidence that the child
82 cannot safely remain in the custody of his parent;

83 (b) a parent engages in or threatens the child with unreasonable conduct that causes the
84 minor to suffer emotional damage and there are no reasonable means available by which the
85 minor's emotional health may be protected without removing the minor from the custody of his
86 parent;

87 (c) (i) the minor or another minor residing in the same household has been physically or

88 sexually abused, or is deemed to be at substantial risk of being physically or sexually abused, by
89 a parent, a member of the parent's household, or other person known to the parent.

90 (ii) For purposes of this Subsection (1)(c), another minor residing in the same household
91 may not be removed from the home unless that minor is deemed to be at substantial risk of being
92 physically or sexually abused as described in Subsection (1)(c)(i) or (iii).

93 (iii) If a parent has received actual notice that physical or sexual abuse by a person known
94 to the parent has occurred, and there is evidence that the parent failed to protect the child by
95 allowing the child to be in the physical presence of the alleged abuser, that fact constitutes prima
96 facie evidence that the child is at substantial risk of being physically or sexually abused;

97 (d) the parent is unwilling to have physical custody of the child;

98 (e) the minor has been left without any provision for his support;

99 (f) a parent who has been incarcerated or institutionalized has not or cannot arrange for
100 safe and appropriate care for the minor;

101 (g) a relative or other adult custodian with whom the minor has been left by the parent is
102 unwilling or unable to provide care or support for the minor, the whereabouts of the parent are
103 unknown, and reasonable efforts to locate him have been unsuccessful;

104 (h) the minor is in immediate need of urgent medical care;

105 (i) (i) a parent's actions, omissions, or habitual action create an environment that poses
106 a threat to the child's health or safety; or

107 (ii) a parent's action in leaving a child unattended would reasonably pose a threat to the
108 child's health or safety;

109 (j) (i) the minor or another minor residing in the same household has been neglected; and

110 (ii) for purposes of Subsection (j)(i), another minor residing in the same household may
111 not be removed unless that minor is deemed to be at substantial risk of being neglected;

112 (k) an infant has been abandoned, as defined in Section 78-3a-313.5;

113 (l) the parent, or an adult residing in the same household as the parent, has been charged
114 or arrested pursuant to Title 58, Chapter 37d, Clandestine Drug Lab Act, and any clandestine
115 laboratory operation, as defined in Section 58-37d-3, was located in the residence or on the
116 property where the child resided; or

117 (m) the child's welfare is otherwise endangered, as documented by the caseworker. This
118 Subsection (1)(m) is repealed on July 1, 2002 unless further authorized by the Legislature.

119 (2) The Division of Child and Family Services may not remove a minor from the custody
120 of his parent solely on the basis of educational neglect.

121 (3) The Division of Child and Family Services may not remove a minor from the custody
122 of his parent solely on the basis of mental illness of the parent in the absence of one of the factors
123 described in Subsection (1).

124 (4) The Division of Child and Family Services may not initiate an investigation or remove
125 a minor from the custody of his parent on the basis of the refusal of the parent to **SOLELY** to
125a consent to:

126 (a) the administration of a psychotropic drug to a child;

127 (b) a psychiatric, psychological, or behavioral treatment for a child; or

128 (c) a psychiatric or behavioral health evaluation of a child.

129 [~~(4)~~] (5) The Division of Child and Family Services shall comply with the provisions of
130 Section 62A-4a-202.1 in effecting removal of a child pursuant to this section.

131 [~~(5)~~] (6) (a) A minor removed from the custody of his natural parent under this section may
132 not be placed or kept in a secure detention facility pending court proceedings unless the minor is
133 detainable based on guidelines promulgated by the Division of Youth Corrections.

134 (b) A minor removed from the custody of his natural parent but who does not require
135 physical restriction shall be given temporary care in:

136 (i) a shelter facility; or

137 (ii) an emergency kinship placement in accordance with Section 62A-4a-209.

FISCAL NOTE

STATE OF ALASKA
2002 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: SB 230
 () Publish Date: _____

Revision Date/Time (Note if correction): _____ Dept. Affected: EED
 Title Psychotropic Drugs for Children BRU Teaching and Learning Support
 Component Special & Supplemental Services
 Sponsor Davis
 Requester S HES Component No. 166

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						
-----------------------------	--	--	--	--	--	--

CHANGE IN REVENUES ()						
-------------------------------	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2002) cost: 0.0
 Check this box (X) if funding for this bill is included in the Governor's FY 2003 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

This bill would prevent school personnel from recommending the use of psychotropic drugs for students demonstrating emotional or behavioral concerns. It also requires that if school personnel perceive that a student may have a behavioral or psychological problem, a letter be sent to the parent recommending an appropriate medical or behavioral evaluation. The bill's sponsor has indicated that the bill will not prevent appropriately trained school personnel, such as school psychologists or school nurses, from discussing factors related to medication with parents as part of their normal duties. While no expense is expected for the department since no additional duties are required for departmental staff, the requirement of a letter will have some fiscal impact on local school districts.

Prepared by: Greg Maloney, Special Education Administrator Phone 465-2972
 Division Teaching and Learning Support Date/Time 3/1/02 4:56 PM
 Approved by: Ed McLain, Deputy Commissioner of Education Date 3/1/2002
 Agency Department of Education & Early Development

ALASKA STATE LEGISLATURE

Senate
Health, Education &
Social Services
Committee

Senate
Labor & Commerce
Committee

Senate
State Affairs
Committee



SENATOR BETTYE DAVIS

While in Session
State Capitol
Juneau, Alaska 99801
(907) 465-3822
Fax: (907) 465-3756

While in Anchorage
716 West 4th Ave.
Anchorage, Alaska 99501
(907) 269-0144
fax: (907) 269-0148

Senate Bill SB 230

"An Act relating to recommending or refusing psychotropic drugs as a treatment for children and to the evaluation and treatment of children with behavioral or psychological problems."

Sponsor Statement

The use of psychiatric drugs in our nation's schools has more than doubled in the first half of the last decade and continues to escalate. There are documented incidences of highly negative consequences in which psychiatric prescription drugs have been utilized for what are essentially problems of discipline, which may be related to a variety of causation. There is also parental concern regarding the issue of diagnosis and medication and their impact on student achievement.

In recognition of the importance that only physicians should make psychiatric diagnoses of behavioral problems, recommend psychiatric screening for specific behavioral problems, and suggest the use of psychiatric medication for a student, this bill would require school boards to adopt policies on recommendations that a student be given psychotropic drugs. It would also prohibit a child from being considered a child in need of aid or taken into state custody based on the refusal of the child's custodian to give psychotropic drugs to the child.

SPONSOR STATEMENT

