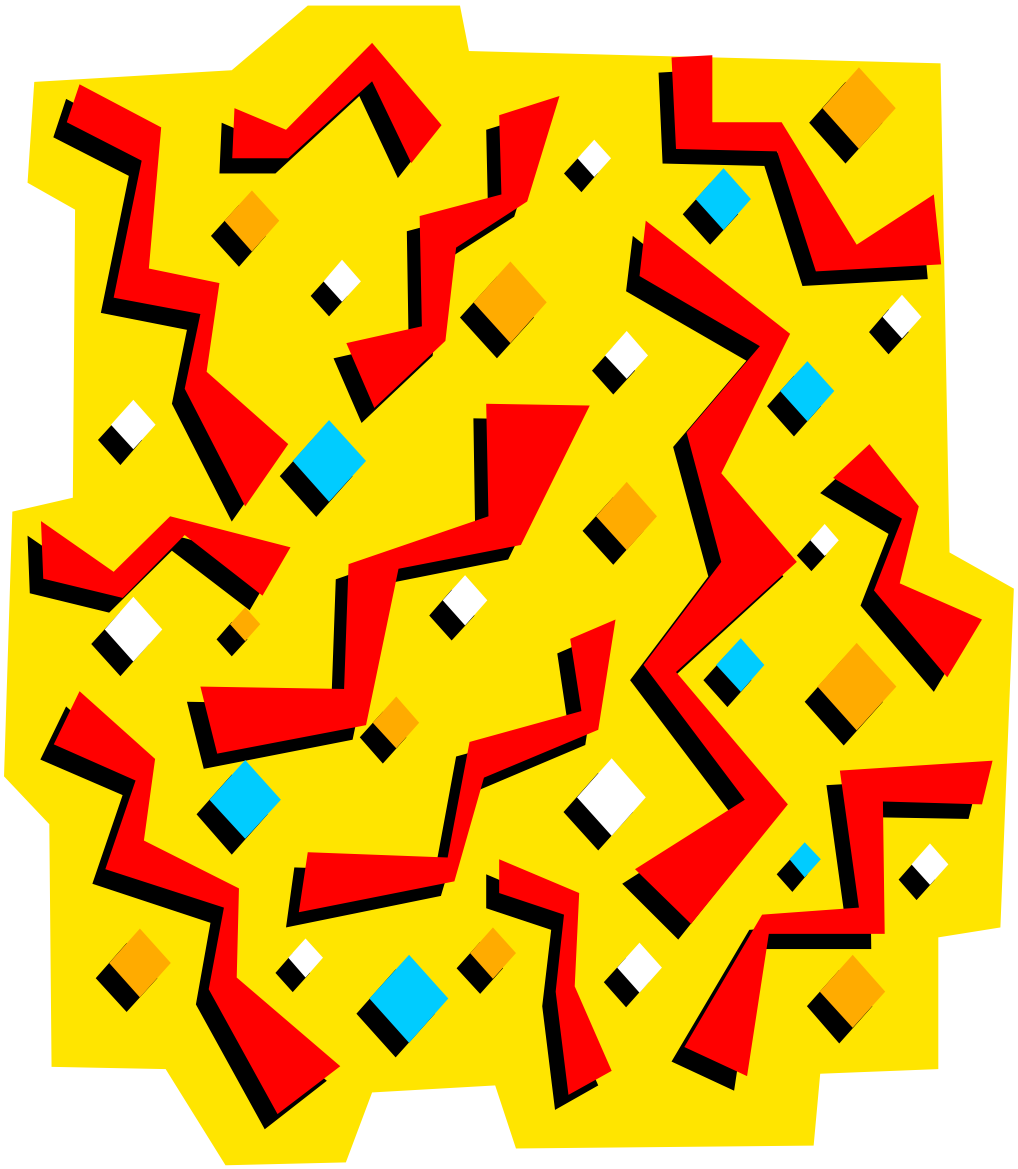

QUEENSLAND CHILDREN AT RISK:

The Over Diagnosis of "ADHD" and the Overuse of Stimulant Medication

Bob Jacobs, Psy.D.

August, 2002

youth affairs network qld

"Working together to improve the quality of life of young people in Queensland and thereby improve the quality of life of society."

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The Overdiagnosis of "ADHD" and the Overuse of Stimulant Medication

YOUTH AFFAIRS NETWORK OF QUEENSLAND
Bob Jacobs, Psy.D.
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Dexamphetamine and methylphenidate (Ritalin) are central nervous system stimulants listed in Schedule 8 of the *Poisons List* and subject to the requirements of the *Poisons and Therapeutic Goods Act 1996*.[1]

> John is a 5-year old boy who was diagnosed as having Attention Deficit Hyperactivity Disorder (ADHD) when he was 3 and ½. He took Ritalin for many months until his mother became alarmed about his severe weight loss, and since he has been given "trials" with several different types of stimulant medication, including dexamphetamine.
>
> John was born at 28 weeks gestation and had significant neo-natal health problems. He had difficulty sleeping, and has continued to have problems sleeping. Not surprisingly, John was very difficult for his young mother to deal with. His father did not want any part of John and quickly withdrew from him. Marital conflict escalated. By the time John was 3 and ½ practically the only time Mom wasn't fighting with Dad was when she was disciplining John. Virtually the only interaction John had with Dad was when Dad was disciplining John. John learned in his dysfunctional family that he could temporarily stop the fighting AND get desperately needed attention from his Dad by misbehaving. John was trying to get his needs met.
>
> Frustrated, John's Mom took him to see their physician complaining that John didn't listen, didn't sleep and was very active. The physician did not say that there was marital conflict that needed to be addressed. The physician did not say that John's Dad needed to be more involved with his son. The physician did not say John was reacting normally to a very bad situation that wasn't his fault. The physician said that this 3 and ½ year old boy was sick; he had a disease called ADHD and needed to take stimulant medication. The physician admitted he didn't have any "proof"; in fact, that he didn't even know what caused ADHD. But he put John on stimulants nonetheless.
>
> Mom was happier, because John was much more docile and compliant. Dad was happier because he could completely withdraw and concentrate on John's younger sibling, with whom he got along well. John's baby sitters were happy with his improved compliance, and when he starts school his teachers will be happier, too. The physician was happy, because he had another "satisfied customer" and John would come back periodically for med checks. The drug companies manufacturing stimulants, and the pharmacies selling them, were VERY happy because they could add to their amazing profits. But there was a victim in all this. The victim was John, an innocent little boy.
>
> By age 5 John already has experienced deficits in growth, and may never attain the same growth he might have without the stimulants. Who knows

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[1] New South Wales Commission for Children and Young People. (2002). *Inquiry Into The Use of Prescription Drugs and Over-The-Counter Medications in Children and Young People,* Issue Paper No. 5: The Use of Prescription Drugs As a Mental Health Strategy for Children and Young People, p. 5.

what effects the drug may have had on his developing brain? We do know John has already learned to identify himself as "sick".

John's story is not unique, and in fact reflects a very "typical" scenario. Children throughout Queensland are being drugged with powerful and dangerous stimulants for a condition that has never been shown to actually exist.

Introduction

This report is written out a desire to protect children. It is written to advocate for the right of children to grow up with healthy bodies and clear minds. It is written as a plea to celebrate the diversity of children and to view their unique expressions as precious gifts, rather than describing them as "sick" when they don't conform, obey or please adults.

If you are not already very concerned about the massive and needless drugging of children in Queensland and throughout Australia and the U.S., you will be after reading this report. And this is just the tip of the iceberg. Significant numbers of highly respected professionals from medicine (including psychiatry), psychology, education and law are speaking out in defence of children on this issue.

I suggest that it is not possible to read this information and conclude that there is no problem, and I ask that those of you who are proponents of the medical model of ADHD have the courage to read this carefully and challenge your pre-existing belief system. There are huge disagreements in this debate, but I think reasonable women and men would have to conclude there is a major problem here.

History has taught us the lesson of "The Big Lie". Whole societies have bought into ideas and concepts that have later proven to range from baseless to maniacal. Reading with any sort of an open mind through the voluminous literature on the topic of ADHD in the early 21st century, one cannot help but be reminded of reading through treatises on slavery in the 18th century. How could something so horrible and so egregious be happening in a "civilized" society? Why didn't those people take a hard look at what they were doing?

I have no doubt that someday people will look back on the massive drugging of children in Australia and America in the same way. ADHD is a catchall description of childhood behaviour invented by people sitting around a table who stood to benefit by the diagnosis professionally and financially. Virtually any child who has ever been a problem for any adult, could qualify for this "diagnosis", and be declared "sick" in the absence of any medical, scientific or organic findings whatsoever. Yet despite the indisputable fact that no one has been able to tell us what ADHD actually is, millions of parents, teachers and doctors are accepting it without question and supporting the use of powerful cocaine-like drugs in children. Meanwhile, pharmaceutical companies are reaping hundreds of millions of U.S. dollars in profits. When dissidents try to speak out they are either ignored, discouraged or attacked with the viciousness historically characteristic of those profiting from a "Big Lie". When the information does get out to the public, we are told to discredit it as "fanaticism" or "extremism". Ultimately truth is the greatest enemy of the "Big Lie". Read this report carefully and find your own truth in your own heart.

When a child is misbehaving, and they can be identified as "sick" and drugged into compliance, the parents no longer have to feel guilty or inadequate, the teachers no longer have to struggle with constant problems in the classroom, the physician has an ongoing customer and the drug company has branded another cash cow. Everyone is happy, except for the child. The child is blamed within the family as the source of the problems, stigmatised and disempowered by the diagnosis, and has to suffer the powerful short-term side effects and possibly the scary long-term side effects of the medication.

Most of all, this report is a plea for agencies and individuals in Queensland concerned about the physical and emotional well being of children to look into this issue and provide the advocacy that is so badly needed and so richly deserved.

A Note To Parents: Parents who have been giving their child(ren) prescribed stimulants are likely to be horrified and upset to read this information. Please do not feel guilty or hopeless! First of all, parents are placed in an impossibly difficult position when they are having problems with a child and a professional gives them a strong recommendation. As we will see, some parents have even been accused of being abusive and neglectful for NOT agreeing to put their children on stimulants. Parents make most of their decisions based on what they believe to be the best thing for their child, and that is all any of us can do. Now, with this new information, parents can make different decisions, and one of the true joys of working with children is that they are amazingly resilient. Whether your child has been taking stimulant medications for one week or ten years, they may be able to recover from some or most of the damage that may have been done. Remember, because these are powerful and dangerous drugs, anyone contemplating discontinuing stimulant drugs should consult a physician about the safest way to titrate (reduce) the dose.

A Note About the Information Presented: It is well known in the scientific community that research reports can be manipulated to support almost any position that an author wants to take. The ADHD controversy has been a classic example of this phenomenon, as advocates on opposite sides have sometimes cited the same research as proof of their position. Even within either side, there have been many times when a particular study has been hailed as demonstrating some dramatic new information, only to fall flat when later studies failed to replicate the findings. One of the problems particular to ADHD research is that it is often done not out of a search for truth, but in an effort to find justification for the use of medication. In the United States a significant portion of the research in this area over the past 20 years has been funded by drug companies, and, as we will see, these companies have influenced the presentation of the data in professional journals. Another issue is that several studies that supposedly revealed the long-sought after physical signs differentiating "ADHD' children from "normal" children later turned out to be using samples of children who were taking stimulant medication. Most likely, any reported changes were due to the toxic effects of the powerful drugs, but in any event, the "confounding variable" of the drugs compromised the validity of the research. This report has purposely tried to steer away from putting a biased spin on research results in order to support a position, and this report has also avoided references to research that was done on a small number of subjects. Although proponents of the medical model of ADHD and the use of stimulants will often point to studies done with 10 or 20 children, it is an

axiom of research that the smaller the sample the less likely the results can be generalized to the larger population. For the reader, the bottom line is to take research reports, even those referenced in this report, with a large grain of salt.

The organization of this report is as follows: There is an Overview of the problem as it exists in Australia and specifically in Queensland, and then 13 sections highlighting specific areas of concerns pertaining to this topic. It is critical in reading this material to be mindful that this does not represent the thoughts of one, or a very few, individuals, but rather a rich and diverse group of international experts in a variety of fields. Therefore, each section is primarily a compendium of quotes taken from many different sources. You are hearing the voices of many, including dozens of highly qualified and respect professionals who are concerned and often outraged.

Overview

The diagnosis of attention-deficit hyperactivity disorder (ADHD) and the use of stimulant medication to "treat" it, are controversial topics today throughout Australia. The Parliament of Australia conducted research last year analysing the use of medication for ADHD by federal electorates, and the last 12 months have seen major inquiries undertaken by the Parliament of South Australia and the New South Wales Commission for Children and Young People. A controversial 1997 report on ADHD by the National Health and Medical Research Council (NHMRC) was strongly in favour of the biopsychiatric model and the use of medication. Obviously, the recent surge in both interest and controversy indicate that the NHMRC report did little to lay this issue to rest.

Since 1 July 2002, there has been significant media coverage of the topic, including a front-page story in the Sydney Sunday Sun-Herald ("School Daze: With the explosion of prescription medication for children a dangerous new drug game is being played in our schools"), a major story in the Brisbane Courier-Mail ("Australian kids first in mind medicine") and coverage on the Australian Broadcasting Company through television and radio.

People have a sense that something is wrong; that children are being declared "sick" for simple misbehaviour, and that parents, teachers and physicians are looking for simple answers to complex problems involving parenting practices, family dynamics, the nature of public education and other society problems.

> "Australia is caught up in the current ADHD 'epidemic'. The impact is being felt by families, schools, doctors and mental health practitioners alike." [2]

> "Most European physicians are extremely reluctant to prescribe methylphenidate or any other stimulant for what they believe to be a conduct or behaviour problem in children…Quite clearly, the United States is the only country in the world that has so thoroughly embraced the notion that a large number of our children are suffering from a 'neurobiological' disorder that needs to be treated with a potent psychostimulant as a first-line treatment for behaviour control."[3]

[2] Atkinson, I., Robinson, J. and Shute, R. (1997). Between a rock and a hard place: An Australia perspective on education of children with ADHD. *Educational and Child Psychology*, 14(1), pp. 21-30.

Unfortunately, this 1995 notion expressed by the United States Drug Enforcement Agency is no longer true today. As the U.S. market levelled off in profitability, the "epidemic" has spread to Australia and Canada in much the same way as tobacco companies targeted third world consumers after virtually all Western nations put restrictions on the sale and advertising of cigarettes, and after the courts established precedent for them being liable for damages.

> "More children in Australia take psychotropic medication than do in the U.S."[4]

In addition to concern over the tremendous increases in the numbers, the federal government in Australia recently acknowledged that the disparities in practices pertaining to diagnosis and treatment are an issue of concern on a national level.

> "…the degree of difference between individual Federal electorates and across the States and Territories is unlikely to be in the best interests of Australia's children and their families. It appears that Australia has some distance to go before achieving best practice in the prescribing of medication for the treatment of ADHD."[5]

> "Medication for ADHD has been controversial, arguably for three main reasons. It is children, often young children, who are being medicated, the medication being prescribed is amphetamine-based, and the number of prescriptions for such medication has been increasing at a quite dramatic rate." [6]

An inquiry done by the South Australia Parliament echoed the concerns expressed in the federal study:

> "Current thought about the existence of ADHD as a disorder, and its nature and treatment, is strained by the multiplicity and disparity of theories and beliefs, especially among professionals."[7]

There are varying estimates about the extent to which Australia has embraced the ADHD phenomenon, but by any account the increase in the number of children being identified and drugged is astounding.

> "It is estimated that at least 50,000 Australian children are now on these prescription drugs."[8]

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[3] Drug Enforcement Agency (DEA) (1995, August 7). Response to C.H.A.D.D. petition concerning Ritalin. Washington, D.C.: DEA, US Department of Justice

[4] Ryan, Siobhain. (2002, July 1). Australian kids first in mind medicine. *The Courier-Mail* (Brisbane, QLD, Australia), p. 5.

[5] Mackey, P. and Kopras, A. (2001, April 3). Medication for Attention Deficit/Hyperactivity Disorder (ADHD): An Analysis by Federal Electorate. Parliament of Australia, Current Issues Brief 11 2000-2001, p. 2.

[6] Id

[7] Inquiry Into Attention Deficit Hyperactivity Disorder (2002, January 10). Parliament of South Australia. Sixteenth Report of the Social Development Committee, p. 28.

[8] Boon, Rosemary, Psychologist. (2002, June 30) quoted in: 50,000 hyperactive children on pills. *The Sun-Herald* (Sydney), p.10.

"Between 1991 and 1998, prescriptions dispensed for dexamphetamine sulfate increased by 2400 per cent, while prescriptions for Ritalin increased by 620 per cent over the same period."[9]

"Australian consumption of dexamphetamine rose 592% between 1991 and 1995, while consumption of methylphenidate rose 490% in the same time period."[10]

The New South Wales Commission for Children and Young People asked for community input and heard many worried voices:

"A great many submissions to the inquiry expressed concern about the increasing use of psychotropic drugs in children with ADD/ADHD, especially the long-term effects."[11]

One of the most incredible aspects of this entire phenomenon is that the amazing growth in the diagnosis has happened despite there being absolutely no proof that a "syndrome" or "disease" actually exists. No one knows what causes "ADHD", so it is not possible to suggest a treatment as a "cure". Instead, stimulant drugs are used to control the "symptoms" of the "disease": the child's behaviour. This troubled the New South Wales Commission for Children and Young People:

"Children and young people with disabilities may be further at risk from inappropriate use of psychotropic drugs that are commonly used for mental health disorders, such as drugs and medication that suppress and not treat the symptoms, or as restraints rather than a curative process."[12]

This concern about treating the symptoms rather than the causes is pervasive in the literature. However, by definition, when you have an unidentified "disease", the only thing you CAN do is "treat the symptoms." In essence, we tell these children: We can't find anything wrong with you but since we (parents, teachers) don't like the way you are acting we hereby declare you "sick".

"If one reads the relevant literature, it is hard to deny that stimulant therapy offers a very effective settling agent to aid in classroom management, and that this furthers the interests of the afflicted child's classmates, teachers and parents seeking an effective means to manage a difficult child while offering little benefit to the learning disabled/ADHD child."[13]

"The question is whether you just use drugs to suppress the symptoms of the situation or do you try to look deeper for the causes and improve the balance of the biochemistry in the brain and body? It's easy to reach for a prescription pad and write a script for a drug which does not address the cause."[14]

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[9] Mackey and Kopras (2001), p. 2.

[10] Shaw, Mitchell and Hilton. (2000, December). Are stimulants addictive in children? *Australian* Family Physician, Vol. 29, No. 12.

[11] New South Wales Commission for Children and Young People (2002). Issue Paper #5, p. 6.

[12] New South Wales Commission for Children and Young People. (2002). *Inquiry Into The Use of Prescription Drugs and Over-The-Counter Medications in Children and Young People,* Issue Paper No. 1: Background Issues. p. 11.

[13] Boon (2002, June 30), p. 10.

"Experts expressed fears that the drugs were being used to subdue and control noisy children."[15]

"Ritalin has no healing or curative power-it is pure symptomatic management, and not very successful at that either"[16]

Even Russell Barkley, the leading proponent of the medical model in the United States, acknowledged 25 years ago that:

"While the drugs seem to facilitate the short-term management of hyperactive children, they have little impact on the long-term social, academic or psychological adjustment of these children"[17]

A meta-analysis conducted by researchers at The University of Queensland, Queensland University of Technology and The University of Auckland looked at many studies internationally dealing with ADHD diagnosis and treatment and concluded that there are reasons for serious concerns:

"The efficacy of a range of interventions for attention deficit disorder is still a matter of lively debate, and there is a growing concern over the increase in diagnosis, the rate of prescription of drugs, and the use of medication as the sole method of treatment."[18]

The New South Wales Commission for Children and Young People voiced a similar concern:

"The Committee is of the view that there are reasons for concern that the use of stimulant medication in general is on the increase."[19]

Here in Queensland, there are fewer restraints on the prescribing of stimulant medication than in New South Wales, because general practitioners are permitted to prescribe stimulants to children in Queensland, whereas only paediatricians and child psychiatrists can write those prescriptions in New South Wales. In addition to the media coverage, there have been official acknowledgements that the diagnosis and treatment of ADHD is an issue of concern in Queensland:

"...there is considerable ongoing public and professional debate about the legitimate use (or potential overuse and abuse) of ADHD prescription drugs in society..."[20]

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[14] Weir, David, Noosa Naturopath (2001, February 4), quoted in David Goding: making it all ADD up. *The Courier-Mail*, magazine p. 8.

[15] Bye, Clarissa (2002, June 30). Drug swapping, the schoolyard scandal. *The Sun-Herald*, p. 10.

[16] Wilkinson, Rosemary. Physician and Medical Director Emeritus of The Institute for the Achievement of Human Potential. quoted at http://www.iahp.org/institutes_report/learning_problems/ritalin.html last visited 02/07/02.

[17] Barkley, R.A. (1977). A review of stimulant drug research with hyperactive children. *Journal of Child Psychology and Psychiatry*, (18), 137-165.

[18] Purdie, N., Hattie, J. and Carroll, A. (2002, Spring) A Review of the Research on Interventions for Attention- Deficit Hyperactivity Disorder: What Works Best? *Review of Educational Research*.

[19] New South Wales Commission for Children and Young People (2002), Issue Paper No. 5, p. 5.

In 2001 Disability Services Queensland, Queensland Department of Families and Education Queensland commissioned research into this issue, specifically on whether ADHD ought to be listed as a disability. Although the report has not been published, several recommendations from that study point to concerns about full disclosure of effects and side effects, public misunderstandings and physicians needing to consider "nonmedical approaches" prior to, or simultaneous with, prescription medications, especially with "early childhood" patients.[21]

Finally, Queensland Health held its first-ever "Think Tank" on June 19, 2002 and chose to devote it to the issue of diagnosis and treatment of ADHD. While the invitees to that meeting were primarily strong proponents of the biomedical model of ADHD, the selection of the topic is an acknowledgement by the Government that this is certainly a pressing issue in Queensland. The lack of significant philosophical diversity at that meeting underscores the critical importance of interested individuals being exposed to the information in this report, the voluminous data supporting it and the legions of highly qualified professionals on "the other side" of the issue.

1) Lack of Reliability of the Diagnosis

No one knows the aetiology of ADHD. That is a fact, and any honest professional, regardless of how strongly they support the biomedical model, will concede as much. For well over 2 decades, as drug companies have poured millions of dollars into research seeking the "smoking gun" that will "prove" the existence of ADHD. Periodically, we hear about some "exciting" research, only to find out later it did not hold up under further scrutiny. In fact, the flimsiness of some of this research, and the ease with which it falls apart when othes attempt to replicate it, raises concerns about the motives of the original researchers, given their funding sources. Yet even today you will find some proponents who, while admitting we don't know the causes of ADHD, will tell you how confident they are that some new theory will eventually prove valid.

The undisputed clinical reality in July of 2002 is this: Physicians are identifying a "disease" based SOLELY on reports and observations of behaviour. The only "tests" are questionnaires about the child's behaviour, usually completed by the parents or teachers whose frustration with the child prompted the doctor visit in the first place. There is no confirmatory physical examination, EEG, CT-scan, X-ray, PET scan or any other diagnostic instrument because there is nothing to look for. By all standards of medicine these are healthy children who we are arbitrarily declaring "sick" because people are not happy with their behaviour.

Needless to say, this creates a situation where one physician might say your child has ADHD, and another might scoff at the diagnosis. In Tampa, Florida (United States), one attending psychiatrist at a residential treatment facility had identified all dozen or so boys in one particular program as ADHD, and was treating them all with

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[20] The Illicit Market for ADHD Prescription Drugs in Queensland. (2002, April). *Crime and Misconduct Commission*, Crime Bulletin Series, #4, p. 2.

[21] Recommendations. (2001, November). Unpublished report submitted to Disability Services Queensland, Queensland Department of Families and Education Queensland.

stimulants. The psychiatrist went to an educational conference where he heard about specific learning disabilities and how they manifest behaviourally in school, and he came back the next week and changed the diagnosis of all the boys from ADHD to LD, taking them all off their medication! If one individual clinician can change his mind so radically, it is easy to imagine that there is little reliability in this diagnosis between different clinicians. It is 100% subjective, and it is 100% arbitrary.

> "Most physicians seem to spend only a few minutes in making the initial diagnosis of ADHD…Children are being diagnosed and medicated on the basis of personal, subjective impressions offered to physicians who then make their own personal, subjective impressions. The entire process is too subjective and imprecise to have objective validity. Yet the drugging of the child is being justified on the basis of medical science."[22]

> "The diagnosis of ADD is entirely subjective….There is no test. It is just down to interpretation. Maybe a child blurts out in class or doesn't sit still. The lines between an ADD sufferer and a healthy exuberant kid can be very blurred"[23]

> "There are no tests available for assessing the chemical status of a living person's brain…The theories are held on to…because they are useful in promoting drug treatment."[24]

> "There are no objective diagnostic criteria for ADHD—no physical symptoms, no neurological signs, and no blood tests. Despite claims to the contrary, there are no brain scan findings and no biochemical imbalances. No physical test can be done to verify that a child has "ADHD".[25]

> "All physicians know that it is the specialty of neurology, my specialty, that deals with organic, medical disorders of the brain and nervous system—not psychiatry."[26]

The 2001 Parliamentary study of ADHD quotes a "prominent health commentator"[27] confirming the obvious fact that having such a subjective diagnosis, made with out any medical evidence whatsoever, is a problem in Australia contributing to the significant disparity among the federal electorates in the identification of children as "ADHD":

> "as soon as you see variations like that in medicine and health, its usually the fact that there's non-evidence-based treatment going on, that there's opinion-based

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[22] Breggin, Peter R. , Psychiatrist (1998). *Talking Back to Ritalin.* Monroe, ME: Common Courage Press, p. 141-142.

[23] Kosterich, Joe, Physician. Federal Chairman of the General Practitioner's branch of the Australian Medical Association, quoted in "ADHD" Facts available at <http://www.fightforkids.com/adhd_facts.htm> last visited 05/07/02.

[24] Valenstein, Elliot S., Ph.D. (1998). *Blaming the Brain.* New York: The Free Press.

[25] Breggin, p. 138.

[26] Baughman, Fred A., Neurologist. (2002, May 15). *Testimony to California Senate Committee on Health and Human Services*, available at http://www.adhdfraud.org/commentary/5-19-02-3.htm last visited 08/07/02

[27] Mackey and Kopras (2001), p. 5.

treatment going on rather than evidence-based treatment going on."[28]

Most of the population has absolutely no idea how psychiatric "diseases" come into being. If they knew, they would be horrified and outraged.

There is an assumption that medical diseases are based on findings in a laboratory, or perhaps through tests on humans or animals. There is no such objective science underlying diagnosis in psychiatry. Illnesses are not discovered in a laboratory, they are invented by people sitting around a table.

A number of professionals have commented at the almost laughable method through which psychiatry decides what to include in its "Diagnostic and Statistical Manual" (DSM):

"The language used to present these criteria and procedures exudes the spirit of technical rationality. The diagnosis comes with its unique code number; references to other complex concepts, e.g., mental age; specifications about precise duration (six months) and the number of symptoms needed; vague references to unspecified research about 'discriminating power' and national field trials; and defined levels of severity. Through these criteria, describing common, everyday behaviours of children, the rhetoric of science transforms them into what are purported to be objective symptoms of mental disorder. On closer inspection, however, there is little that is objective about the diagnostic criteria."[29]

(Commenting on her observations of the 1987 APA DSM hearings process) "The low level of intellectual effort was shocking. Diagnoses were developed by majority vote on the level we would use to choose a restaurant. You feel like Italian, I feel like Chinese, so let's go to the cafeteria. Then it's typed into the computer."[30]

"Given their farcical empirical procedures for arriving at new disorders with their associated symptom lists, where does the American Psychiatric Association get off claiming a scientific, research-based foundation for its diagnostic manual? This is nothing more than science by decree. They say it is science, so it is."[31]

"Finally, why must the APA pretend to know more than it does? DSM IV (the fourth edition) is the fabrication upon which psychiatry seeks acceptance by medicine in general. Insiders know it is more of a political than scientific document."[32]

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[28] Swan, Norman. (2000, October 23). *The Health Report.*

[29] Kirk, S. and Kutchins, H. (1992). *The selling of science in psychiatry.* New York: Aldine DeGruyter.

[30] Caplan, Paula, Ph.D. *They're Driving Us Crazy* quoted in Death from Ritalin: The Truth Behind ADHD available at <http://www.ritalindeath.com/Page/Contro4.html> last visited 05/07/02.

[31] Hagen, Margaret, Ph.D., Professor of Psychology, Boston University. Quoted in Death from Ritalin: The Truth Behind ADHD available at <http://www.ritalindeath.com/Page/Contro4.html> last visited 05/07/02.

[32] Mosher, Loren, M.D., Psychiatrist, former Chief of the National Institute of Mental Health's Center for the Study of Schizophrenia, quoted in Death from Ritalin: The Truth Behind ADHD, available at <http://www.ritalindeath.com/Page/Contro4.html> last visited 05/07/02.

The answer to the last question, asked by a respected American psychiatrist, is that most laypeople would not accept the idea of drugging children without a diagnosis. The APA must pretend to know more than it does in order to provide "official" validation for the multi-billion dollar pharmaceutical industry.

If doubt remained about the subjective, arbitrary and totally non-scientific way that psychiatric diagnoses are invented, one need only look at some recent history. In the DSM-II (second edition) one of the "diseases" was homosexuality! If a gay or lesbian person went to a psychiatrist prior to 1980 and divulged their sexual preference they were likely to be given an "official" label as being "sick". Only when this became a political nightmare for psychiatry with the gay rights movement did they remove it from the list. It was removed in just the way it was added: based on expedience and politics, with no relation to science whatsoever.

In the 1980's the APA attempted to add a category for premenstrual syndrome, and currently in the United States there are strong advocates for adding Road Rage Disorder and Internet Addiction Disorder (IAD) to the list of "mental disorders". Criminal defendants in the United States have already pled not guilty to roadside violence, claiming they are victims of this new Road Rage "disease", and inattentive spouses and others have claimed they spend hours on the computer not because they want to but because they can't control their "IAD". New "diseases" are being invented by the dozens, and the ones that will not encounter public outcry will surely be incorporated into the new DSM edition. More diseases equal more patients; and more patients equal more prescriptions. It is an incredible and outrageous process through which more and more children and adults are being told they are "sick" with no evidence and no basis.

The DSM's history of ADHD is interesting. In DSM-II, there was a syndrome for children struggling at home and at school and it was called "Minimal Brain Dysfunction". When the APA convened to discuss changes for the DSM-III, there was strong sentiment that this name had to go. Psychiatrists were worried they were frightening away parents with such a scary sounding phrase, and they were embarrassed when parents quite naturally wanted an explanation of what part of their child's brain was minimally dysfunctional, and, of course, there was no explanation to provide. So by a show of hands, they changed the name of this "syndrome" and invented Attention Deficit Disorder, a much more agreeable and benign phrase.

The APA invents, but it is more than happy to adjust its inventions to meet political and financial demands (as we saw with the homosexuality example). When people questioned why virtually only boys were diagnosed with ADD, the APA invented ADD with or without hyperactivity, to enable the inclusion of girls even though they are typically socialized to be less active and more compliant in school. When clinicians reported that their patients were able to focus for hours at their PlayStation games but not at school, the APA added an "intermittent type" to explain that even though children were only inattentive in certain situations, it wasn't about the situation, the child was still "sick".

The most damning expose of the diagnosis of ADHD is provided by looking at the DSM itself. Separate from the "diagnostic criteria", the APA issues this warning:

"Symptoms typically worsen in situations that require sustained attention or mental effort or that lack intrinsic appeal or novelty (e.g., listening to classroom teachers, doing class assignments, listening to or reading lengthy materials, or working on monotonous, repetitive tasks). Signs of the disorder may be minimal or absent when the person is under strict control, is in a novel setting, is engaged in especially interesting activities, is in a one-on-one situation (e.g., the clinician's office), or while the person experiences frequent rewards for appropriate behaviour."[33]

It doesn't take Freud or Einstein to recognize that if a child can "turn off" their "symptoms" when they are really interested, or when they are being rewarded, the behaviour is in their control and not the result of some imaginary "sickness".

The DSM is the "Bible" of psychiatric diagnosing in Australia and in the United States. Interestingly, the United Kingdom utilizes a different manual, the ICD (International Classification of Diseases), and one result is that the prevalence of ADHD in the U.K. is generally estimated at 1% or less, whereas it is at least 10-12 times greater than that in Australia and the U.S. Unless there are phantom ADHD germs in the water outside of England, the discrepancy in the prevalence rates points to the lack of reliability of the diagnosis. If we were looking at a "real" entity that we could measure, the prevalence ought to be relatively the same in different populations.

Even a child could see the absurdities in the DSM diagnostic criteria for ADHD. It is well worth re-printing them here. In order to qualify for the diagnosis and be considered to have a "psychiatric disease" the doctor must decide that the child has:

A. Either (1) or (2):

(1) six (or more) of the following symptoms of inattention have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Inattention

(a) often fails to give close attention to details or makes careless mistakes in schoolwork, work or other activities
(b) often has difficulty sustaining attention in tasks or play activities
(c) often does not seem to listen when spoken to directly
(d) often does not follow through on instructions and fails to finish schoolwork, chores or duties in the workplace (not due to oppositional behaviour or failure to understand instructions)
(e) often has difficulty organizing tasks and activities
(f) often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
(g) often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books or tools)
(h) is often easily distracted by extraneous stimuli
(i) is often forgetful in daily activities

[33] Diagnostic and Statistical Manual, ed. 4. Washington, DC, American Psychiatric Association, 1994.

(2) six (or more) of the following symptoms of hyperactivity-impulsivity have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Hyperactivity

(a) often fidgets with hands or feet or squirms in seat
(b) often leaves seat in classroom or in other situations in which remaining seated is expected
(c) often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
(d) often has difficulty playing or engaging in leisure activities quietly
(e) is often "on the go" or often acts as if "driven by a motor"
(f) often talks excessively

Impulsivity

(a) often blurts out answers before questions have been completed
(b) often has difficulty awaiting turn
(c) often interrupts or intrudes on others (e.g., butts into conversations or games)

B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years.

C. Some impairment from the symptoms is present in two or more settings (e.g., at school (or work) and at home).

D. There must be clear evidence of clinically significant impairment in social, academic or occupational functioning.[34]

Many people reading this for the first time are stunned that something so absurd is so widely accepted without question, and used as the basis for drugging thousands of children with dangerous stimulants. There are a few areas that deserve special focus for the purpose of this report:

First, the behaviours described in the diagnostic criteria are normal childhood behaviours, or at worst, the normal behaviours of children being difficult. How many of us have not had difficulty sustaining attention, especially to tasks we found boring? How many of us haven't been forgetful, disorganized, easily distracted or had difficulty waiting our turn? How many of us have fidgeted? A "disease" has actually been constructed around such things as avoiding or even just being reluctant to do homework, losing things and not finishing chores! Virtually ANY child, other than the most compliant, passive and inactive, could qualify for this diagnosis, and that is the way it was designed. That explains why more and more children are able to meet these absurd "criteria" every year.

[34] *Diagnostic and Statistical Manual*, ed. 4 (DSM-IV). Washington, D.C.: American Psychiatric Association, 1994.

Second, since when is it a "disease" to not obey and comply? Several "symptoms" (e.g., 1d, 2b, 2c) specify behaviours where a child isn't doing what they are told. When did disobedience become an illness? Similarly, how can not doing schoolwork be a "disease"? There are some societies that do not have formal schooling; how can their children manifest this "disease"? It could not be plainer that these criteria are about the adaptation of a child to society and society's expectation, not something about the child. If society changed, for example to reward high energy levels, independent thought and creativity, suddenly the "sick" children would be well and the well children would be "sick". Is this medicine?

Finally, the criteria themselves are ridiculously vague; so vague that they result in the rampant unreliability and discrepancies in the diagnosis. Incredibly, every descriptor in the main category (A) uses the word "often". What constitutes "often"? Who decides if something is happening "often"? Is 3 times in 6 months often, or 30 times? There are no guidelines, not even an operational definition. It is up to the physician.

Even aside from "often" the rest of the definition is riddled with ambiguous and vague terminology. Which mistakes are "careless" ones? What constitutes being spoken to "directly"? What constitutes "difficulty" in organizing things? Who decides what activities require "sustained mental effort"? What is "easily" distracted? When does a small movement qualify as a "fidget" or a "squirm?" Who determines when "remaining seated is expected?" When is running or climbing or talking "excessive?"

The APA tells us that someone is "sick" if they leave their seat in a situation in which they are supposed to remain seated. So if ten children are standing up with permission, and then the teacher comes in and tells them all to sit and only nine do, the one remaining standing has a "disease"?

If these descriptors were used to describe a crime, any criminal judge would declare the defendant not guilty because the criteria were too vague. Yet innocent children who have committed no crime are sentenced to having their bodies invaded with powerful and dangerous drugs, because of these amazingly vague, subjective, arbitrary and often ludicrous, criteria.

The diagnosis itself, identifying something within the child as the culprit for whatever problems he or she is having at home or at school, is itself destructive. Given the complete subjectivity of the diagnosis, this is a significant concern. In a 1992 report by the Australia Clearinghouse for Youth Studies, many of the participants (individuals working with youth) expressed concern about the destructiveness inherent in labelling a child:

> "The use of terms which focus on the (presumed) aetiology of problems, rather than on the nature of the problems was preferred by some participants. Once again, this appeared to be an attempt to avoid labelling or blaming the young people for their problem."[35]

[35] *Mental health and young people: A report into the nature of mental health problems experienced by young people and implications for service provision.* Australia Clearinghouse for Youth Studies, Hobart: 1992. Chapter 3, p. 10, available at http://www.acys.utas.edu.au/ncys/nyars/mental/contents,html last visited 14/06/02.

The Queensland media has recently begun to put together the twin phenomena of the subjectivity of the diagnosis with the incredible rise in the number of people diagnosed:

> "A recent State of the Nation report found a 14-fold increase in the past decade in the number of prescriptions of dexamphetamine and Ritalin to treat attention deficit disorder and attention deficit hyperactivity disorder. But the report said there was no test to classify the existence or severity of the condition."[36]

With a completely subjective diagnosis and without any physical data to confirm the diagnosis, there is significant disparity in how physicians evaluate a child. Unfortunately, as one physician points out, the diagnosis can be made on the basis of a most cursory assessment:

> "We deplore the careless manner in which its (Ritalin's) use is regarded by many educators, psychologists, and medical personnel. It is often prescribed hastily, without adequate evaluation, and by authority figures who may place unreasonable pressure on parents whose overwhelming wish is to do the best for their child."[37]

In 1998, the United States' National Institute of Health convened a major ADHD Consensus Conference. Rather than arrive at any sort of a consensus, the conference raised major questions about psychiatric practices in diagnosing and treating ADHD, and led to the two following acknowledgements from panellists, both of whom are renowned American psychiatrists with a strong biomedical predisposition:

> "The diagnosis is a mess."[38]

> "There is no current validated diagnostic test."[39]

With a "messy" diagnosis, there are two risks: children are identified with whom there is nothing "wrong", or children are identified with whom there is a separate problem, and the misdiagnosis of "ADHD" prevents the real issue from being addressed. The South Australia inquiry looked at the child's behaviour being explained by their environment, rather than because they are "sick":

> "There are situations, too, in which children are diagnosed as having ADHD when, in fact, they are displaying a set of behaviours that can be attributed to insufficient mental and physical stimulation at home."[40]

> "We (school counsellors) have some concerns about the diagnosis. School counsellors can cite cases where they are assured the child diagnosed does not, in

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36 *The Courier-Mail* (Brisbane): 13/11/01, p. 3.

37 Wilkinson, Roselie (Physician)

38 Vonnegut,, Mark M.D., Massachusetts Pediatrician and panel member. (1998, November 16-19). NIH Consensus Development Conference on Diagnosis and Treatment of ADHD.

39 Kupfer, David J., M.D., University of Pittsburgh Psychiatry Professor and panel chairman (1998, November 16-19). NIH Consensus Development Conference on Diagnosis and Treatment of ADHD.

40 *Inquiry into Attention Deficit Hyperactivity Disorder*. (2002 January 10). Parliament of South Australia, Sixteenth Report of the Social Development Committee, p. 22.

fact, have ADHD but is in need of mental stimulation and physical activity, as well as clearly set behavioural boundaries, both at home and at school. Many school counsellors feel that ADHD is over-diagnosed."[41]

The National Association of Practicing Psychiatrists (NAPP) expressed the concerns about rampant misdiagnosis quite directly to the South Australia Parliamentary inquiry:

"…other conditions are being misdiagnosed as ADHD and (that) children are unnecessarily being given powerful drugs which can substantially affect their emotional development"[42]

There are many theories about why children might have behaviour problems, and many practitioners are concerned that various different "real" issues get missed or otherwise swallowed by the indiscriminate and voracious ADHD "machine":

"Dr. Terry Sands, a consulting paediatrician at the Illawarra Sleep Disorders Service informed the Committee of research which indicates that ADD/ADHD is, in some cases, caused by sleep apnoea and that many children are being treated with stimulants for ADD/ADHD when they should be treated for sleep apnoea which involves the use of *non-medicinal treatment*, including the removal of tonsils and adenoids and the use of 'constant positive airway pressure'."[43]

"According to Brad Habermehl, O.D., an optometrist with the Vision Therapy Group in Flint, Mich., about 30% of all children have a binocular vision problem that prevents them from focusing, resulting in double vision, blurred vision and eye strain. This inability to focus causes ADHD-like symptoms in this population, and, Habermehl believes, leads to a misdiagnosis of ADHD. 'Nine out of 10 have been diagnosed with ADD or ADHD' he said."[44]

"Many ADD children display symptoms corresponding with those of essential fatty acid deficiency."[45]

Sydney biochemist and nutritional consultant Ann Catelin: "There has been a lot of research over the past five to six years into this particular area. The growing incidence of ADD has come about because our diet has changed so dramatically over the past 20 years."[46]

There is (however) evidence that exposure to lead, even at subclinical toxicity

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[41] Eagles, Brett. President, South Australia Primary School Counsellors Association, Inc. (2001, September 28). Oral presentation to Parliament of South Australia Inquiry into Attention Deficit Hyperactivity Disorder, Hansard, p. 146.

[42] National Association of Practicing Psychiatrists. (2002). Written submission to the Parliament of South Australia Inquiry into Attention Deficit Hyperactivity Disorder.

[43] New South Wales Commission for Children and Young People (2002). *Inquiry Into The Use of Prescription Drugs and Over-The-Counter Medications in Children and Young People,* Issue Paper No. 6: Alternatives to the Use of Prescription Drugs and Over-the-Counter Medications by Children and Young People., p. 6.

[44] Magill-Lewis, Jillene. (2002, July 3). Psychotropics and Kids. *Drug Topics* . 35-42. available at <http://proqust.umi.pqdweb>.

[45] The Sunday Mail (Brisbane) (2001, February 4). Magazine, p. 8.

[46] Id.

levels, is associated with small but significant decrements in intellectual performance and with distractible impulsive behaviour."[47]

A major study reported this month in *The Medical Journal of Australia* found that, even if one accepts the "diagnostic criteria", 23% of the 3597 children receiving stimulant medication for ADHD did not meet them![48] The study found medical cases where stimulants were being used to treat autism, developmental delays and "chemical imbalance in the brain"[49], and concluded:

> "There is a great need to clarify the circumstances under which stimulant medication should be used as part of the treatment of ADHD."[50]

2) Lack of Validity of the Diagnosis

The naked Emperor proclaimed that he was wearing the most beautiful royal robes, and everyone in the kingdom began discussing how to purchase more fabric, where to get the correct dyes, who would sew the additional garments, etc. Only the little boy who trusted his own eyes wanted to scream out "The Emperor is naked!"

In a society that often deifies medical science, non-medical people are frequently intimidated from engaging physicians in debate. When a physician starts talking about "dopamine receptors" or "basal ganglia" we assume there is a vast, esoteric knowledge base to which only the medically trained are privy. The stark reality is that ADHD is a "naked" diagnosis, with nothing substantive to support it, yet many professionals in the field continue to accept it without question. They are scared of questioning "authority", scared of losing their jobs and probably most of all, scared of being considered "uneducated" by the powerful proponents of the ADHD myth.

Dr. John Jureidini, Head of Department of Psychological Medicine at Adelaide's Women's and Children's Hospital, was asked by the South Australia Parliamentary Inquiry why there is such a polarity of views among professionals about ADHD, why so many professionals follow along with the neurobiological explanation and the DSM despite its tremendous and well documented flaws:

> "There is monumental literature that takes as a given that ADHD is a neurobiological condition and starts from there to talk about different forms of treatment. Once you have many thousands of articles published about something how can it possibly make sense for someone to stand up and say 'This is not an entity'? I want to emphasize that I quite clearly acknowledge that there are children who are very compromised because of difficulties with impulsiveness, attention and activity. I am not saying that these children are not suffering or are not worthy of attention. I am saying that, as a disorder, ADHD is a spurious

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[47] Attention Deficit Hyperactivity Disorder. (1997). *National Health and Medical Research Council* (NHMRC), 1.3.5.

[48] Sawyer, Michael G., Rey, Joseph M., Graetz, Brian W., Clark, Jennifer J. and Peter A. (2002, July 1). Use of medication by young people with attention-deficit/hyperactivity disorder. *The Medical Journal of Australia*, Volume 177, Number 1, p. 21-25.

[49] Id.

[50] Id.

entity."[51]

There are countless professionals in medicine, psychology, eduction and other fields who do not mince words in their disdain for the concept of "ADHD":

Psychology professor Diane McGuiness, Ph.D.: "Methodologically rigorous research indicates that ADHD and hyperactivity as 'syndromes' simply do not exist."[52]

Neurologist Fred A. Baughman, M.D.: "We are not mis-diagnosing or over-diagnosing, mis-treating or over-treating ADHD. It has been a total, 100% fraud throughout its 35-year history."[53]

Associate Professor Robert Reid, University of Nebraska: "the causes of ADHD are simply not known."[54]

The (Australian) National Association of Practicing Psychiatrists (NAPP): "(ADHD) is not an inherited genetic disorder or organic disease" and "scientific evidence to support ADHD as a disorder is unproven."[55]

Psychiatrist Dennis Donovan, M.D.: "ADD is a bogus diagnosis. Parents and teachers are rushing like lemmings to identify a pathology….Our current pathologizing of behaviour leads to massive swelling of the ranks of the diseased, the dysfunctional, the disordered and the disabled."[56]

Physician William B. Carey, M.D. of Children's Hospital of Philadelphia: "What is now most often described as ADHD in the United States appears to be a set of normal behavioural variations. This discrepancy leaves the validity of the construct in doubt."[57]

Psychologist John Breeding, Ph.D.: "The diagnosis of ADHD is, itself, fraudulent."[58]

Tunku Varadarajan, Wall Street Journal Deputy Editor: "...its just as much

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[51] Jureidini, John. (2001, September 21). Oral testimony to the South Australia Parliamentary Committee's Inquiry into Attention Deficit Hyperactivity Disorder. Hansard, p. 119.

[52] McGuinness, D. (1989). Attention deficit disorder: The emperor's new clothes, animal 'pharm,' and other fiction. In Fisher, S. and Greenberg, R.P. (Eds.). *The limits of biological treatments for psychological distress*. Hillsdale, NJ: Lawrence Erlbaum Associates, pp. 151-188.

[53] Baughman, Fred A., M.D. *The Totality of the ADD/ADHD Fraud. A*vailable at <http://www.home.att.net/~Fred-Alden/Es5.html> last visited 08/07/02.

[54] Reid, Robert. (2001, June 1). Oral testimony to the South Australia Parliamentary Committee Inquiry into Attention Deficit Hyperactivity Disorder. Hansard, p. 9.

[55] Anaf, Gil, M.D., President, National Association of Practicing Psychiatrists. (2001, August 24), Oral testimony to the South Australia Parliamentary Committee Inquiry into Attention Deficit Hyperactivity Disorder. Hansard, p. 61.

[56] Donovan, Dennis, M.D. (1998). Quoted in "ADHD" Facts available at <http://www.fightforkids.com/adhd_facts.htm> last visited 05/07/02.

[57] Carey, William B., M.D. (1998). *National Institute of Health Consensus Conference on ADHD*, November 16-18, 1998.

[58] Breeding, John, Ph.D. (2000, July). Does ADHD Even Exist?: The Ritalin Sham. *Mothering.* available at <http://www.wildcolts.com> last visited 05/07/02.

nonsense-on-stilts as ADHD as it was pure poppycock as ADD."[59]

Author Beverly Eakman: "These drugs make children more manageable, not necessarily better. ADHD is a phenomenon, not a 'brain disease'. Because the diagnosis of ADHD is fraudulent, it doesn't matter whether a drug 'works'. Children are being forced to take a drug that is stronger than cocaine for a disease that is yet to be proven."[60]

Psychologist Richard DeGrandpre, Ph.D., citing a study in *Pediatrics*, a US Medical journal, showing that 80% of children reported as hyperactive at home or school showed exemplary behaviour and no signs of hyperactivity in the physician's office: "This finding is consistent with numerous studies, showing, and dozens of newspaper articles reporting, considerable disagreement among parents, teachers, and clinicians about who qualifies for a diagnosis. This can only raise questions about the existence of ADD as a real medical phenomenon since it is these symptoms alone that are the basis of the diagnosis."[61]

Psychiatrist Peter R. Breggin, M.D.: "It is important for the Education Committee to understand that the ADD/ADHD diagnosis was developed specifically for the purpose of justifying the use of drugs to subdue the behaviours of children in the classroom."[62]

United States Senator Hillary Rodham Clinton: "Some of these young people have problems that are symptoms of nothing more than childhood or adolescence."[63]

Psychiatrist Sydney Walker, III, M.D.: "The medical community has elevated Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD) to the status of diagnoses, and most people believe these are real diseases. They aren't and doctors who label children ADD or ADHD don't have a clue what's really ailing them."[64]

Educator and Research Brenton Prosser, Ph.D.: "The dominant definition of the condition argues that it is physiologically based, and is best treated with amphetamines, while there remains no biological basis for these claims."[65]

Perhaps the most damning testimony of all questioning the existence of ADHD is provided by some of its strong proponents:

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[59] Varadarajan, Tunku, Deputy Editor, The Wall Street Journal. (2001, August 21). *Shrinking to Excess: I'll be damned if I let a psychiatrist near my son."* The Wall Street Journal.

[60] Eakman, Beverly, author of *Cloning of the American Mind.* Quoted in "ADHD" Facts at <http://www.fightforkids.com/adhd_facts.htm> last visited 05/07/02.

[61] DeGrandpre, Richard, Ph.D., from *Ritalin Nation*, quoted in "ADHD" Facts available at <http://www.fightforkids.com/adhd_facts.htm> last visited 05/07/02.

[62] Breggin, Peter R. M.D. (2000, September 29). Testimony Before Subcommittee on Oversight and Investigations, Committee on Education and the Workforce, U.S. House of Representatives.

[63] Clinton, Hillary Rodham. (2001, March), *USA Today* (Magazine).

[64] Walker III, Stanley, M.D. Quoted in Death from Ritalin, The Truth Behind ADHD. Available at <http://www.ritalindeath.com/Page/Contro1.html> last visited 05/07/02.

[65] Prosser, Brenton. (1998, August). *Hearing Silenced Voices: using narrative research with marginalised youth.* Flinders Institute for the Study of Teaching, available at <http://www.users.senet.com.au/~tolls/rants/hearingsilenced.htm> last visited 03/07/02.

An Australian study by proponents of ADHD: "The findings suggest that ADHD is best viewed as the extreme of a behaviour that varies genetically throughout the entire population rather than as a disorder with discrete determinants."[66]

National Health and Medical Research Council Report of ADHD: "The aetiology of ADHD is essentially unknown."[67]

Psychiatrist Joseph T. Coyle, M.D., Harvard Medical School Psychiatry Department: "...the validity and reliability of the diagnosis of ADHD (has) not been demonstrated."[68]

National Institute of Health (U.S.): "...we do not have an independent, valid test for ADHD, and there are no data to indicate that ADHD is due to a brain malfunction."[69]

In 1992, the Australian Clearinghouse for Youth Studies did a major report on "Mental health and young people." Among the findings in that study were problems in communication and funding engendered by the lack of specificity of terminology, passionate concerns among youth workers of the destructive effects of psychiatric labels on young people, lack of a known aetiology for childhood "mental illness" and cultural disparities in the way the subjective "diagnoses" are employed.[70]

A scholarly meta-analysis by Australian researchers of ADHD just completed dealt with the issue of the questionable validity of the diagnosis in detail.[71] The following excerpts are taken from that report:

"Diagnosis of ADHD is complicated and often subjective in nature. There is no current acceptable single measure to diagnose ADHD."[72]

"...geographical disproportionality in diagnosis seems to indicate the prevalence of diagnostic predisposition as a causal factor."[73]

"A medical model of disability assumes that there is a readily identifiable norm of

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[66] Levy, F., Hay, D.A., McStephen, M., Wood, C., and Waldman, I. (1997) Attention-deficit disorder: A category or a continuum? Genetic analysis of a large scale twin study. *Journal of the American* Academy of Child and Adolescent Psychiatry, 36, 737-744.

[67] Attention Deficit Hyperactivity Disorder. (1997). *National Health and Medical Research Council* (NHMRC), end of part 1: Diagnosis and Assessment.

[68] Coyle, Joseph T., M.D. (2001, March). Quoted in *USA Today* (Magazine).

[69] National Institute of Health Consensus Development Conference on ADHD. (1998, November 18). Final Statement.

[70] *Mental health and young people: A report into the nature of mental health problems experienced by young people and implications for service provision.* Australia Clearinghouse for Youth Studies, Hobart: 1992. Chapter 3, p. 10, available at <http://www.acys.utas.edu.au/ncys/nyars/mental/contents,html> last visited 14/06/02.

[71] Purdie, N., Hattie, J. and Carroll, A. A Review of the Research on Interventions for Attention-Deficit Hyperactivity Disorder: What Works Best? *Review of Educational Research*, Spring, 2002.

[72] Id., p. 6.

[73] Id., p. 7.

behaviour. The basic cause of an individual's diversion from the norm is an underlying pathology or disease which requires appropriate diagnosis so that symptoms can be effectively treated. In an education context, symptoms are usually based on the failure of a child to function appropriately in the classroom. But the line between acceptable and unacceptable classroom behaviour and performance is extremely blurred. This means that notions of what constitutes 'normal' classroom behaviour have led to the label of ADHD being applied to some children who simply move around too much, who do not pay proper attention to the task in hand (usually one imposed by the teacher), or who blurt out answers without stopping to think about what they are saying. For these children, the educative role of the school can become subordinate to the medical role that is forced upon it by the medicalizing trends at work in the wider society. The graphic descriptions of lunchtime queues of children receiving their medication for ADHD is a stark reminder of this trend."[74]

"…there are no laboratory or radiological confirmatory tests, no physical features, the diagnostic criteria have changed frequently, and the rates can differ dramatically across locations as well as across countries."[75]

Dr. Fred Baughman is a U.S. neurologist who has passionate concerns about what he considers the fraudulent nature of the ADHD diagnosis.

"Between 1993 and 1997, neurologist Fred Baughman corresponded repeatedly with the Food and Drug Administration (FDA), the Drug Enforcement Agency (DEA), Ciba-Geigy (now Novartis, manufacturers of Ritalin), and top ADHD researchers around the country—including the National Institute of Mental Health—asking them to show him any article(s) in the peer-reviewed scientific literature constituting proof of a physical or chemical abnormality in ADHD and thereby qualifying it as a disease or a medical syndrome. Through sheer determination and persistence, Dr. Baughman eventually got these entities to admit that no objective validation of the diagnosis of ADHD exists."[76]

Today, Dr. Baughman continues to speak out forcefully on what he sees as a bastardisation of his professional field of medicine.

"As a neurologist making 'disease' vs 'no disease' determinations daily, I have discovered and described real diseases but found no disease in children labelled ADHD…no abnormality. Nor does the scientific literature hold proof that ADHD is a disease; i.e., that the children are 'diseased'—'abnormal'."[77]

Whether one's theory is that the ADHD diagnosis is a conspiracy between the American Psychiatric Association and pharmaceutical companies, or just plain lousy science, there seems to be no question that the validity of the diagnosis is highly questionable.

"For all of psychiatry's pretensions to being a science, the ADHD scientific

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[74] Id.
[75] Id., p. 29.
[76] Breeding, John, Ph.D. *Mothering.*
[77] Baughman Jr., Fred A., M.D. *The ADHD Consensus Conference: End of the Epidemic.* Available at <http://www.home.att.net/~Fred-Alden/Es30.html> last visited 05/07/02.

'discovery' process was literally a vote by a show of hands at an American Psychiatric Association (APA) Committee meeting."[78]

No one is more offended than Dr. Baughman, who apparently took his Hippocratic Oath quite seriously:

"They made a list of the most common symptoms of emotional discomfiture of children; those which bother teachers and parents most, and in a stroke that could not be more devoid of science of Hippocratic motive—termed them a 'disease'."[79]

The travesty of science that is the ADHD diagnosis, and the dilemma now facing the proponents of the bankrupt biomedical model, was summed up by Dr.McGuiness:

"We have invented a disease, given it medical sanction, and now must disown it. The major question is how we go about destroying the monster we have created. It is not easy to do this and still save face, another reason why physicians and many researchers with years of funding and an academic reputation to protect are reluctant to believe the data."[80]

3) Stimulants Don't Help

Even if we made the assumption that ADHD was an entity or syndrome that actually existed, there would remain the question of how best to "treat" it. The use of psychostimulant medications, primarily dexamphetamine and methylphenidate (Ritalin), is a subject of great controversy. Not only is there overwhelming evidence of serious short and long-term side effects from these potent drugs, but, amazingly, there is very little "benefit" in the short run, and none in the long run! To put it another way, we may be seeing widespread treatment of a disease that doesn't exist, with dangerous medicines that don't work.

The South Australia Parliamentary Inquiry acknowledged the controversy:

"Just as there are those professionals and lay people who embrace the use of psychostimulant medications, so there are those who challenge such widespread reliance on them. Nothing has been as heatedly debated in the treatment of ADHD as these medications."[81]

In the 1980's, proponents of the biomedical model used to argue that they could prove ADHD existed because "sick" children were calmed down by the amphetamines, whereas "normal" children were not. This is called "retrospective diagnosing" in psychiatry: We don't know what's wrong with someone but if we give them a drug anyway and the drug "works" we base our diagnosis on the drug response. Of course,

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[78] *ADHD Facts.* Available at <http://www.fightforkids.com/adhd_facts.htm> last visited 05/07/02.

[79] Baughman Jr., Fred A., M.D. Quoted in *Attention Deficit Hyperactivity Disorder* available at <http://www.adhdfraud.org> last visited 08/07/02.

[80] McGuinness, D. (1989). Attention deficit disorder: The emperor's new clothes, animal 'pharm,' and other fiction. In Fisher, S. and Greenberg, R.P. (Eds.). *The limits of biological treatments for psychological distress.* Hillsdale, NJ: Lawrence Erlbaum Associates, pp. 151-188.

[81] *Inquiry into Attention Deficit Hyperactivity Disorder*. (2002 January 10). Parliament of South Australia, Sixteenth Report of the Social Development Committee, p. 42.

retrospective diagnosing is absurd on its face: If someone was having trouble with low energy and we gave them cocaine, their energy level would no doubt increase, at least initially. Would it then make sense to conclude they had been suffering from "cocaine deficiency"? Yet physicians have clung to this idea that a differential diagnosis of ADHD could be made retrospectively, based on medication response. Unfortunately for the advocates of this theory, it was completely discredited over time, to the extent that today, virtually everyone acknowledges that ALL children have a similar response to stimulant drugs:

> "Indeed, stimulant medications have been shown to have similar types of effects in children with diagnosed ADHD and individuals regarded as normal controls (Peloquin and Klorman, 1986; Rapoport, Buschsbaum and Monte, 1980; Rapoport, Buschsbaum and Zahn, 1978). These results emphasize that the diagnosis of ADHD cannot be determined by a positive response to medication."[82]

> "Although medication can reduce behaviour problems and improve memory, this does not confirm a diagnosis of ADHD—many authors have noted that there can be similar effects of medication on the activity, memory, and vigilance of students who are not diagnosed with ADHD."[83]

Even many advocates of the use of stimulant drugs for ADHD feel that the "condition" is overdiagnosed and therefore the use of medication is too widespread. These individuals will discuss "differential diagnosis": the process through which a clinician determines which disease a patient has from among several choices. It is popular among ADHD advocates to use educational impairment as one of the keys to making the ADHD diagnosis; to differentiate it from other problems. However, the 2002 Australian meta-analysis substantiates what many have observed over the years: stimulant medication DOES NOT result in ANY improvement in academic functioning.[84] This finding leaves proponents scrambling for an explanation. If ADHD is a disease and one of its primary signs is reduced academic performance, than the treatment for the disease ought to improve academic performance. Yet this is undisputedly not the case.

The lack of benefit of stimulant drugs is not limited to academic performance. While the drugs cause the children to be less active, more compliant and therefore easier to control and less active, they do not appear to have any actual benefit for the children themselves:

> "Certainly, the improved behaviour of children with ADHD has benefits for teachers and for the parents of these children but for the children themselves the benefits appear to be limited to improved social functioning. There does not appear to be an improvement in emotional well-being or school-based achievement."[85]

> "There are no positive long-term effects in any aspect of child functioning—social, behavioural, or academic—associated with the use of Ritalin."[86]

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[82] Attention Deficit Hyperactivity Disorder. (1997). *National Health and Medical Research Council* (NHMRC), 4.1.
[83] Purdie, et al., p. 29.
[84] Id.
[85] Purdie, et al., p. 28.
[86] Breeding, *Mothering.*

" . . . evidence is lacking that stimulants result in improved long-term outcomes for education, social situations or employment."[87]

"Williams et al. (1999) noted that medicated ADHD are no more likely to attend university that non-medicated ADHD children; nor are they less likely to become delinquent than their non-medicated ADHD peers."[88]

"I do not remember having a kid on medication who consistently behaved better as a result of the prescription."[89]

"Treating ADHD solely with medication will do little to address damage caused by previous negative experiences at school and in the community."[90]

It is common in medicine to use powerful drugs with significant side effects when they are the only effective treatment for a very serious disease. Chemotherapy for cancer is the best example of this. It is unconscionable to use powerful drugs with significant side effects when they are NOT even effective, especially when we are talking about children and especially when there are numerous other "treatments" for something that, as we have seen, may well not even be a "disease", let alone a serious one.

In fact, not only does the use of stimulants have no benefit beyond creating a more docile, compliant and manageable child (and it is highly debatable whether this ought to be consider a "benefit" or a side effect), but in various ways, even aside from the considerable side effects, stimulant treatment can make the overall situation worse for the child and his or her family and teachers:

"Swanson et al. (1993) published a "review of reviews" on the effects of stimulant medication on children with ADHD. Swanson's team of researchers compared three types of reviews published in the late 1970s and 1980s. . . (which) found that stimulants have an effect on attention, concentration and motivation but no clear effect on academic performance or learning, that stimulants may be used as a 'crutch' when implemented in the short term, and that medication treatments may postpone the use of nonpharmacological interventions which may be more effective in the long term."[91]

"Research suggests that when only medical intervention is used to treat individuals with ADHD in the primary school years, the risk of significant problems increase with the additional social and academic demands of secondary school."[92]

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[87] Shaw, Mitchell and Hilton. (2000, December). Are stimulants addictive in children? *Australian* Family Physician, Vol. 29, No. 12.

[88] Purdie, p. 28.

[89] Eagles, Brett. (2001, September 28).

[90] Prosser, B., and Reid, R. (2001, April). *Issues for the Treatment of Attention Deficit Hyperactivity Disorder (ADHD) in South Australia.* Submission to the Social Development Standing Committee, 49th South Australian Parliament, p. 9.

[91] Purdie et al, p. 8.

[92] Prosser and Reid., p. 7.

The meta-analysis conclusion that children on stimulant drugs show no improvement in school actually raises a disturbing possibility. It is well established in educational research that teachers tend to attribute more positive academic performance to students who are not behaviour problems than to those who are. In other words, all else being equal, the compliant child will tend to get better grades that the difficult child. Based solely on this you would expect that drugged children, since they are behaving better, would receive better grades, but this is NOT the case, creating concern that their academic performance is actually worse, but the drop off is compensated by the teacher's favourable reaction to their "improved" behaviour (compliance).

This concern that children actually learn *less* on stimulants is consistent with many self-reports of young people who feel like they are "in a fog" when taking these drugs. Dr. Peter Breggin explains this quite logically through a concept he calls "cognitive toxicity":

> "In evaluating the potential value of Ritalin, it is important to realize that Ritalin not only fails to improve learning and academic performance, it impairs mental function. Ritalin commonly causes "cognitive toxicity"—drug-induced impairments in higher mental processes including flexible problem-solving and other 'higher-order' functions. Stimulants tend to produce obsessive over-focusing on otherwise boring or uninspiring tasks."[93]

4) Long-Term Side Effects

> "Stephanie Hall, of Canton, Ohio, believed ADHD was a disease. She took her Ritalin, religiously. Her parents, Mike and Janet Hall, believed it too. Stephanie Hall died in her sleep, 6 days before her 12th birthday, not from ADHD—because there is no such thing—but from Ritalin, because Ritalin is an amphetamine and because amphetamines have a long history of causing sudden cardiac deaths, even in the young."[94]

> "Death caused from long term use of methylphenidate (Ritalin)": Death certificate of 14 y/o Matthew Smith, 21/03/01, Oakland County, Michigan.[95]

You don't hear much in the media about children like Stephanie Hall and Matthew Smith. They die, and they are forgotten. They are included in this report not to imply that many children who take stimulant drugs die. They are included in this report to emphasize the fact that sometimes a child *does* die from taking a prescribed dose of a stimulant drug. The meta-analysis indicates the children dying from taking stimulant drugs as prescribed may be not be as uncommon as we might think:

> "There have even been reports of death resulting from the pharmacological treatment of people with ADHD."[96]

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[93] Breggin. *Talking Back to Ritalin.*, p. 104.
[94] Baughman Jr., Fred A., M.D. *The ADHD Consensus Conference: End of the Epidemic.*
[95] Smith, Lawrence, Parent. *Ritalin Prescription Takes Life of 14 Year Old.* Available at <http://www.rense.com/general25/14.htm> last visited 05/07/02.
[96] Purdie, et. al., p. 28.

The fact that there are still some ADHD proponents who refer to stimulants as "benign" drugs is shocking, considering the overwhelming and tragic evidence to the contrary. In 1995 the United States Drug Enforcement Agency (DEA) made this abundantly clear:

> "The documentation in this report directly contrasts to the assertions that methylphenidate is a benign, mild stimulant that is not associated with abuse or serious side effects."[97]

Of course, given the information we have already seen, even a small child could see that stimulants are obviously *very* potent and dangerous drugs.

> "Both dexamphetamine and methylphenidate are controlled drugs under Schedule 8 of the Health (Drugs and Poisons) Regulation 1996, and they are classified as specified condition drugs under section 78 of the same regulations, with additional supply and use restriction."[98]

In Queensland, as in other states in Australia, physicians must get approval for every prescription they write for stimulants, and if the treatment persists beyond two months, they must provide an explanation. Why would these precautions be necessary for a "benign" drug?

The Queensland Crime and Misconduct Commission obviously believes stimulants are anything but "benign":

> "Stimulants of this type have a marked abuse potential, and their misuse can have severe adverse medical and social consequences including long-term damage to brain cell structure and function."[99]

> "Effects of withdrawal and misuse may include agitation, hostility, tremors, tachycardia (accelerated heartbeat), heart palpitations, hypertension and drug craving. Psychotic episodes, paranoid delusions, hallucinations and other behavioural characteristics have also been linked the methylphenidate abuse."[100]

The myriad of withdrawal effects that children suffer when discontinuing stimulant drugs is bad enough, but concern is compounded by research indicating the potential of these drugs to cause physiological and psychological dependence:

> "In animals, a compulsive urge to use stimulants, which persists in spite of adverse circumstances and in spite of prolonged periods of abstinence, has been demonstrated."[101]

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[97] Drug Enforcement Agency (DEA) (1995, August 7) Response to CHADD petition concerning Ritalin. Washington, D.C.: DEA, US Department of Justice.

[98] *Is Drugging Children the Answer?* (2002, July 1). Media Release, Youth Affairs Network of Queensland.

[99] The Illicit Market for ADHD Prescription Drugs in Queensland. (2002, April). *Crime and Misconduct Commission*, Crime Bulletin Series, p. 2.

[100] Id.

[101] Shaw, et al. (2000, December).

It has long been reported by parents that children taking stimulants sometimes appear to be sad or less "lively". More and more information is now pointing to the concern that this "sadness" can develop into serious depression.

> "A warning was sounded, however, that some less common side effects such as depression and growth suppression are more serious and parents and teachers need to be alert to their symptoms."[102]

> "Long-term withdrawal from amphetamine use has clearly been associated with severe depression."[103]

Unfortunately, but not surprisingly, when you have a group of children feeling very depressed, there is an increase in the risk of suicide.

> "The (South Australia Parliamentary) Committee was disturbed to hear or read the examples of a number of children who had expressed suicidal thoughts."[104]

> "Suicide is a major complication of withdrawal from this stimulant and similar amphetamine-like drugs."[105]

Drugs in general, and stimulants in particular, pose a particular long-term risk with children, because of their potential developmental effects. It is intuitively obvious that powerful drugs could effect the process of growth and development in a child, and this has been widely acknowledged in the mainstream press, even by the American Psychiatric Association (publishers of the DSM) itself:

> "The term developmental toxicology refers to unique or especially severe side effects caused by interaction between a drug and the process of growth and development. Children and adolescents are growing and developing not only physically but also cognitively and emotionally. It is important that medications not interfere with learning in school or with the development of social relationships within the family or with peers."[106]

Inevitably, we must face the fact that if stimulants effect growth and development they very likely effect the developing brain.

> "There is now a mountain of evidence that stimulants disrupt growth hormone production on a daily basis and that they also can reduce the child's overall growth, including height and weight…It is hard to imagine a more serious warning flag that growth inhibition, since it effects the overall growth of the body and all its organs, including the brain."[107]

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[102] *Inquiry into Attention Deficit Hyperactivity Disorder*. (2002 January 10). Parliament of South Australia, Sixteenth Report of the Social Development Committee, p. 56.

[103] Kean, B. (2002). The Rights of the Child, Attention Deficit Hyperactivity Disorder (ADHD) and Robbie's Case. Southern Cross University.

[104] *Inquiry into Attention Deficit Hyperactivity Disorder,* p 56

[105] *ADHD Facts.* Available at <http://www.fightforkids.com/adhd_facts.htm> last visited 05/07/02.

[106] Dulcan, M. (1994) Treatment of Children and Adolescents. In R.Hales, Yudofsky,S and Talbort, J. (Eds.), *The American Psychiatric Press textbook of psychiatry,* (Second Edition), pp. 1209-1250. Washington, D.C.: American Psychiatric Association.

"The drug commonly used to help Australian children with attention deficit hyperactivity disorder may cause long-term changes in the brain. University of Buffalo scientists have found that Ritalin produced changes in the brains of rat similar to those seen with stimulants such as amphetamines and cocaine, Study author Professor John Balzer said the findings belied the belief that Ritalin, known generically as methylphenidate, was short acting."[108]

"By issuing psychotropics to children, we do, in fact, create an interaction between the chemical, the drug, and the developing organism, and in particular the developing brain, which is the target organ of a psychotropic."[109]

"Stimulants such as Ritalin and amphetamine (also) have grossly harmful impacts on the brain—reducing overall blood flow, disturbing glucose metabolism, and possibly causing permanent shrinkage or atrophy of the brain."[110]

Again, if there is one thing most everyone agrees on pertaining to the long-term side effects of dexamphetamine and methylphenidate usage in children, it is that more research is needed.

"The Australian Medical Association is concerned that insufficient research has been done into the effects of stimulants on brain development."[111]

"We don't know what long term damage is being done."[112]

"…further research into the long-term safety and efficacy of the drugs is required and at this stage, 'convincing evidence for long-term benefit is lacking'."[113]

"The (New South Wales Inquiry) Committee notes the deficiency in reliable and long term research to show the possible side-effects of the use of psychotropic medication."[114]

"There is no information regarding the safety and effectiveness of long-term treatment in children. However, suppression of growth has been seen with the long-term use of stimulants…"[115]

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[107] Breggin, *Talking Back to Ritalin*, p. 25.

[108] *The Brisbane Courier-Mail.* (2001, November 13), p. 3.

[109] Benedetto Vitiello, (1995) at National Institute of Mental Health (NIMH) and Food and Drug Administration (FDA) joint conference on future testing and use of psychotropic drugs in children.

[110] Breggin, p. 54.

[111] Boon, Rosemary. (2002, June 30) quoted in: 50,000 hyperactive children on pills. *The Sun-Herald* (Sydney), p.10.

[112] Weir, David, Noosa Naturopath (2001, February 4), quoted in David Goding: making it all ADD up. *The Courier-Mail*, magazine, p. 8.

[113] Mackey, P. and Kopras, A. (2001, April 3). Medication for Attention Deficit/Hyperactivity Disorder (ADHD): An Analysis by Federal Electorate. Parliament of Australia, Current Issues Brief 11 2000-2001., p. 4, FN 14.

[114] New South Wales Commission for Children and Young People. (2002). *Inquiry Into The Use of Prescription Drugs and Over-The-Counter Medications in Children and Young People,* Issue Paper No. 5: The Use of Prescription Drugs As a Mental Health Strategy for Children and Young People, p. 7.

[115] *Ritalin.* Health Square website, at <http://www.healthsquare.com/newrx/RIT1383.HTM>, p. 2.

It is difficult to sum up the major fears concerning the long-term side effects of stimulant drugs, but a good effort was provided by the International Center for the Study of Psychiatry and Psychology (ICSPP):

> "...the manifold serious adverse effects of Ritalin, from brain damage to withdrawal and rebound, addiction, impaired learning, psychosis, depression and apathy, obsessive-compulsive disorder, motor tics, cardiovascular disease and growth suppression."[116]

Given these major concerns, and the acknowledgement by governmental authorities and others that little is known about the long-term side effects of stimulant use in children, how can we continue to administer these drugs to innocent children by the thousands? Wouldn't it make more sense to wait until more is known, until sufficient research has been done? The combination of insufficient knowledge/research and tremendous anecdotal evidence and widespread concerns adds up to the inescapable fact that the children of Queensland are being used as human guinea pigs, with potential lifelong consequences.

5) Short-Term Side Effects

As noted in the last section, we do not yet know the extent of the long-term side effects of stimulant drugs in children. We know several children have died, some children become depressed and suicidal and there are good reasons to suspect long-term deficits in growth and development, including brain development.

It is impossible to overstate the tragedy of inflicting these things on our children, yet in some ways the short-term side effects are even more tragic. While death and suicide may be relatively rare side effects (although that is no consolation whatsoever for the parents who have lost a child because of prescribed stimulant drugs) there are a myriad of short-term side effects that are quite common.

Probably the most common side effect, and perhaps the saddest, is the "zombie effect":

> "The look in the eyes of a child on Ritalin is like the look in Peter Pan's eyes when Tinkerbell is mortally wounded; like the magic has been snuffed out."[117]

Almost any clinician or teacher who works with children can tell stories about children exhibiting this zombie effect, referred to in psychiatry as a "constricted affect":

> "One way that Ritalin quiets or subdues children is by creating what has been called a zombie effect. The medication can constrict, flatten or suppress a child's mental activity and behaviour, often making the child more obedient or compliant."[118]

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[116] *National Institute of Mental Health Fails in its Latest Effort to Push Ritalin on America's Children.* ICSPP Website at <http://www.icspp.org>.

[117] McCready, Kevin, Ph.D. (1997). Director, San Joaquin Psychotherapy Center, Clovis, California, personal communication to Peter Breggin.

Shockingly, two of the leading biopsychiatric advocates in the United States, L. Eugene Arnold and Peter S. Jensen, acknowledged the "zombie effect" in their chapter on ADHD in the *Comprehensive Textbook of Psychiatry:*

> "The amphetamine look, a pinched, somber expression, is harmless in itself but worrisome to parents…The behavioural equivalent, the 'zombie' constriction of affect and spontaneity, may respond to a reduction of dosage, but sometimes necessitates a change of drug."[119]

Other physicians have chimed in, describing the "zombie effect" in very direct language:

> "In some disruptive children, drug-induced compliant behaviour may be accompanied by isolated, withdrawn, and overfocused behaviour. Some medicated children may seem 'zombie-like' and high doses which make ADHD children more 'somber', 'quiet', and 'still' may produce social isolation by increasing 'time spent alone' and decreasing 'time spent in positive interaction' on the playground."[120]

> "…nearly one-quarter of the children will suffer from an adverse mental effect of irritability or sadness. Sadness and depression are closely related to the robotic effect."[121]

As if it weren't horrific enough to think of 25% of children drugged with stimulants experiencing this sadness and related "zombie effect", some estimates are even higher! In *Psychotropic Drugs fast facts* depression is listed as an adverse effect in 39% of patients taking amphetamines!"[122]

Ironically, one of the strongest arguments advocates of stimulant drugs for children have relied upon through the years is that the drugs help children to do better in school. As we saw in Section 3, there is absolutely no evidence that stimulant drugs have any positive effect on children's educational performance whatsoever. However, listening to the voices of the drugged children helps to uncover the bitter irony that many children find themselves unable to learn *because* they are drugged with stimulants.

> "He told of his private thoughts, his feelings that he was not disordered, and that ADHD only seemed a problem at school. As the story unfolded he expressed concern that while medication enabled him to sit down and be still, it made him so vague that he could not remember things. He desperately wanted to advance to the next year level, but felt unable to learn."[123]

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[118] Breggin, Peter, M.D. *Talking Back to Ritalin,* p. 9.

[119] Arnold, L. Eugene and Jensen, Peters S., M.D. (1995), in *Comprehensive Textbook of Psychiatry.*

[120] Swanson, J.M., Cantwell, D., Lerner, M., McBurnett, K., Pfiffner, L. and Kotkin, R. (1992, fall). Treatment of ADHD: Beyond medication. *Beyond behaviour* 4:No. 1, pp. 13-16 and 18-22.

[121] Breggin, p. 13.

[122] Maxmen, J.S. and Ward. N.G. (1995) *Psychotropic Drugs fast facts, second edition.* New York: W.W. Norton.

[123] Prosser, Brenton. (1998, August). *Hearing Silenced Voices: using narrative research with marginalised youth.* Flinders Institute for the Study of Teaching, available at

> Another child said "My Mum took me to the doctor and he gave me some medication. While it worked a bit to help me calm down, I couldn't remember anything. I felt stupid and trapped."[124]
>
> From a 14-year old writing in his school newspaper: "It screws up our train of thought and makes us one-dimensional. …It takes away that extra imagination and flow of the mind, hence destroying the true, purest ideas of my mind."[125]

One Australian educator has researched learning among children on stimulants and found that what children learn in their drugged condition may not translate to when they are drug-free:

> "The effect of a range of drugs in creating state-dependent learning effects has been downplayed under the hegemonic medical model of ADHD."[126]

Dr. Breggin explains the reduced ability to learn in terms of the chemical's effects on the brain's higher functioning:

> "(This) drug-induced docile behaviour is caused by chemically blunting or subduing the child's higher brain function. That part of the child's brain requiring creativity, freedom, play, energetic activity, consistent discipline, and inspiring educational activities will be blunted."[127]

One incomprehensible marketing strategy adopted by ADHD support groups and drug companies is to recount which historical figures had ADHD. The list usually include such names as Michelangelo, Picasso and Einstein, among many others. Aside from the amusing and obvious question: since professionals in 2002 can't come close to agreeing on who has ADHD today how can we "know" who "had ADHD" 100's of years ago?, it is difficult to discern where they are going with this revelation. The implication seems to be that these great minds would have been identified and therefore drugged with stimulants as children. Are they suggesting this would have been a good thing? Maybe if Michelangelo would have learned to sit still during his tutoring he would have done a better job on the Sistine Chapel? Or Einstein on Ritalin would have written a much more compelling Theory of Relativity? This advertising totally backfires, as it sends out a clarion call of warning of where we might be heading. One United States newsweekly picked up on this, and Dr. Breggin suggests the obvious answer:

> "Recently *Newsweek* asked 'Where do the great minds come from? And why are there no Einsteins, Freuds or Picassos today?' There is a tragic possibility: they are being psychiatrically diagnosed and drugged. Any biography of Einstein, Freud or Picasso will demonstrate enough childhood 'pathology' to warrant

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<http://www.users.senet.com.au/~tolls/rants/hearingsilenced.htm> last visited 03/07/02.

[124] Id.

[125] Scherbel, Matt. (1995). *The Pyle Print.* Bethesda, Md.

[126] Kean, B. (2002). The Rights of the Child, Attention Deficit Hyperactivity Disorder (ADHD) and Robbie's Case. Southern Cross University.

[127] Breggin, Peter R. M.D. Upcoming Government Conference on ADHD and Psychostimulants Asks The Wrong Questions, available at http://www.breggin.com/consensuswrong.html LV 05/07/02.

diagnosis and drugging with the inevitable suppression of his unique contribution to life."[128]

The "zombie effect" may be the most prevalent side effect of stimulant drugs, but it is only one of a very long list. A study of 20 controlled clinical trials between 1976 and 1998 reported the following side effects, sometimes almost cruelly identified as "beneficial effects" of stimulant drugs:

Stereotypical activities (2 studies)
Obsessive-Compulsive Behaviour (4)
Perseverative Behaviour (4)
Cognitive Perseveration (1)
Inflexibility of Thinking (1)
Over-focusing or excessive focusing (2)
Social withdrawal and isolation (3)
General dampening of social behaviour (1)
Reduced social interactions, talking or sociability (6)
Decreased responsiveness to parents and other children (3)
Increased solitary play (2)
Diminished play (1)
Compliance, especially in structured environments (4)
Reduced curiosity (1)
Somber (1)
Subdued (1)
Apathetic; lethargic: "tired, withdrawn, listless, depressed, dopey, dazed, subdued and inactive" (3)
Bland, emotionally flat, affectless (2)
Depressed, sad, easy/frequent crying (6)
Little or no initiative or spontaneity (1)[129]

The literature and research on the use of stimulant drugs, especially with children, is filled with reports of a wide range of short-term side effects, ranging from annoying to disabling:

"The FDA (Food and Drug Administration) reported on May 2, 2000 that 'A total of 4,400 health-related complaints of adverse reactions to methylphenidate have been received since 1969. Thirty percent of those, more than 1,300 complaints, were reported in the last 15 months, including complaints of convulsions and tics, drug dependence, heart ailments, and death.' Some estimate only about one percent of all complaints is ever reported to the FDA."[130]

"Both drugs caused appetite suppression, and DEX caused insomnia…insomnia, irritability, proneness to crying, anxiety, unhappiness, and nightmares were more

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[128] Breggin, Peter R., M.D. (1994) *The War Against Children* NY: St. Martin's Press, p. 72.

[129] Breggin, Peter R., M.D. (1998, November). *Presentation to NIH Consensus Conference.* Table 5: Adverse Drug Reactions from Stimulants Mistakenly Identified as "Beneficial. Data from 20 controlled clinical trials.

[130] The Consequences of Stimulants for ADHD: Suicide and Death. In *Death From Ritalin: The Truth behind ADHD.* Available at <http://www.ritalindeath.com/Page/Contro3.html> last visited 05/07/02.

severe on DEX than MPH."[131]

"…there are some negative effects of using Ritalin, e.g., increased dysphoria and increases in nocturnal enuresis and insomnia."[132]

"In children, loss of appetite, abdominal pain, weight loss during long-term therapy, inability to fall or stay asleep, and abnormally fast heartbeat are more common side effects. Less common or rare side effects may include: Abdominal pain, abnormal heartbeat, abnormal muscular movements, blood pressure changes, chest pain, dizziness, drowsiness, fever, hair loss, headache, hives, jerking, joint pain, loss of appetite, nausea, palpitations (fluttery or throbbing heartbeat), pulse changes, rapid heartbeat, reddish or purplish skin spots, skin reddening, skin inflammation with peeling, skin rash, Tourette's Syndrome (severe twitching), weight loss during long-term treatment."[133]

"This drug (Ritalin) should not be prescribed for anyone experiencing anxiety, tension, and agitation, since the drug may aggravate these conditions."[134]

"Adverse effects of irritability and sadness have not been well studied, but have been reported in up to 22% of children receiving stimulant medication."[135]

"A study of 102 children with ADHD found that many actually felt worse when taking stimulants. The only benefits children perceived were behavioural, eg. able to sit still."[136]

"Side effects of the medication include headaches, sleep problems and loss of appetite."[137]

"…a number of side effects of medical treatments (such as weight loss, shakiness, dry mouth, appetite loss, somatic effects of treatment) have been highlighted."[138]

"Several submissions to the inquiry drew the Committee's attention to the connection between the side effects and withdrawal symptom of the use of Ritalin in children and an increased tendency to suicide."[139]

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131 Efron D., Jarman FC, Barker MJ. (1997). *A Comparison of methylphenidate (MPH) and dexamphetamine (DEX) in children with attention deficit hyperactivity disorder (ADHD): efficacy,* side effects and predictors of response. Royal Children's Hospital Research Foundation.

132 Bailey, Jeffrey G. University of Southern Queensland, Toowoomba. *Medication Practices and Effects for ADHD Students symposia*. SY EDC (1) 1.

133 Health Square website. *Ritalin.* Available at <http://www.healthsquare.com/newrx/RIT1383.HTM>, p. 2.

134 Id.

135 Drug Enforcement Agency (DEA). (1995, October.) *Methylphenidate (A Background Paper).* Washington, D.C.: Drug and Chemical Evaluation Section, Office of Diversion Control, DEA, US Department of Justice.

136 Shaw, Mitchell and Hilton. (2000, December). Are stimulants addictive in children? *Australian* Family Physician, Vol. 29, No. 12.

137 The Illicit Market for ADHD Prescription Drugs in Queensland. (2002, April). *Crime and Misconduct Commission*, Crime Bulletin Series, #4.

138 Purdie, N., Hattie, J. and Carroll, A. A Review of the Research on Interventions for Attention-Deficit Hyperactivity Disorder: What Works Best? *Review of Educational Research*, Spring, 2002, p. 9.

> "Typical of the side effects are those reported by Hedges et al. (1995) who found that 39 per cent of individuals had significant problems with side effects, particularly fatigue and confusion, and had difficulty staying on their medication. Fifty per cent of individuals in the Hedges et al. study experienced nausea, and 17 per cent experienced lower energy, gas, diarrhoea or pain, insomnia, tremor, muscular tension or teethgrinding."[140]

For years the proponents of the biomedical model of ADHD downplayed the side effects of stimulants, calling them "benign" and even likening them to "candy for the brain". The mountains of evidence to the contrary have caused all but the most fanatical zealots to admit that many children taking these drugs are suffering. Needing to still justify the use of stimulants, the proponents came up with the theory that it is not the stimulants that are causing the side effects, it is the "disease"! There is, of course, absolutely no evidence that ADHD (even if it existed) "causes" any of the laundry list of side effects we have just seen, but the proponents have never needed evidence to make their outrageous claims. What they would have us believe is that if a perfectly healthy child starts taking amphetamines and immediately develops tics, irritability, etc., etc., it is because of his "illness" and unrelated to the recently started powerful drugs. This desperate attempt to cling to a discredited theory (that stimulants are safe) is nothing short of an obscenity.

In fact, one of the hallmarks of a dangerous drug is what's called a "rebound" effect, where the problems the drug was supposed to treat get worse when someone tries to discontinue it. Often in psychiatry, patients trying to discontinue their psychotropic medication mistake withdrawal and rebound effects for a return of their "illness", with the result that they gladly resume taking the meds. The rebound effect has been observed in some children taking stimulants:

> "After the drug wears off or is discontinued, a minority of children may show behavioural rebound, a general worsening of behaviour (e.g., increased excitability, impulsivity or talkativeness)."[141]

The Queensland Crime and Misconduct Commission was very clear in describing how dangerous these stimulant drugs actually are:

> "Research clearly indicates similarities between the pharmacological and behavioural effects of these drugs (methylphenidate and dexamphetamine) and amphetamines and cocaine."[142]

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[139] New South Wales Commission for Children and Young People. (2002). *Inquiry Into The Use of Prescription Drugs and Over-The-Counter Medications in Children and Young People,* Issue Paper No. 5: The Use of Prescription Drugs As a Mental Health Strategy for Children and Young People, p. 7.

[140] Purdie et. al., p. 28.

[141] Whalen C. and Henker, B. (1997). Stimulant pharmacotherapy for attention-deficit/hyperactivity disorders: An analysis of progress, problems and prospects. In S. Fisher, and R. Greenberg (Eds.) *From placebo to panacea: Putting psychotherapeutic drugs to the test*, pp. 323-356. New York: J. Wiley & Sons.

[142] The Illicit Market for ADHD Prescription Drugs in Queensland. (2002, April). *Crime and Misconduct Commission*, Crime Bulletin Series, #4, p. 2.

"Methylphenidate is listed as a dangerous drug in schedule 2 and 5 of the Drugs Misuse Regulation 1987, with trafficking carrying a maximum penalty of 25 years' imprisonment."[143]

"(However), both methylphenidate and dexamphetamine are controlled drugs under Schedule 8 of the Health (Drugs and Poisons) Regulation 1996. Owing to their nature and toxicity, they are also classes as specified condition drugs under section 78 of the Health (Drugs and Poisons) Regulation and have additional supply and use restriction."[144]

"(In addition) doctors are required to notify the Chief Health Officer of lengthy treatment (over two months) with methylphenidate and dexamphetamine."[145]

As with any drug, it is certainly true that there are some children who do not experience the more severe side effects of stimulants. It is equally true that these drugs, dexamphetamine and methylphenidate, are among the most powerful and dangerous drugs available to the public by prescription. Anyone who suggests to you that these are benign drugs is insulting your intelligence.

6) Use in Children Under Six

As upsetting as it is to think about any child being drugged with powerful stimulants, it shocks the conscience even more strongly when the child is extremely young. Despite the fact that the "ADHD" drugs have never been approved for use in children under 6, they are routinely prescribed for preschoolers, toddlers and even babies! In Queensland there was one baby prescribed dexamphetamine at 18 months old, and another where the prescription was recommended at 12 months of age. And there is no reason to believe these are aberrations.

We have seen how arbitrary, and often absurd, the ADHD diagnosis is with any child. But how do you diagnose "inattention" in a 18 month old? Perhaps the baby was not sufficiently focused on her building blocks. How do you determine when a 12 month old is "hyperactive"? Excessive crawling?

Fortunately, the drugging of very small children has gotten the attention of many people, and even among "moderates" on the overall ADHD issue there are movements to stop exposing babies and toddlers to dangerous stimulant drugs:

"There are moves in the US for a complete moratorium on the prescription of powerful psychiatric drugs, including Ritalin and the antidepressant Prozac, to children younger than six."[146]

At least one Australian researcher commented on the obvious difficulty in identifying "ADHD" in small children, even if one utilizes the DSM criteria:

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[143] Id.
[144] Id.
[145] Id.
[146] Boon, Rosemary. (2002, June 30) quoted in: 50,000 hyperactive children on pills. *The Sun-Herald* (Sydney), p. 10.

"Accurate diagnosis is particularly difficult in the early childhood years since many of the behaviours of children diagnosed with ADHD are typical in less extreme forms in all very young children."[147]

There can be no question that there are significant number of pre-school age children exposed to stimulant drugs.

"The 2000 report in JAMA reporting 'an alarming increase in the general use of psychiatric drugs for preschoolers'."[148]

"The treatment in NSW in December 2000 of 1,362 children aged six and younger with stimulants, despite Ritalin and dexamphetamine being labelled as approved for use for children older than six"[149]

"The Committee (South Australia Parliamentary Inquiry) heard evidence of toddlers being prescribed amphetamines, which is completely unacceptable."[150]

Although "the labelling of Ritalin and dexamphetamine is that it is approved for us in children with ADD, or ADHD, over six years of age . . . the Committee heard many reports of Ritalin prescribed for children under six."[151]

"Published research shows that there has been some increase in the prescribing of psychotropic drugs in preschoolers, and the increase in children younger that 4 years who are started on stimulant medication is due to an increase in the number of 3 year olds starting the treatment for the first time."[152]

Although many small children are being given stimulant drugs, there is almost no research into possible long or short term effects.

"There is virtually no clinical research on the consequences of pharmacologic treatment of behavioural disorders in very young children…it would seem prudent to carry out much more extensive studies to determine the long-term consequences of psychotropic drugs at this early stage of childhood."[153]

Logically, the concerns about damage to the developing brain are only amplified when we are talking about children at an earlier stage of development.

"These drugs were approved decades ago before their long-term effects on

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147 Porter, L. Selected perspectives on ADD and ADHD. *Australian Journal of Early Childhood.* 22(4), p. 7-14.

148 USA Today Magazine. (2001, March).

149 Bye, Clarissa (2002, June 30). Drug swapping, the schoolyard scandal. *The Sun-Herald*, p. 11.

150 Kanck, Sandra. (2002, January 11). *Australian Democrats News Release.*

151 New South Wales Commission for Children and Young People (2002). *Inquiry Into The Use of Prescription Drugs and Over-The-Counter Medications in Children and Young People,* Issue Paper No.4: The Use by Children and Young People of Prescription Drugs and Over-The-Counter Medications Developed for Adults, p. 5.

152 New South Wales Commission for Children and Young People. (2002). *Inquiry Into The Use of Prescription Drugs and Over-The-Counter Medications in Children and Young People,* Issue Paper No. 5: The Use of Prescription Drugs As a Mental Health Strategy for Children and Young People, p. 4.

153 Coyle, Joseph T., M.D. (2001, March). Quoted in *USA Today* (Magazine).

young children, whose brains are still developing, could be studied and have yet to be fully established."[154]

"There is evidence that the overuse and incorrect use of medication in very young children can affect future brain development."[155]

Given the concerns about future brain development and the unknowns about using powerful stimulants in very young children, the study commissioned jointly by Disability Services Queensland, Queensland Department of Families and Education Queensland recommended:

"In early childhood ADHD, consideration should be given to nonmedical approaches prior to, or simultaneous with, the use of prescription medications."[156]

This is certainly a step in the right direction, but drugs are not typically dispensed to populations on whom they have not been tested, and we need to remember the unequivocal warnings about stimulant use in children:

"This drug should not be given to children under 6 years of age; safety and effectiveness in this age group have not been established."[157]

In a recent editorial, the Sydney Sun-Herald suggested the obvious:

"Perhaps it is time to ask the question: should toddlers and young children six years and under be given mood-altering drugs at all?"[158]

It does not take much common sense to come up with the answer to that question.

7) Recreational Use of Stimulants

"School Daze: With the explosion of prescription medication for children, a dangerous new drug game is being played in our schools" was the headline of a recent edition of the Sydney Sun-Herald.[159] Children are discovering the cocaine-like properties of the stimulants prescribed for "ADHD", and the illicit use of the prescription drugs has become a major problem in society, both in Australia and the U.S.

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[154] Boon, Rosemary.

[155] Parmenter, Trevor., Professor. Director, Centre for Developmental Disability Studies. Royal Rehabilitation Centre, Sydney. (2001, June 18). Evidence presented to New South Wales Inquiry Into the Use of Prescription Drugs and Over-the-Counter Medications in Children and Young People, p. 31.

[156] Recommendations. (2001, November). Unpublished report submitted to Disability Services Queensland, Queensland Department of Families and Education Queensland.

[157] Health Square website. *Ritalin.* Available at <http://www.healthsquare.com/newrx/RIT1383.HTM>, p. 3.

[158] Overdose of parental folly. (2002, June 30). *Sydney Sun-Herald,* p. 20.

[159] *Sydney Sun-Herald*. (2002, June 30).

"Producing cocaine-like stimulant effects, snorted or injected Ritalin is just the latest trend in a resurgence in abuse of stimulant drugs that recalls the 'Speed Freak' era of the late 1960's…Even when taken according to the prescription directions, there is a risk of developing dependence and tolerance to the drug."[160]

"Known on the street as vitamin R, or Ritty, Ritalin is fast becoming the "New Coke" for the younger generation."[161]

"Submissions to the inquiry noted that some school students were using stimulant prescription drugs and medication during exam times and other times of stress or just for fun."[162]

"Prescription drugs used to treat attention deficit hyperactivity disorder are being abused by party-going stimulant users."[163]

"The primary ADHD treatment drugs, methylphenidate and dexamphetamine, go by street names such as poor man's cocaine, the chill pill, get smart, Vitamin R and kiddie cocaine."[164]

"Children are swapping, sharing and selling potentially harmful prescription drugs in the schoolyard."[165]

"(S)tudents (are) using stimulants at exam time as well as 'just for fun'."[166]

"Concern was expressed, in several submissions to the inquiry, about school children selling, swapping or sharing their prescription drugs or medication with other children at school."[167]

"Stuff like Ritalin..everyone takes it! There's so many people selling it."[168]

The illicit use of ADHD drugs is a major problem in Queensland, as noted by the Crime and Misconduct Commission:

"The abuse of ADHD prescription drugs is a potential problem for society, the public health system and law enforcement agencies."[169]

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[160] Bailey, W.J. (1995). Factline on non-medical use of Ritalin (methylphenidate). *Indiana Prevention and Resource Center at Indiana University* available at <http://www.drugs.indiana.edu/pubs/factline/ritalin>.

[161] *PDR.net drug alerts*. (2002). Available at <http://www.pdr.net/drug_alerts/mw_DrugAlerts.jsp>.

[162] New South Wales Commission on Children and Young People. (2002). *Inquiry Into The Use of Prescription Drugs and Over-The-Counter Medications in Children and Young People,* Issue Paper No. 3: Children and Young People and the Misuse and Abuse of Prescription Drugs and Over-the-Counter Medications, p. 2.

[163] Ravers on Child Behaviour Drugs. (2002, May 13). *Brisbane Courier-Mail*, p. 3.

[164] Id.

[165] Drug swapping, the schoolyard scandal. (2002, June 30). *Sydney Sun-Herald*, p. 10.

[166] Id., p. 11.

[167] New South Wales Commission on Children and Young People. (2002). Issue Paper 3, p. 6.

[168] Id., p. 7.

[169] The Illicit Market for ADHD Prescription Drugs in Queensland. (2002, April). *Crime and Misconduct Commission*, Crime Bulletin Series, #4, p. 2.

In one widely publicized Queensland case, a 15-year old Logan girl drugged nine other children in her foster home with her prescribed ADHD medication to "quiet them down".[170]

The Queensland Crime and Misconduct Commission, noting the ease with which children obtain these prescription drugs, warned that the abuse of ADHD drugs is a growing problem in the United States and all over the world:

> "DEA (Drug Enforcement Agency, U.S.) information (2000) suggests that those who are illegally using methylphenidate and dexamphetamine products are obtaining them from people who have been prescribed these medications for ADHD. Adolescents do not have to rob a pharmacy or forge a prescription when they have little difficulty obtaining the drug from classmates at school."[171]

> "The INCB (International Narcotics Control Board) is the UN agency that monitors drug addiction and abuse throughout the world. In its annual reports of 1995 and 1996, the INCB highlighted several cases of abuse and warned of the increasing abuse of methylphenidate worldwide."[172]

This would not be such a major public health issue if these were not such dangerous and addictive drugs. The Commonwealth Government actually targeted Ritalin among a range of drugs deemed "problematic" in terms of abuse during its "National Illicit Drug Campaign".[173]

Every state and territory in Australia has adopted the Standard for the Uniform Scheduling of Drugs and Poisons, which describes Ritalin, a Schedule 8 drug, as follows:

> "Drugs of addiction: Substances which should be available for us but require restriction of manufacture, supply, distribution, possession and use to reduce abuse, misuse and physical or psychological dependence."[174]

The short and long term side effects of the ADHD drugs are devastating in themselves, but the symptoms of overdose are downright frightening:

> "Agitation, confusion, convulsions (may be followed by coma), delirium, dryness of mucous membranes, enlarging of the pupil of the eye, exaggerated feeling of elation, extremely elevated body temperature, flushing, hallucinations, headache, high blood pressure, irregular or rapid heartbeat, muscle twitching, sweating, tremors, vomiting."[175]

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[170] *Brisbane Courier-Mail.* (2002, January 5), p. 8.
[171] The Illicit Market for ADHD Prescription Drugs in Queensland, p. 3.
[172] Id.
[173] New South Wales Commission on Children and Young People. (2002). *Inquiry Into The Use of Prescription Drugs and Over-The-Counter Medications in Children and Young People,* Issue Paper No. 1: Background Issues, p. 13.
[174] Standard for the Uniform Scheduling of Drugs and Poisons. (1998, September).
[175] Health Square website. *Ritalin.* Available at <http://www.healthsquare.com/newrx/RIT1383.HTM>, p. 5.

The amount varies from child to child, but it does not take a tremendous number of pills to cause an overdose.

> "Nearly one-fourth of toxic exposures to methylphenidate CHI (Ritalin) reported to a regional poison control centre in Detroit resulted from accidental overdose. They occurred most frequently in children age 6 to 11, usually because a caregiver administered too many pills..."[176]

Apparently, even parents have discovered they can obtain an inexpensive and legal cocaine substitute by stealing their children's ADHD drugs and chopping them up:

> "Elizabeth Wurzel, writing in The New York Times of April 1, 2000, says that Ritalin has been a gateway drug for many with whom she has interacted at Narcotics Anonymous meetings, where mothers have admitted stealing Ritalin prescribed for their kids, and discussed her own experience of chopping up Ritalin pills and snorting them through her "nostrils almost continuously."[177]

As parents, as adults, as members of society, we have to ask ourselves: are these really the kinds of substances we want our children to be around?

8) Drugs: Society's "Quick Fix"

One of the many ironies about giving drugs to children to change their behaviour is that we live in a world where everyone claims to be concerned about substance abuse in young people. What message are we sending children when we give them a drug so they can adapt better? Children are not stupid, and the message of "take this pill, it will help the teacher to like you " is not that different from "take this pill, it will help that girl to like you". Either we teach children to use drugs to enable them to act differently or we don't.

When private psychiatric hospitals were so popular (and profitable) in the United States during the 1980's and early 1990's, it was a common sight to see children who were hospitalised for substance abuse be stopped on their way to a lesson or lecture on the dangers of drugs, to be given a drug by one of the nurses. Talk about a mixed message!

A powerful mainstream expression of concern about these issues came from the Drug Enforcement Agency (DEA) in the United States:

> "(T)he use of stimulants for the short-term improvement of behaviour and underachievement may be thwarting efforts to address the children's real issues, both on an individual and a societal level. The lack of long-term positive results with the use of stimulants and the spectre of previous and potential stimulant abuse epidemics, give cause to worry about the future. The dramatic increase in the use of methylphenidate in the 1990's should be viewed as a marker or warning to society about the problems children are having and how we view and

[176] White, S.R. & Yadao, C.M. (2000). Characterization of methylphenidate exposures reported to a regional poison control center. *Arch. Pediatr. Adolesc. Med.*, 154(12), 1199.
[177] USA Today Magazine. (2001, March).

address them."[178]

The issue of how we view childhood problems is critical because we are constantly providing role models for our children. How we view problems, and how we see solutions, is likely to become internalised by the next generation. This caused some concern for the Queensland Crime and Misconduct Commission:

> "...the widespread availability of prescription drugs is causing children to view drugs and drug-taking as normal."[179]

Prominent people from all walks of life are beginning to voice serious concerns about how we have come to view childhood behaviours, and how we address them. Jan Burnswoods, a member of the New South Wales Parliament and the Committee for the New South Wales Commission for Children and Young People, has some strong feelings on the issue:

> "I'm worried if it is indeed the attitude that 'this child is noisy, being a nuisance, so let's give them a pill'. I was fairly surprised by the relaxed attitude, even by the Health Department, at the medicalisation of childhood. That's the broad issue of concern."[180]

The underlying issues and values in our society that have led to what Ms. Burnswoods refers to as the "medicalisation of childhood" have led many others to express grave concerns for where we are heading:

> "There is a growing tendency in our society to medicalise problems that are not medical, to find psychopathology where there is only pathos, and to pretend to understand phenomena by giving them a label."[181]

> "(Drug treatment for ADHD) seems it can be, and often is, used as a quick fix for many problems that are socially based."[182]

> "...this increased reliance on drugs reflects a society in distress."[183]

> "Ultimately, we must examine the values that encourage us to drug our children rather that to improve the capacity of our families and schools to meet their individual normal developmental needs."[184]

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[178] Drug Enforcement Agency (DEA) (1996, December 10-12). *Conference report: Stimulant use in the treatment of ADHD.* Washington, D.C.: DEA, U.S. Department of Justice.

[179] The Illicit Market for ADHD Prescription Drugs in Queensland. (2002, April). *Crime and Misconduct Commission*, Crime Bulletin Series, #4, p. 4.

[180] Burnswoods, Jan, MLC. (2002, June 30). Quoted in Drug swapping, the schoolyard scandal. *Sydney Sun-Herald* , p. 11.

[181] Kutchins, Herb and Kirk, Stuart, Psychiatry Professors. (1998). From *Making Us Crazy* . Quoted by Varadarajan, Tunku, Deputy Editor, The Wall Street Journal. (2001, August 21). *Shrinking to Excess: I'll be damned if I let a psychiatrist near my son."* The Wall Street Journal.

[182] Eagles, Brett. (2001, September 28). Oral presentation to Parliament of South Australia Inquiry into Attention Deficit Hyperactivity Disorder, Hansard, p. 146.

[183] Breeding, John, Ph.D. (2000, July). Does ADHD Even Exist?: The Ritalin Sham. *Mothering.* available at <http://www.wildcolts.com> last visited 05/07/02.

[184] Breggin, Peter R. M.D. Upcoming Government Conference on ADHD and Psychostimulants Asks

"…there will often be pressure from parents to obtain some magical pill that will solve all the problems in the shortest possible time without extra effort on anybody's part, particularly if they have heard from another parent that his or her child improved on medication."[185]

"(Or) are we failing as parents, and using drugs to control our children because we don't know any other way to do it?"[186]

"Underlying this veneer of medical benevolence is the harsh reality that it often appears easier for adults to suppress a child with drugs, rather than face the challenging task of transforming themselves and their institutions in a way that really meets the need of that child."[187]

"Many of them understand that they have been given pills instead of love, understanding, or attention….They will assume that adults are supposed to give pills to children instead of giving them psychological and spiritual support. The children will end up blaming themselves for wanting more love and attention than they have been given."[188]

The messages about solving problems with a "magic pill" would be worrisome enough, but in the case of the ADHD drugs it is compounded by evidence that dexamphetamine and methylphenidate are "gateway" drugs. The chilling reality is that children who are drugged with stimulants are more likely to become involved with and perhaps addicted to, illicit drugs in the future.

"…a number of recent studies, drug abuse cases, and trends among adolescents from various sources, indicates that methylphenidate use may be a risk factor for substance abuse."[189]

"A recent study by researchers at the University of California at Berkeley—a study of 500 children over 26 years—found that Ritalin is basically a "gateway" drug to other drugs, in particular, cocaine. Lead researchers Nadine Lambert, as reported in the *Wall Street Journal*, concluded that Ritalin 'makes the brain more susceptible to the addictive power of cocaine and doubles the risk of abuse."[190]

"Too often stimulants become gateway drugs to illicit drugs. As noted, the use of prescription stimulants predisposes children to cocaine and nicotine abuse in young adulthood."[191]

The Wrong Questions, available at http://www.breggin.com/consensuswrong.html LV 05/07/02.

[185] Martin, Graham, Powrie,Rosalind and Ashforth, Peter. ADHD in Children and Adolescents. . (1997, February). *Current Therapeutics,* pp. 28-39.

[186] Overdose of parental folly. (2002, June 30). *Sydney Sun-Herald,* p. 20.

[187] *Informed Consent and the Psychiatric Drugging of Children*. Available at <http://www.wildestcolts.com/mentalhealth/consent2.html> last visited 08/07/02.

[188] Breggin, Peter R. *Talking Back to Ritalin*, p. 93.

[189] Drug Enforcement Agency (DEA). (1995, October.) *Methylphenidate (A Background Paper).* Washington, D.C.: Drug and Chemical Evaluation Section, Office of Diversion Control, DEA, US Department of Justice.

[190] Massachusetts News: *Ritalin. Violence Against Boys.* Available at <http://www.massnews.com/vioboy.htm> last visited 02/07/02.

[191] Breggin, Peter R. M.D. (2000, September 29). Testimony Before Subcommittee on Oversight and

If we want our children to believe us when we warn of the dangers of drugs, we have to stop drugging them when they are difficult for us to handle. If we want our children to believe in themselves and become strong, self-reliant and responsible members of society, we want to teach them to look inside themselves when they have a problem, not look in the medicine cabinet or the school bathroom for a bottle of pills.

9) Getting Rich by Drugging Children

When illicit drugs first invaded our middle-class schoolyards and middle-class sensibilities in the 1960's the evil was personified by the "drug pusher". Even as children we were warned to be wary of the shady looking adult lurking around the playground seeking child victims for his wares.

As our society has evolved over the past 40 years, the "drug pushers" have changed their looks. The sleazy figures on the playground have been replaced by corporate executives in fancy suits, working for pharmaceutical companies.

The involvement of the drug companies in the promotion of the diagnosis of ADHD and the use of stimulant drugs is well documented, although its extent remains somewhat shocking. But the drug companies cannot sell their prescription drugs directly to the public; they need a middleman. The middleman has been the physician; typically the paediatrician in Australia or the child psychiatrist in the United States. Three of the most prominent psychiatrists in the United States have expressed their outrage at psychiatry's complicity in the drugging of our children:

Leon Eisenberg, M.D., Professor of Psychiatry and Social Medicine at Harvard Medical School: "This whole trend toward giving pills to children as a solution to everything, particularly in the absence of evidence that they work, is fundamentally unethical. It's driven by the convenience of the doctor, the profitability of the drug company, and the notion that there is nothing more meaningful to life than bio-chemistry."[192]

Paul R.McHugh, Professor of Psychiatry, Johns Hopkins University School of Medicine: "...In its recent infatuation with symptomatic, push-button remedies, psychiatry has lost its way not only intellectually but spiritually and morally. Even when it is not actually doing damage to the people it is supposed to help,...it is encouraging among doctors and patients alike the fraudulent and dangerous fantasy that life's every passing 'symptom' can be clinically diagnosed and, once diagnosed, alleviated if not eliminated by pharmacological intervention."[193]

Peter R. Breggin, M.D., Author and Founder of the International Center for the Study of Psychiatry and Psychology: "When these children developed depression, delusions, hallucinations, paranoid fears and other drug-induced

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Investigations, Committee on Education and the Workforce, U.S. House of Representatives.

[192] Eisenberg, Leon, M.D. Quoted in Leonard, M. (1997 May 25). Children are the hot new market for antidepressants. *Boston Globe*, p. D1.

[193] McHugh, Paul R., M.D. Quoted in Childhood Behaviour Redefined available at <http://www.fightforkids.com> last visited 05/07/02.

> reactions while taking stimulants, their physicians mistakenly concluded that the children suffered from 'clinical depression', 'schizophrenia' or 'bipolar disorder' that has been 'unmasked' by the medications. Instead of removing the child from the stimulants, these doctors mistakenly prescribed additional drugs, such as antidepressants, mood stabilizers, and neuroleptics. Children who were put on stimulants for 'inattention' or 'hyperactivity' ended up taking multiple adult psychiatric drugs that caused severe adverse effects, including psychoses and tardive dyskinesia."[194]

Just as the diagnosis of ADHD has little to do with medical science, there appear to be political and economic explanations for the surge in popularity of the diagnosis, and especially of the drug treatment for it, in the past 20 years.

> "Instead of being based on new findings, the resurgence of ADHD/Ritalin is a matter of politics. Biological psychiatry interest groups have been pressing for decades to capture the child market for drugs and for their professional services."[195]

> "For psychiatrists to receive payment from health insurance companies, they must find a way to label a patient with a recognized condition—which is why they recognize more, and more, and more conditions. Wait for the next DSM, and there will be at least another 50 conditions added to the existing list."[196]

> "The unlabeled masses are a vast untapped market, the virgin Alaska oilfields of mental disorder."[197]

With "the market for ADHD products estimated at $670 million (U.S.) annually"[198] the drug companies have gotten more and more aggressive in their marketing. The New York Times reported last year that:

> "Drug companies are breaking with 30-year-old international marketing restrictions to advertise directly to parents, selling the idea that drugs may be the answer to their children's problems at school."[199]

The millions of dollars poured into direct advertising have not been spent in vain. Parents, increasingly seduced by the simplistic, misleading ads depicting the dangerous stimulants as benign panaceas, are going to their physicians clamouring for drugs for their children. The Sydney Sun-Herald editorialised that "We have simply succumbed to the blandishments of the drug companies."[200]

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[194] Breggin, Peter R, M.D.. Confirming the Hazards of Stimulant Drug Treatment. Available at <http://www.breggin.com/ritalinconfirming the hazards.html> last visited 05/07/02.

[195] Breggin, Peter R. *Talking Back to Ritalin,* p. 176.

[196] Varadarajan, Tunku, Deputy Editor, The Wall Street Journal. (2001, August 21). *Shrinking to Excess: I'll be damned if I let a psychiatrist near my son."* The Wall Street Journal.

[197] Kutchins, Herb and Kirk, Stuart, Psychiatry Professors. (1998). From *Making Us Crazy* . Quoted by Varadarajan, Tunku, Deputy Editor, The Wall Street Journal. (2001, August 21). *Shrinking to Excess: I'll be damned if I let a psychiatrist near my son."* The Wall Street Journal.

[198] Magill-Lewis, Jillene. "Psychotropics and Kids." Drug Topics 3 Jul. 2000: 35-42. ProQuest. 5 Sept. 2000 <http://proquest.umi.pqdweb>.

[199] *New York Times.* (2001, August 19).

[200] Overdose of parental folly. (2002, June 30). *Sydney Sun-Herald,* p. 20.

Unfortunately, the reality is not that simple. Because their wares are only available through prescription, it is not enough for drug companies to appeal directly to consumers. They have to seduce the physicians, and they have gone about that seduction in the most insidious manner.

It is common practice for drug company representatives ("drug reps") to visit physician's offices bearing gifts for the doctor and the office staff. Desk accessories, miniature clocks, calendars and pens, with the drug's name dutifully inscribed, are all popular. Obviously, this is a woefully inadequate incentive for physicians, most of whom can well afford to purchase their own knick-knacks.

The drug companies do employ the "gift" strategy on a grander scale, inviting physicians to fancy conferences at exotic locations. According to Dr. George Halasz of the Australia National Association of Practicing Psychiatrists (NAPP): "the relationship between pharmaceutical companies and the psychiatric profession is a major focus of professional debate."[201] Still, though, these classic capitalists were faced with the grim reality that the vast majority of physicians could not be bought and would only prescribe a drug if they thought it was helpful and safe. This presented a major problem for the makers of stimulant drugs, because their products were neither safe nor effective.

One of the basic principles of marketing is that it what your product is matters less than what people believe it is. If the products were not safe or effective, the products could still sell if the research indicated they *were* safe and effective. This realization has led to one of the greatest controversies in recent medical history: the extent to which the drug companies influence the research of their drugs.

According to Dr. Elliot Valentin, University of Michigan neuroscientist and Professor Emeritus of Psychology:

> "I am convinced that the pharmaceutical industry spends enormous amounts of money to increase its sales and profits by influencing physicians and the public in ways that sometimes bend the truth and that are often not in the best interests of science or the public."[202]

In the United States it is common knowledge among applicants that the vast majority of the research on ADHD that gets funded is supportive of the biomedical approach. This "stacked deck" is anathema to real science and sets up a vicious cycle, where any discordant research can be rejected because there is no body of work preceding it. It is the same motus operandi that was used to scorn Copernicus when he said the Earth was round: just get 100 others who are willing to say the earth is flat, and then discredit Copernicus because the "body of knowledge" proves he's an extremist. However, the connection between the drug companies and the professional journals may be even more insidious.

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[201] Halasz, George, M.D. (24 August 2001). Oral presentation to Parliament of South Australia Inquiry into Attention Deficit Hyperactivity Disorder. Hansard, p. 64.

[202] Valenstein, Elliott. Quoted in *Death from Ritalin: The Truth Behind ADHD* available at <http://www.ritalindeath.com/Page/Contro6.html> last visited 05/07/02.

> "The influence of the major drug companies in marketing strategies using professional publications is heavily underestimated. NAPP is also mindful that professional information in regard to drug management is disseminated via articles in professional journals. There is increasing concern that these same articles that purport to set objective standards are indeed caught up in conflicts of interest, occasioned by the fact that drug companies often heavily influence the reported findings."[203]

Recently, two of the most prestigious United States medical journals, the New England Journal of Medicine and the Journal of the American Medical Association (JAMA) have called for a new policy concerned publication of drug-related articles.

> "This came about because of the impossible position in which editors were put where submissions excluded certain negative findings from the drug companies. The drug companies funded the research. Therefore, they felt they had a right to contribute to the editing process which seems on the surface reasonable. However, the editors of the journal found that the degree to which the editing was taking place was no longer consistent with ethical medical publication. This is the degree to which the relationship between pharmaceutical companies and individual practitioners and the medical publishing world is current at major debate."[204]

Russell Barkley, the most prolific author of pro-biomedical model "research" on ADHD, reportedly has received financial support from Novartis, the makers of Ritalin. The huge U.S. ADHD support group, CHADD (Children and Adults with Attention Deficit Disorder) has acknowledged receiving significant financial assistance from Novartis. Several major lawsuits in the United States are currently pending alleging a conspiracy between Novartis and the American Psychiatric Association to invent and promote an "illness", ADHD, for financial reasons.

The inescapable bottom line is that drugging children is a multi-million dollar industry, and a lot of people have a lot at stake. It is important to take what you hear and what you read on this topic with a healthy dose of skepticism.

10) Iatrogenics: When the Problem is Caused by the Treatment

The hallmark of emotional health is a sense of empowerment and personal responsibility. Having a sense of being in charge of one's own life can turn an unhappy "victim" into a happy, responsible adult.

The flip side of emotional health is feeling depressed, and we feel depressed when we feel helpless. One of the most famous experiments in psychology coined the phrase "learned helplessness". In Seligman's famous work, dogs were randomly administered electric shocks in their cages. At first they learned how to avoid the shocks by moving to the other side of the cage, but then that stopped working.

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[203] National Association of Practicing Psychiatrists. (2002). Written submission to the Parliament of South Australia Inquiry into Attention Deficit Hyperactivity Disorder.

[204] Halasz, George, M.D. (24 August 2001). Oral presentation to Parliament of South Australia Inquiry into Attention Deficit Hyperactivity Disorder. Hansard, p. 64.

Eventually, the dogs gave up trying to escape the shocks and just laid there without even trying to escape the pain of the electrical jolt. They had learned to be helpless.

It is axiomatic among psychotherapists that the goal of therapy is to "empower" clients; to help them feel strong and responsible for their own happiness. Therapists will often tell clients "you have everything you need" to be happy in the world.

Psychiatric diagnoses in general, and the diagnosis of ADHD specifically, have the opposite psychological effect of therapy. Children are told they are sick (there is even a well known children's book written for "ADHD" children using the analogy of a car with faulty brakes) and in need of *outside* intervention. Children are told, overtly or otherwise, that they are not responsible for their own actions.

The iatrogenic effect of the ADHD diagnosis on the child is the creation of someone who labels themself as impaired and does not accept responsibility for their own actions:

> "Biopsychiatry appeals to people who feel so helpless that they want to give up responsibility for themselves, and to parents and teachers who feel so frustrated or baffled that they uncritically turn to the experts….But biopsychiatry has no place in a world in which children need attention, love, improved parenting, better schooling, and more equal opportunity. It has no place in a society in which adults take responsibility as parents, teachers, or child advocates."[205]

> "The aim of school is to educate children to become productive members of a democratic society. We want our children to become self-confident, successful persons who can assume responsibility for their behaviour. (Children labelled ADHD) come to believe that external events such as luck, fate, or other people are responsible for their success or failure. Such an attitude is hardly conducive to the development of self-confidence and success. Rather, it leads to low self-esteem, depression, and feelings of ineffectiveness."[206]

> "(The uses of stimulants has) indirect and inadvertent cognitive and social consequences, such as lower self-esteem and self-efficacy; attribution by child, parents, and teachers of both success and failure to medication, rather than to the child's effort; stigmatisation by peers; and dependence by parents and teachers on medication rather than making needed changes in the environment."[207]

Adults who have worked with children diagnosed as "ADHD" and prescribed drugs as "treatment" all have variations on this story: A small child wakes up in the morning and throws a tantrum. When the parent/teacher/caregiver begins discussing discipline, the child protests on the grounds that they are sick and cannot, in all fairness, be held responsible.

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[205] Breggin, Peter R., M.D. (1994) *The War Against Children* NY: St. Martin's Press.

[206] Lavin, Paul, Ph.D. (1991). Coordinator for children with attention deficit disorder. *Elementary* School Guidance & Counseling, 26, 115-116.

[207] Dulcan, M. (1994) Treatment of Children and Adolescents. In R.Hales, Yudofsky,S and Talbort, J. (Eds.), *The American Psychiatric Press textbook of psychiatry,* (Second Edition), pp. 1209-1250. Washington, D.C.: American Psychiatric Association.

> "The child can conclude that he is not responsible for his behaviour. 'I can't help being bad today. I haven't had my pill.' The child comes to believe not in the soundness of his own brain and body, not in his growing ability to learn and to control his behaviour, but in 'my magic pills that make me into a good boy and make everyone like me.'"[208]

As previously discussed, children are not stupid, and they have reached the correct conclusion given the information they were provided. If a child is sick and their sickness is what causes them to misbehave, then punishing them for misbehaviour would be no fairer than punishing an epileptic for having a seizure. How far a leap is it to imagine a teenager blaming his delinquency on his "sickness" in a not guilty plea? We may be raising a disempowered generation of children, considering themselves to be impaired victims and ready to blame anything but themselves for what they do and for the direction of their lives. This could well be the fruit borne by the iatrogenics of the treatment of ADHD.

> "…in the grip of a dogma that holds that all troubles in people are the product of some internal dysfunction, we have had a veritable proliferation of madness. The ascendancy of this view can be linked, among other things, to a decline in the belief in individual responsibility."[209]

> "The people who prescribe chemotherapy for inattention and restless action have no idea how damaging it is…As for mental effects, such as the child coming to see himself as a damaged person, these prescriptors remain quite oblivious."[210]

But it is not just the children who are caught up in the disempowering web of biomedical ADHD. One of the most striking phenomena of ADHD has been the stridency with which parents have embraced the biomedical model:

> "Solely biological causality has been questioned from scientific and social perspective on a number of grounds. However, the neuro-psychological perspective continues to be presented and accepted as factual, especially in the popular press. Parents and parent advocacy groups also fiercely embrace it. Nothing is more likely to rouse the ire of a parent of a child with ADHD or an advocate than to question the existence of biological cause of ADHD."[211]

Dissidents from the biomedical model in the United States have been subjected to cruel personal attacks from parent support groups. You might think that parents would be delighted to hear someone suggest that perhaps their child is not "sick" and does not need any medication. However, these parents instead react angrily to the possibility. Understanding the dynamics of that reaction is critical to understanding the iatrogenics within the family of ADHD labelling and medicating.

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[208] Strouf, L.A., and Stewart, M.A. (1973) Treating problem children with stimulant drugs. *New* England Journal of Medicine, 289, 407-412.

[209] Varadarajan, Tunku, Deputy Editor, The Wall Street Journal. (2001, August 21). *Shrinking to Excess: I'll be damned if I let a psychiatrist near my son."* The Wall Street Journal.

[210] Kiersey, David, Ph.D. (1988) Personal correspondence to Peter Breggin.

[211] Reid, R. (1996) Three Faces of Attention Deficit Hyperactivity Dirorder. *Journal of Child and Family Studies*, 5(3), pp. 249-265.

It is axiomatic that children do not come with an owner's manual, and the vast majority of parents are trying to do their very best with whatever information they have. In competitive societies like Australia and the United States, people tend to evaluate themselves based on their "performance", and parenting is an area people care deeply about. The result is that people judge themselves as parents based on how well their child is doing, and the external signs of "how well they are doing" are typically school and behaviour. If a child is a behaviour problem many parents assume it is because they are somehow inadequate or failing in their roles. They feel guilty, and burdened with a responsibility (to "fix" it) that seems overwhelming.

If someone comes along and suggests that the problem is that their child is sick, there is quite literally a 180 degree shift in the psychodynamics. Instead of parents being (in their own perception) inadequate and guilty, they become victims, deserving of pity and praise for their heroic efforts in dealing with their diseased child. By virtue of the child being sick, the parents can breathe a sigh of relief. They are off the emotional hook, and that is the seductiveness of the biomedical model of ADHD for parents.

> "A child, his parents, teachers, etc. all become dependent on the ingestion of pills per se, independent of the chemical effects of a drug…Handing a child a pill each day is a simple task, and it allows the parents the comfort of placing the explanation for their child's hyperactive behaviour on his physiological makeup. They are thereby absolved of any responsibility."[212]

> "The most difficult part of parenting is instilling discipline. Small wonder, then, that if science suggests bad behaviour might be a medical condition treatable by popping a pill, we accept it."[213]

> "Because it is so convenient and guilt-reducing to be able to attribute a child's difficult behaviour to a neurochemical problem rather than a parenting or broader social one, there is a risk this problem will become dangerously overmedicalised."[214]

Stigmatized and irresponsible children are only half the iatrogenic fallout of the ADHD craze and the use of stimulant drugs. Helpless and disempowered parents are the other half; parents who have been so indoctrinated into a belief system where they are OK because their child is sick that they react violently to someone telling them that perhaps their child is normal and healthy. Dr. Breggin summarizes this tragic iatrogenic cycle:

> "Finally, when we diagnose and drug our children, we disempower ourselves as adults. While we may gain momentary relief from guilt by imagining that the fault lies in the brains of our children, ultimately we undermine our ability to make the necessary adult interventions that our children need. We literally become bystanders in the lives of our children."[215]

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[212] Stableford, W., Butz, R., Hasazi, J., Leitenberg, H. and Peyser, J., University of Vermont psychologists. (1976). Sequential withdrawal of stimulant drugs and use of behaviour therapy with two hyperactive boys. *American Journal of Orthopsychiatry.* 46, 302-312.

[213] Overdose of parental folly. (2002, June 30). *Sydney Sun-Herald.*

[214] Gliksman Michael, M.D., Sydney public health physician. (2002, June 30). Quoted in Overdose of parental folly. (2002, June 30). *Sydney Sun-Herald,* p. 20.

11) Since When Is Problem Behaviour A "Disease"?

Individuals having the courage to deviate from social and political norms were at the root of every great movement against oppression and mistreatment in history. The individual refusing to comply with the Nazis in 1940 Germany was a deviant. The American landowner refusing to own slaves in 1850 was a deviant. Gandhi and Jesus Christ were deviants. When the group in power begins to define deviance as "disease", and drug people as a consequence, a very scary situation emerges.

> "While the ability to adjust socially may be important, it is not always a "good" thing. In its most extreme form, social adjustment leads to conformity and compliance, which has resulted in dire social phenomena, including slavery and genocide."[216]

As Dr. Brenton Prosser notes, the method of diagnosing ADHD "has raised some professional concern as it proposes a medical response to what are primarily breaches of contemporary social norms."[217] This seemingly simple observation is actually quite profound and raises a series of troubling issues. If, in the words of Dr. Levy and associates, "…the problem is one of deviance from an acceptable norm"[218], then we have to ask who determines the norm, and how medicine got involved in what is essentially a political issue.

Historically, people in power would determine what "normal responses" were, and might punish responses they considered "abnormal". In the 21st century, when human sensibilities have evolved to a place where most people would consider such direct and arbitrary exercise of political power abhorrent, the job of "policing" has quite literally been handed over to psychiatry. Not only does this avoid the stigma of the powerful controlling the powerless arbitrarily, it gives a medical imprimatur to the process. We are not declaring you abnormal because you violate our subjective standards of normalcy and disrupt our neat little world; we are declaring you abnormal because the doctor says you are "sick". It is a scary and insidious process. It is much easier to rally support for political prisoners than for "prisoners" of psychiatric drugging, especially when the prisoners are children.

> "What we appeared to be looking at was the increasingly routine use of 'treatment' as punishment; the psychiatric policing of children."[219]

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[215] Breggin, Peter R. M.D. (2000, September 29). Testimony Before Subcommittee on Oversight and Investigations, Committee on Education and the Workforce, U.S. House of Representatives.

[216] Breeding, John, Ph.D. (2000, July). Does ADHD Even Exist?: The Ritalin Sham. *Mothering.* available at <http://www.wildcolts.com> last visited 05/07/02.

[217] Prosser, Brenton. (1998, August). *Hearing Silenced Voices: using narrative research with marginalised youth.* Flinders Institute for the Study of Teaching, available at <http://www.users.senet.com.au/~tolls/rants/hearingsilenced.htm> last visited 03/07/02.

[218] Levy, F., Hay, D.A., McStephen, M., Wood, C., and Waldman, I. (1997) Attention-deficit disorder: A category or a continuum? Genetic analysis of a large scale twin study. *Journal of the* American Academy of Child and Adolescent Psychiatry, 36, 737-744.

[219] Armstrong, L. (1993) *And They Call it Help: The Psychiatric Policing of America's Children.* New York: Addison-Wesley Publishing Co.

ADHD became extremely fashionable in the United States during the 1980's, which were politically the Reagan-Bush years. The government in power sought to roll back social programs and scapegoat the poor, the disenfranchised, and minority groups for crime and other social problems, including their own poverty. In Australia, there was a "trend within Australian neo-conservative policy and economics to define problems as individual deficits."[220] The recent meta-analysis on ADHD touched on this issue as well:

> "…economic factors (that) have led to reductions in mental health, education and managed care services, thereby promoting the "mediatisation" of ADHD."[221]

The conservative political ethic of the day dovetailed perfectly with the ADHD movement as psychiatry located the source of the problem inside the child, instead of looking for answers in the environment. Instead of the government having to spend tax dollars to address social problems that money could go back to the wealthy and the corporations, while individuals poured money into the drug companies to get the magic pill to fix their diseased children. Of course, this approach is inherently racist and elitist, as it ignores the problems of racism and poverty as causative factors in the behaviour of children who are poor, who are members of racial minorities, or who are otherwise disenfranchised. When you have to live in abject squalor and terrible danger with little hope of ever escaping, who decides what behavioural response is "normal"? Is it appropriate for a group composed primarily of rich, old, white men to sit in judgment on the behavioural appropriateness of children living in such horrible situations?

> "The approach was most commonly employed by youth workers who argued that young people with problems are responding normally to abnormal family and social environments."[222]

Other researchers have commented on this failure to look at the context of the child's life and instead rushing to make a judgment of internal pathology:

> "Because of the medical model, we are too often willing to localise academic and behavioural problems solely within the individual child rather than looking for contributing factors in the larger contexts of the child's experience."[223]

> "When a child fails to adjust to school, we should at the very least think about our abilities to consider the child's needs. …young children must be enabled to express their unique gifts within their communities."[224]

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[220] Thomson, P. (1997). Back on the borderline: the marginalisation of equity in federal schools policy. *Education Leader*, 9(1), 1-9.

[221] Purdie, N., Hattie, J. and Carroll, A. A Review of the Research on Interventions for Attention-Deficit Hyperactivity Disorder: What Works Best? *Review of Educational Research*, Spring, 2002, p. 4.

[222] *Mental health and young people: A report into the nature of mental health problems experienced by young people and implications for service provision.* Australia Clearinghouse for Youth Studies, Hobart: 1992. Chapter 3, p. 10, available at <http://www.acys.utas.edu.au/ncys/nyars/mental/contents,html> last visited 14/06/02.

[223] Damico, J.S. & Augustine, L.E. (1995) "Social Consideration in the Labeling of Students Attention Deficit Hyperactivity Disorder" *Seminars in Speech and Language*, 16(4), 259-274.

The idea that psychiatric drugging is used as a political means of social control over low income and minority children has been frequently cited:

> "A higher proportion of those on the drugs were living in low-income, single parent or blended families, and families with unemployed parents."[225]

> "(M)edication use was more likely in areas of low income and employment".[226]

> "'We call it the racism pill…This is a pervasive feeling in many minority communities because schools have not created an environment that is hospitable to our children."[227]

When the quasi-scientific jargon is stripped away, the essence of the identification and "treatment" of ADHD is identifying children whose behaviour bothers adults, and then drugging them into compliance, or at least passivity.

> "Children become diagnosed with ADHD when they are in conflict with the expectations or demands of parents and/or teachers. The ADHD diagnosis is simply a list of the behaviours that most commonly cause conflict or disturbance in classrooms, especially those that require a high degree of conformity….The medicating of the child then becomes a coercive response to conflict in which the weakest member of the conflict, the child, is drugged into a more compliant or submissive state."[228]

> "For fifty years now, the drug methylphenidate …has been the principle agent of social control used by the medical community to fit creative or wilful children into mediocre classrooms."[229]

> "If Huckleberry Finn and Tom Sawyer were in a school in Massachusetts today, they'd be drugged with Ritalin, according to many psychiatrists and other experts. The drug is being used to sedate active, young boys because the teachers are unable to relate to them."[230]

With another right-wing, reactionary government in power in the United States, there are many who fear that political pressure in support of psychiatry will increase.

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[224] Breeding, John, Ph.D. (2000, July). Does ADHD Even Exist?: The Ritalin Sham. *Mothering.* available at <http://www.wildcolts.com> last visited 05/07/02.

[225] Australian kids first in mind medicine. (2002, July 1) *Brisbane Courier-Mail*, p. 5.

[226] Prosser, B. *Behaviour Management or Management Behaviour? A sociological study of Attention Deficit Hyperactivity Disorder (ADHD) in Australian and American secondary schools.* Available at <http://www.ozemail.com.au/~bjpreoss/adhd.html> last visited 03/07/02.

[227] Jordan, Dixie., a Native American parent. (1995). American quoted at a recent NIMH conference on psychopharmacology and children.

[228] Breggin, Peter R. M.D. (2000, September 29). Testimony Before Subcommittee on Oversight and Investigations, Committee on Education and the Workforce, U.S. House of Representatives.

[229] Woodward, John R., M.S.W., Center for Independent Living of North Florida, Inc.: *Ritalin Abuse: The Chemical Dependency of Inadequate Schools*. Available at <http://www.wnydf.bfn.org/library/ritalin.text> last visited 02/07/02.

[230] Massachusetts News: *Ritalin. Violence Against Boys.* Available at <http://www.massnews.com/vioboy.htm> last visited 02/07/02.

> "Our society's tolerance for behaviours appears to be shrinking, we are rapidly moving towards a version of 'one size fits all' where any behavioural deviation from the norm is unacceptable."[231]

At least two recent incidents suggest that these fears are well grounded in reality:

> "Jill and Michael Carroll were concerned that their son, Kyle, was sleeping only five hours a night and eating only one meal a day. So they told school officials they wanted to take Kyle off the Ritalin for two weeks to see if that helped. Sounds reasonable, but that's when they got a call, and then a visit, from a Child Protective Services worker, based on a complaint from Kyle's school guidance counsellor. The charge was 'child abuse' in the form of 'medical neglect'."[232]

> "This February, Tammy Kubiak of Buffalo, New York lost custody of her 12-year old son for taking him off three psychiatric drugs which she reports were making him 'zombie-like'."[233]

As we will see in the next section, legislation is being introduced in various parts of the United States to protect parents like these, and hopefully with more education the coercion in support of psychiatric drugs will become a thing of the past. In the meantime, though, there are significant reasons for parents to worry that they might have difficulty protecting their own children from the physical and emotional ravages of this diagnosis and these drugs:

> "We are witnessing a frightening, draconian assault on families. Parents who attempt to protect their children from the dangerous, harmful effects of psychiatric drugs are accused of irresponsible neglect and threatened with state removal of their children. This is a family's worst nightmare come true, and it is a shame and a disgrace. The therapeutic state is truly out of control."[234]

12) Legal Issues: Lack of Informed Consent

There is nothing more basic than the legal right to bodily integrity. A hallmark of most legal systems is that innocent people are protected from anything happening to their own body without their consent. According to an article in the *DePaul Journal of Health Care Law:*

> "true consent to what happens to ones self is the informed exercise of choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each."[235]

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[231] Reid, R. (1996) Three Faces of Attention Deficit Hyperactivity Dirorder. *Journal of Child and Family Studies*, 5(3), pp. 249-265.

[232] *A Call to Legislative Action: Stop the Mass Psychiatric Drugging of United States School Children.* Available at <http://www.wildestcolts.com/safeEducation/stopthemass.html> last visited 08/07/02.

[233] Id.

[234] Id.

[235] Baker, J. (1997). Tardive Dyskinesia: Reducing Medical Malpractice Exposure Through a Risk-Benefit Analysis. DePaul Journal of Health Care Law.

Neither parents nor children given a prescription for dexamphetamine or methylphenidate receive anything approaching true informed consent. Parents are told their child has a "brain disease"; they are typically not told that no one knows what ADHD is or whether it even exists, or that there is absolutely no test to determine if their child "has it" or not. Parents are often told that the stimulant drugs may have some side effects, but they are typically not told that the drugs are not recommended in children under 6 and may cause growth deficits, deficits in brain development, or death.

Children themselves are typically given no right to informed consent at all, despite the fact that in many cases they are fully competent to understand the risks and benefits involved in the proposed treatment.

The issue of consent to health care of young people was the subject of a major 1996 report issued by the Queensland Law Reform Commission[236] It has also been identified by representatives of various organizations as a major issue throughout Australia:

> "The Commissioner for Children and Young People advised the committee that issues of confidentiality and consent to health care of young people were major concerns raised by representatives of more than thirty youth and health-related organizations at a National Youth Health Summit organized by the Australian Medical Association held in Canberra in July 2001."[237]

There is vast legal precedent for failure to provide informed consent constituting per se medical malpractice, and:

> "As is the case with adults, health care providers may be liable for criminal ad/or civil assault for any touching involved in the provision of health care to a young person of any age (0-17 years of age) if they do not have a valid consent. Additionally, they may be liable if the health care is not in the best interests of the young person."[238]

Given the significant ethical and legal consequences of failure to provide informed consent, you would think that a statute requiring truly informed consent for ADHD treatment would be supported by people on either side of the debate. You would be wrong.

In the United States, California Senate Bill 1290, currently under consideration, has been opposed by the following organizations: American Academy of Pediatrics, California Academy of Family Physicians, California Medical Association, California Psychiatric Association, California School Nurses Association, and NAMI (National Association for the Mentally Ill) California.[239] In attempting to understand where

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[236] *Consent to Health Care of Young People*. (1996, December). Volume Three: Summary of the Commission's Report, Report No. 51, Queensland Law Reform Commission.

[237] New South Wales Commission on Children and Young People. (2002). *Inquiry Into The Use of Prescription Drugs and Over-The-Counter Medications in Children and Young People,* Issue Paper No. 1: Background Issues, p. 15.

[238] *Consent to Health Care of Young People*. (1996, December). Volume Three: Summary of the Commission's Report, Report No. 51, Queensland Law Reform Commission, p. 1.

[239] SB 1290: Senate Health and Human Services-Committee Analysis. Available at

these groups, all strong proponents of the biomedical model of ADHD and supporters of the use of stimulant drugs, are coming from it is instructive to review the proposed legislation:

California Senate Bill 1290 has the following provisions:

1. Requires a physician and surgeon, before prescribing, dispensing, or furnishing a "psychotropic drug" that is "used primarily to treat Attention Deficit/Hyperactivity Disorder" and is a Schedule II medication, to inform the child's parent or guardian of their right to accept or refuse the medication.

2. Requires a physician and surgeon, before prescribing, dispensing, or furnishing a psychotropic drug that is used primarily to treat Attention Deficit/Hyperactivity Disorder and is a Schedule II medication, to provide the child's parent or guardian with information, as specified in the bill, including:

   - The nature of the child's mental condition;
   - The reasons for taking the medication, including the likelihood of improving or not improving without the medication;
   - That the parent's or legal guardian's consent may be "withdrawn" at any time "by stating that intention to any member of the treating staff";
   - The "reasonable alternative treatments" if any;
   - The "type, range of frequency, and amount, including PRN orders", method and duration of taking the medications;
   - The "probable" side effects of the medications known to commonly occur and "any particular side effects likely to occur with the particular child";
   - The "possible additional side effects which may occur if the medication is taken beyond three months" as well as "other immediate side effects".

3. Requires the physician to provide the above information in the parent's or legal guardian's "native language, if possible".

4. Requires that the physician and surgeon, before prescribing Schedule II medications that are primarily used for the treatment of ADHD, obtain a "signed consent form" from the child's parent or legal guardian that includes all the information specified in (1) and (2) above.

5. Provides that it shall constitute "unprofessional conduct" for a physician to prescribe Schedule II medications used primarily for the treatment of ADHD if all of the informed consent requirements described in (1), (2) and (3) above, are not met. Also, provides that a physician whose failure to comply with the requirements of SB 1290 constitutes unprofessional conduct would not be subject to Business and Professions Code Section 2314 (i.e., would not be a misdemeanor).

6. Provides that a physician and surgeon may prescribe, dispense, or furnish any psychotropic medication to a child who has been judged a dependent or ward of the court, pursuant to a judge's order, as provided in existing Welfare and

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<http://www.chaddnorcal.org/VAN/Bills/SB%201290/sb_1290_senate_analysis.htm> last visited 08/07/02.

Institutions Code Section 369.5.[240]

What in the world are proponents of the biomedical model afraid of in this legislation? A careful review of the provisions reveals that it promises nothing more than a physician is responsible for providing with any procedure: true informed consent. Yet it has engendered bitter opposition from "mainstream" providers. It is incumbent upon us all to ask: Why?

Of course, the likely (and only?) explanation is that biomedical providers do not want to tell their patients the whole truth about ADHD and stimulant drugs.

> "..to say or even imply that what a patient has is biologic and a disease when there is no such proof (as in all psychiatric 'diseases') is conscious deception and abrogates informed consent. That this has become the 'standard of practice' in psychiatry does not excuse it. The abrogation of informed consent is de facto medical malpractice."[241]
>
> "Psychiatric patients are never told that their alleged disease is theoretical or metaphorical."[242]
>
> "…there has been a severe dereliction of duty with regards to informing parents fully about the causes of classroom behaviour and learning problems, thereby violating the very essence of informed consent."[243]
>
> "Every time they tell you a psychiatric condition or diagnosis is a disease, they lie to you and trample your fundamental right to informed consent."[244]
>
> "The bottom line is that, without confirmatory evidence of disease, the 'treatment' of children with chemical substances, even if psychiatry calls such substances 'medicine' is a complete fraud. To say otherwise is a total abrogation of the right of parents to authentic informed consent in decisions on behalf of their children."[245]
>
> "It is apparent that virtually all professionals of the extended ADHD 'industry' convey to parents, and to the public-at-large, that ADHD is a 'disease' and that children said to have it are 'diseased'-'abnormal'. This is a perversion of the scientific record and a violation of the informed consent rights of all patients and of the public-at-large".[246]

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[240] Id.

[241] *Informed Consent and the Psychiatric Drugging of Children*. Available at <http://www.wildestcolts.com/mentalhealth/consent2.html> last visited 08/07/02.

[242] Id.

[243] *The Controversy Behind ADHD.* Available at <http://www.ritalindeath.com/Page/Controversy.html> last visited 08/07/02.

[244] Baughman Jr., Fred A. M.D. *ADHD Treatment Deaths: Assault & Battery—Murder*. Available at <http://www.adhdfraud.org/commentary/7-6-02-2.htm> last visited 08/07/02.

[245] *A Call to Legislative Action: Stop the Mass Psychiatric Drugging of United States School Children.* Available at <http://www.wildestcolts.com/safeEducation/stopthemass.html> last visited 08/07/02.

[246] Baughman, Fred A. M.D. (2001, May). The American Academy of Pediatrics Guideline (diagnostic) on ADHD. *Pediatrics*: 1239.

A group of clinicians and researchers got together and came up with a model Informed Consent for "ADHD" parents. Reviewing it makes it more clear why biomedical proponents are reluctant to allow a process that truly informs:

A Condensed Model Consent Form[247]

I understand that my child has been assigned a DSM-IV diagnostic label, based on my doctor's (and perhaps others) subjective observation of my child's behaviour. I am aware that there is no medical evidence that my child has a medical problem, and no scientific evidence that proves the existence of the illness which my child is said to have.

I am aware that I will never be able to remove this diagnostic label or any other from my child's medical record, and that this record may interfere with possible educational and vocational directions of my child. I have been informed that the drug or drugs my doctor is prescribing for my child cannot cure whatever "illness" or "chemical imbalance" this doctor may believe my child to have, but can only affect "symptoms." I understand that psychiatric drugs have not been demonstrated to have long-term positive effects on any measure of learning, behaviour or social development in children.

I understand that the review process of psychoactive drugs by the FDA is both controversial and complicated, and that, therefore, all psychiatric drugs must be considered experimental. I have been informed of all the known effects of any recommended drug, and I have a copy of the current information listed on these drugs in the Physicians Desk Reference. I also am aware of the up-to-date accumulation of FDA adverse reaction reports of any prescribed drug; I understand that it is necessary to multiply the number of reported reactions by up to 100 to estimate the actual incidence of these reactions. I understand that these drugs are addictive and create dependency, and that drug withdrawal can pose serious problems.

I understand that taking psychiatric drugs may cause severe pain and discomfort to my child, worsen my child's condition, or even cause my child permanent damage or death. I also understand that no body of research clearly shows that the problems indicated by my child's diagnosis require or respond more favourably to drug treatment than to one or more forms of nondrug treatment.

I understand that this brief statement is only the "tip of the iceberg" regarding psychiatric diagnosis and drug treatment of my child, and that it is my responsibility to take the necessary time and trouble to fully research the relevant necessary information in order to make an informed decision on behalf of my child.

I understand that since psychiatric diagnosis and drug treatment of children is considered customary and usual medical practice, doctors are generally not held liable for harm resulting from such treatment. Therefore, I understand that the

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[247] *Informed Consent and the Psychiatric Drugging of Children*. Available at <http://www.wildestcolts.com/mentalhealth/consent2.html> last visited 08/07/02.

> effects of such treatment are, practically speaking, my complete responsibility as a parent.

In general, the standards for the requirement of providing informed consent are fairly clear:

> "The consent requirement primarily protects the patient's bodily integrity. In the case of competent persons, it also protects personal autonomy. Because of the critical interests at stake, consent must be "informed" in order to be valid; the individual must know to what he is consenting. If the physician has not given the patient all the information that a patient needs to make a knowledgeable decision regarding the medical care, any consent the patient gives is ineffectual."[248]

> "…all of the potential risks and benefits posed by the patient's condition must be weighed against all of the potential risks and benefits of the treatment(s) available for consideration".[249]

> "Appropriate, relevant and up-to-date information on ADHD should be available and accessible for children, families and professionals."[250]

There is also no question that something as invasive as the ingestion of stimulant drugs requires informed consent. Ironically, Australia's Model Criminal Code Offenders Committee (MCCOC) expressed concern about child offenders' rights to consent to the collection of DNA samples. The MCCOC classified the collection procedures (blood, saliva, buccal swabs) as "intimate"[251] and noted that "placing something inside someone's mouth against the person's consent is invasive."[252] In essence, then, we want to afford offenders a right of consent when samples are being sought (presumably) for a legitimate purpose, but there is no similar right for totally innocent children dealing with a much more invasive procedure. No research indicates that anyone has ever had their brain development slowed, or died, from a buccal swab. Yet the MCCOC noted the need to ensure that whenever samples are proposed to be taken from a child offender "the person from whom it is taken will have the right to have the procedure considered by a magistrate."[253] Surely our sons and daughters who have committed no crime are entitled to at least the same protection.

The argument that children taking stimulants are not necessarily doing so against their wishes is not legally persuasive, because when someone is not informed that they even have a choice the procedure is prima facie absent of their consent.

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[248] The Journal of Contemporary Health Law and Policy. (2000, Fall). Volume 17.

[249] Baughman, Fred A., (2002, May 15). *Testimony to California Senate Committee on Health and Human Services*, available at <http://www.adhdfraud.org/commentary/5-19-02-3.htm> last visited 08/07/02.

[250] Attention Deficit Hyperactivity Disorder. (1997). *National Health and Medical Research Council* (NHMRC).

[251] Johnson, R. (2001, October). Two steps forward, one big step back. *Alternative Law Journal*, 26(5), 236-241.

[252] Id.

[253] Id.

Lawrence Smith's 14-year old son will never have a chance to decide whether to consent to treatment, because he died from taking Ritalin. His father clearly feels that neither he nor his son was given anything approaching a right of informed consent:

> "The violation of a parent's rights is when they are not told of the unscientific nature of so-called disorders such as ADHD or the risks of the treatments involving (drugs) and they certainly are not told of alternatives to their child's behaviour such as undiagnosed allergies or food sensitivities, which could manifest with the symptoms of what psychiatry calls ADHD."[254]

We have seen that very young children, even babies, are being prescribed stimulant medication. Obviously, an 18-month old child is not in a position to give informed consent to treatment.

> "Children (however) are not able to give fully informed consent to drug use—especially those under six years of age, a group in whom we are witnessing a dramatic increase in psychiatric drug prescription. It is, therefore, our responsibility as adults to ensure every possible opportunity for optimal development for our children, to protect and defend our children from powerful toxic drugs, particularly those prescribed for psychiatric purposes."[255]

In the perfect world, the wishes of parents and the wishes of children would always coincide, but we know that is not the case. Both the Queensland Law Reform Commission and the Model Criminal Code Offenders Committee recognized this problem:

> "(the parent's role) should always be subject to what is in the best interests of the child—and there will be circumstances where what the parents want for the child and what the child needs are two different things."[256]

> "parents or guardians will not always look after the best interests of the child."[257]

The Queensland Law Reform Commission studied the issue in depth and concluded that it is not clear at what point the child becomes legally competent to give consent to treatment:

> "The Commission has also been concerned that its recommendations should recognise the autonomy of the individual. This is a concept which underlies the legal requirement for consent to health care. That requirement is intended to ensure protection for the patient against unauthorised interference with her or her right to bodily integrity. The right in each person to bodily integrity is the right in an individual to choose what occurs with respect to his or her own person. The right to bodily integrity also extends to young people although where the young

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[254] Smith, Lawrence. *Ritalin Prescription Takes Life of 14 Year Old.* Available at <http://www.rense.com/general25/14.htm> last visited 05/07/02.

[255] Breeding, John, Ph.D. (2000, July). Does ADHD Even Exist?: The Ritalin Sham. *Mothering.* available at <http://www.wildcolts.com> last visited 05/07/02.

[256] *Consent to Health Care of Young People*. (1996, December). Volume Three: Summary of the Commission's Report, Report No. 51, Queensland Law Reform Commission, p. (i).

[257] Johnson, R. (2001, October). Two steps forward, one big step back. *Alternative Law Journal*, 26(5), 236-241.

person is not legally competent to consent, others, such as his or her parents, may consent on the young person's behalf in certain circumstances".[258]

"For there to be a valid consent from a young person of any age (0-17 years of age), the young person must be intelligent and mature enough to understand the nature and consequences of the proposed health care…Presumably a very young child could be competent to consent to relatively minor procedures and a young person of any age, depending on his or her maturity and understanding, could consent to any health care, however serious."[259]

"A health care provider can obtain a valid consent to treat a young person from a parent, *although it is not clear whether a parent can still give a valid consent once the young person is competent to consent on his or her own behalf."*[260] (italics added).

Ultimately, the Commission adopted the following recommendation:

"The Commission recommends that for the purposes of the legislative scheme a young person should be able to provide a valid consent to health care if he or she: understands the nature and consequences of the health care; and communicates his or her decision about the health care in some way."[261]

This recommendation comports with the international requirement of the United Nations Convention on the Rights of the Child (CRC), to which Australia is a signatory:

"States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child."[262]

The guidelines recommended by the Commission establish what is essentially a two-part test for competency: <u>understanding</u> the proposed health care, and <u>communicating</u> a decision. Arguably, children as young as 8 or 9 could understand that stimulant drugs will help them get into less trouble at home and school, but may make them feel badly and may cause them to be smaller when they are adults. In any event, it would be difficult to contend that a 14-17 year old is unable to understand the concept of taking stimulant medication. Yet children are routinely denied the right to make an informed choice when it comes to ADHD "treatment".

The most significant case in Australian law pertaining to competency of children to consent to medical treatment is an English case: *Gillick v. West Norfolk and Wisbech Area Health Authority* (1986)[263]. In this case a mother of five girls under the age of 16 sought assurances from her local health authority that no contraceptive advice or treatment would be given to any of her children without her consent. When the

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[258] *Consent to Health Care of Young People.* Summary, p. i-ii.
[259] Id., Volume 3, p. 1.
[260] Id., Volume 3, p. 2.
[261] Id., Volume 3, p. 10.
[262] *Convention on the Rights of the Child.* (1989). Article 12(1). Geneva: United Nations.
[263] 1 AC 112.

authority declined to offer such assurance the mother commenced an action stating that such action (offering her children advice or treatment) would compromise her position as parent and guardian. Legislation in the United Kingdom already specified that once a young person had attained the age of 16 they were competent to consent to medical, dental or surgical treatment, so the issue in *Gillick* pertained to children aged 15 and younger.

The trial court dismissed the action, the appellate court reversed, and ultimately the House of Lords found that parental rights exist "only so long as they are needed for the protection of the person and property of the child."[264] The most often cited opinion from the case in Australian law was Lord Scarman's: "as a matter of law the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed. It will be a question of fact whether a child seeking advice has sufficient understanding of what is involved to give a consent valid in law."[265]

While this opinion has been criticized for its vagueness, the prevailing standard in Australian law has been what the Queensland Law Reform Commission described as "Gillick competence": "the young person must be intelligent and mature enough to understand the nature and consequences of the proposed health care."[266] Based on "Gillick competency" there can be no question that countless Queensland children are being drugged without being afford their well-established legal right to informed consent.

A related legal issue involves the rule in "Marion's case"[267], a 1992 case where a mother attempted unsuccessfully to have her 14 year old daughter, who was intellectually and physically disabled, sterilised. The court held that such a procedure could not happen solely on the petition of the parent or guardian but instead required a court order. The principle from "Marion's case is, in the words of the Queensland Law Reform Commission, that "Parents are unable to consent to certain non-therapeutic forms of health care (such as sterilisations for non-therapeutic purposes) of their children without first obtaining court approval."[268]

According to the Australian Pocket Oxford Dictionary[269] "therapeutic" is defined as "of or for or tending to the cure of disease"[270]. "Disease" is defined as "unhealthy condition, (specific) disorder, illness".[271] Even proponents of the biomedical model would have a hard time arguing that ADHD meets the dictionary definition of a "disease". The children are certainly not "unhealthy", there is no specific disorder yet identified, nor is there any known illness. Since, by definition, it is impossible to

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[264] Id.
[265] Id.
[266] *Consent to Health Care of Young People*. (1996, December). Volume Three: Summary of the Commission's Report, Report No. 51, Queensland Law Reform Commission.
[267] *Secretary, Department of Health and Community Services v. JWB and SMB* (1992) 175 CLR 218.
[268] *Consent to Health Care of Young People*. (1996, December). Volume Three: Summary of the Commission's Report, Report No. 51, Queensland Law Reform Commission, p. 2.
[269] *The Australian Pocket Oxford Dictionary*. (1989). Melbourne: Oxford University Press.
[270] Id., p. 732.
[271] Id., p. 202.

have a *therapeutic* intervention in the absence of a *disease* then interventions for ADHD are prima facie *non-therapeutic*. Therefore, according to the rule of law established in "Marion's case", a non-consenting child could only be placed on ADHD medication through a court order.

Even when parents and children consent to treatment, the consent is bogus on its face. Not only are parents denied the right to *informed* consent, and children denied the right to *any* consent, but they are often pressured by school personnel to take medication, often before the child has even been seen by a physician. In the United States, public school officials were threatening parents with expulsion of their child unless the parent complied with the demand that the child be placed on medication. Often this was not even under a pretence of being in the child's best interests medically. It was a more simple equation: Your child is disrupting the class, so we want him drugged into compliance. Not only would schools threaten expulsion, but they would also threaten to call the authorities and report parents for medical neglect and abuse for failing to supply their child with the drugs the school felt were needed in order for the child to adapt.

The problem got so out of hand that the pendulum has swung in the U.S., and at least six states have passed legislation prohibiting schools from recommending medication or coercing parents in any way. The resolution of the Texas State Board of Education is instructive as a potential model for this sort of administrative mandate or legislation in Australia:

Texas State Board of Education Resolution[272]
November 3, 2000

WHEREAS, The mission of the public education system of this state is to ensure that all Texas children have access to a quality education that enables them to achieve their potential and fully participate now and in the future in the social, economic, and educational opportunities of our state and nation; and

WHEREAS, The State Board of Education envisions in its long-range plan for public education a system of public education that is based on the fundamental principles that all students can learn, and all educators can develop the knowledge and expertise to implement programs that ensure all students can learn; and

WHEREAS, the Texas State Board of Education dedicates itself to improving the academic achievement of all students; and

WHEREAS, the responsibility of school personnel is to ensure student achievement; and

WHEREAS, only medical personnel can recommend the use of prescribed medication; and

WHEREAS, a Consensus Development Panel conducted in November 1998 by the

[272] Available at <http://www.wildestcolts.com/mentalhealth/consent2.html> last visited 08/07/02.

National Institutes of Health (NIH) to resolve controversies surrounding Attention Deficit Hyperactivity Disorder (ADHD) reported that: "there is no valid independent test for ADHD...further research is necessary to firmly establish ADHD as a brain disorder...additional efforts to validate the disorder are needed"; and

WHEREAS, the NIH Consensus Development Panel reported that stimulant drugs such as methylphenidate (Ritalin) result in "little improvement in academic or social skills," and

WHEREAS, 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 lack of academic success; and

WHEREAS, up to one million school-age children in Texas are taking psychiatric drugs, and

WHEREAS, the Texas State Board of Education recognizes that there is much concern regarding the issue of diagnosis and medication and their impact on student achievement; and

WHEREAS, in its long-range plan for public education, the State Board of Education challenges students, parents and families, educators, and community leaders to participate actively in making their schools safe learning environments; and

WHEREAS, this plan further states that ensuring safety for Texas public education will take nothing short of a coordinated effort by the state and each community to keep violence, prevent the abuse of prescription and illicit drugs, and disruptive behaviour out of schools; now, therefore, be it

RESOLVED, That the State Board of Education does hereby urge all local school district boards of trustees and superintendents to become aware of and concerned about the use of psychotropic drugs in their schools, and to determine the extent to which such drugs are in use in their schools, and the current processes by which such drugs are being prescribed for the students; and be it further

RESOLVED, That the State Board of Education encourage local boards and superintendents to require local school personnel to use proven academic and/or management solutions to resolve behaviour, attention, and learning difficulties. The State Board of Education suggests that programs such as tutoring, vision testing, phonics, nutritional guidance, medical examinations, allergy testing, standard disciplinary procedures, and other remedies known to be effective and harmless, be recommended to parents as their options; and be it further

RESOLVED, That the State Board of Education urge local school personnel to respect the exclusive authority of physicians to make psychiatric diagnoses of behavioural problems, recommend psychiatric screening for specific behavioural problems, and suggest the use of psychiatric medication for a student; and be it further

RESOLVED, That the State Board of Education recommend that each local school district implement a special policy with regard to storing and distribution of psychoactive drugs; and be it further

RESOLVED, That the State Board of Education urges local school boards to adopt and implement a policy that requires prescription medications dispensed on school property be administered by a medical practitioner licensed by the state to dispense medication; and be it further

RESOLVED, That the State Board of Education encourages greater communication and education among parents, educators, and medical professionals about the effects of psychotropic drugs on student achievement and our ability to provide a safe and civil learning environment.

WITNESS our signatures this third day of November, two thousand, in Austin, Texas.

Chase Untermeyer, Chair
Rosie Collins Sorrells, Ed.D., Secretary

A final legal issue concerns whether there are other violations of international law in the drugging of children with stimulant medication. In addition to Article 12 (cited previously) which mandates that children be given the right to express their views and have those views considered, there are at least two additional articles of the Convention on the Rights of the Child that are potentially violated by the practices involving ADHD in Australia. Article 33 of the Convention says that:

"States Parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances…"[273]

Given the widespread black market in stimulants it would seem that they are too readily available to afford Queensland children the protection contemplated in this article. In addition, there is serious question whether the prescribing of drugs for a "disease" that has never been shown to exist would constitute "illicit" use.

Article 19(1) of the CRC says:

"States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child."[274]

It is not far-fetched to consider drugging children for behavioural compliance a form of child abuse. It is well settled in the law that parents do not have free rein to do whatever they wish to get their children to behave. We do not allow parents to hit their children over the head with frying pans, but we DO allow them to wield a

[273] *Convention on the Rights of the Child.* Article 33.
[274] Id., Article 19(1).

pharmaceutical frying pan. We know that stimulants cause children short-term discomfort and potential long-term serious deleterious effects, so why would this fail to constitute abuse as expressed by the CRC? Similarly, it seems that we fall short of taking "all appropriate measures" to protect children from injury or maltreatment when we allow them to be drugged on the basis of a highly questionable diagnosis.

Southern Cross University educator Brian Kean sees the biomedical model as inherently violative of the basic human rights of "ADHD" children:

> "(There is a) flaw of the hegemonic medical model that labels children as deviant, treats them with psychotropic medications that have no demonstrated long-term benefits and isolates them as different from the normal population."[275]

It is always easier to think of other cultures committing "atrocities" than our own. However, American neurologist Dr. Fred Baughman makes a compelling statement that the treatment of "ADHD" children is violative of the codes defined for medical ethics and experimentation during the Nuremberg tribunals:

> "The Nuremberg Code does not allow the abrogation of informed consent (de facto medical malpractice) or the drugging of normal, disease-free, children."[276]

13) Alternatives to Drug Treatment

It is very popular in the mainstream literature to recommend "multimodal" treatment for "ADHD". This means that a variety of interventions are utilized, and it is suggested even by the most ardent supports of the use of stimulants.

Dr. Graham Martin, a psychiatrist and the director of Child and Adolescent Psychiatry at Royal Brisbane Hospital, makes a very logical point about "multimodal treatment"[277]:

> In supposed cases of ADHD it is clear that, while medication may be helpful in the long term in only a very small minority of cases, the following will be helpful in all cases:
>
> - Appropriate parenting advice
> - Behavioural interventions and brief solution-focused therapy approaches
> - General supportive counselling for the family
> - Practical help in the home for parents
> - Appropriate respite care

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[275] Kean, B. (2002). The Rights of the Child, Attention Deficit Hyperactivity Disorder (ADHD) and Robbie's Case. Southern Cross University.

[276] Baughman, Fred A., M.D. *The Totality of the ADD/ADHD Fraud. A*vailable at <http://www.home.att.net/~Fred-Alden/Es5.html> last visited 08/07/02.

[277] Martin, Graham, Powrie,Rosalind and Ashforth, Peter. (1997, February). ADHD in Children and Adolescents. *Current Therapeutics,* pp. 28-39.

The obvious question is: With there being interventions that are considered effective even by biomedical proponents, why is stimulant medication so often used as the first line of treatment?

> "Medication treatment is insufficient in isolation – it must be combined with behavioural, educational and psychological support."[278]

> "Just as there are big gaps in our understanding of ADHD, there are even bigger gaps in our understanding of stimulant medication. Therefore, for children with mild symptoms, drugs should not be the first choice of treatment." Porter, L. "Selected perspective on ADD and ADHD."[279]

> "Multimodal therapy is widely accepted as being a more effective mode of management than any individual form of management used in isolation."[280]

The recommendations from various researchers, inquiries and clinicians are fairly unanimous in favour or multimodal treatment as the "treatment of choice":

> Sandra Kanck, Deputy Leader of the South Australia Democrats and Health spokesperson called on the South Australia state government to adopt the findings of its parliamentary inquiry: "Adoption of the recommendations of the Committee would steer kids with ADHD away from dependence on amphetamines and into a multi-modal approach of treatment."[281]

> "This project recommends greater emphasis on the expertise of professionals other than medical practitioners in the diagnosis of ADHD and implementation of the multi-modal approach".[282]

> Formal recommendation of South Australia Parliamentary Inquiry: "A multi-modal approach to diagnosis be developed, to complement multimodal therapy and treatment" AND "A centre be established jointly by DHS (Dept. of Human Services) and DETE (Department of Education, Training and Employment) to develop and disseminate best practice treatment protocols based on the multimodal philosophy."[283]

> "Collaborative management is essential, involving individuals with ADHD, their families, teachers and professionals from health care and other agencies. The multimodal approach is endorsed by professional groups after consultation over

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[278] Reid, R., Reason, R., Maag, J., Prosser, B. & Xu, C. (1998). Attention Deficit Hyperactivity Disorder in Schools: a perspective on perspectives. *Educational and Child Psychology.* 15(4), pp.56-67.

[279] Porter, L. Selected perspectives on ADD and ADHD. *Australian Journal of Early Childhood.* 22(4), p. 7-14.

[280] Attention Deficit Hyperactivity Disorder. (1997). *National Health and Medical Research Council* (NHMRC). Section 3: Overall Management.

[281] Kanck, Sandra. (2002, January 11). Chance to End ADHD 'Drug Reliance'. *South Australian Democrats News Release.*

[282] Prosser, B. *Behaviour Management or Management Behaviour? A sociological study of Attention Deficit Hyperactivity Disorder (ADHD) in Australian and American secondary schools*. Available at <http://www.ozemail.com.au/~bjpreoss/adhd.html> last visited 03/07/02.

[283] *Inquiry into Attention Deficit Hyperactivity Disorder*. (2002 January 10). Parliament of South Australia, Sixteenth Report of the Social Development Committee, p. 9.

years and in professional and government reports following multidisciplinary discussions."[284]

One study, even embracing Barkley's theory of ADHD as a "disorder of response inhibition" noted that:

"Parents can teach their children response inhibition by providing consistent and predictable consequences for impulsive behaviour as well as positive consequences for compliance."[285]

Even in the face of this overwhelming preference for multimodal therapy in theory, in practice the vast majority of "ADHD cases" are treated primarily, or solely, with medication.

In a South Australia study: "Despite the multi-modal treatment approach being recommended by medical authorities and assurances from governments that this approach was available to all young people with ADHD, all participants used solely medication and expressed surprise to discover treatments other than medication for ADHD."[286]

"It is not that previous responses to ADHD have failed to conceptualise how to successfully treat the disorder, rather it has been the focus on the controversial issue of psychostimulant use that has trivialised and obstructed multi-modal treatment."[287]

While there are powerful psychological, political and economic reasons for providers using stimulant drugs first, and all the safer and more effective modalities later, the choice is simply not available for some families:

"Although a combination of medical and behavioural treatment is recommended as the most effective form of intervention, many families have little choice since they face long waiting lists for 'free' government psychological services or prohibitive costs. This effectively denies them access to alternative interventions forcing reliance on paediatricians, child psychiatrists or general practitioners."[288]

In practice, this means that indigent or minority children wind up receiving "drug-only" treatment instead of the safer and more effective (and recommended) multi-

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[284] Attention Deficit Hyperactivity Disorder. (1997). *National Health and Medical Research Council* (NHMRC). Section 3: Overall Management.

[285] Bor, William, Sanders, Matthew R. and Markie-Dadds, Carol. (2002). *The effects of the Triple P-Positive Parenting Program in preschool children with co-occurring disruptive behaviour and attentional/hyperactive difficulties.*

[286] Prosser, B. *Behaviour Management or Management Behaviour? A sociological study of Attention Deficit Hyperactivity Disorder (ADHD) in Australian and American secondary schools*. Available at <http://www.ozemail.com.au/~bjpreoss/adhd.html> last visited 03/07/02.

[287] Prosser, B., and Reid, R. (2001, April). *Issues for the Treatment of Attention Deficit Hyperactivity Disorder (ADHD) in South Australia.* Submission to the Social Development Standing Committee, 49th South Australian Parliament.

[288] Atkinson, I., Robinson, J. and Shute, R. (1997) Between a rock and a hard place: An Australia perspective on education of children with ADHD. *Educational and Child Psychology*, 14(1), pp. 21-30.

modal therapy. Since children with access to other interventions may never see the ominous prescription bottle, children already living in poverty and already disenfranchised are disproportionately drugged.

Families with access to traditional multimodal treatment are offered such things as parenting education, respite care, family therapy and supportive counselling in place of, or in addition to, the use of stimulant drugs. However, there are countless other approaches available for assisting families having difficulties with a child's behaviour. The fact that there are so many alternative treatments makes the reliance on powerful and dangerous drugs all the more unacceptable.

> "According to NSW Health evidence, the mental health needs of children and young people can be effectively addressed through a combination of strategies and programs, comprising of behavioural intervention programs, parenting programs, etc."[289]

This author, in clinical practice, observed dozens of children diagnosed and prescribed medication for ADHD successfully adapt without medication following parent education, marital/family therapy, etc.

> "It was recently reported that researchers at the *Royal Hospital for Women* in Sydney are trialing the ancient art of meditation as a drug-free alternative for some sufferers of ADD/ADHD. Researchers have conducted a focus group trialing *Sahaja Meditation* as a form of therapy for children suffering from ADHD. It was reported that after just six weeks, 16 children with ADHD all showed a marked improvement. A full-scale clinical trial on meditation and ADHD is to be conducted, but even without scientific proof parents who took part in the clinic are reportedly convinced of its merit."[290]

There are literally hundreds of alternative theories for the aetiology and for the treatment of "ADHD". In the 1970's and 1980's Dr. Ben Feingold's theory of food allergies was extremely popular. Many parents swore by it and there were hundreds of anecdotal reports of "hyperactive" children becoming calm and focused by dietary management.

A theory of a pharmacist named Hertha Hafer that ADD is caused by excess dietary phosphate is promoted on her website. Presumably, reducing the dietary phosphate would remediate the symptoms.

The *Brisbane Sunday Mail* reported that: "Nutritional therapists are increasingly turning to essential fatty acid supplements to treat ADD. Many are impressed with the results."[291]

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[289] New South Wales Commission for Children and Young People. (2002). *Inquiry Into The Use of Prescription Drugs and Over-The-Counter Medications in Children and Young People,* Issue Paper No. 5: The Use of Prescription Drugs As a Mental Health Strategy for Children and Young People, p. 11.

[290] New South Wales Commission for Children and Young People (2002). *Inquiry Into The Use of Prescription Drugs and Over-The-Counter Medications in Children and Young People,* Issue Paper No. 6: Alternatives to the Use of Prescription Drugs and Over-the-Counter Medications by Children and Young People, p. 6.

[291] The Sunday Mail (Brisbane) (2001, February 4). Magazine, p. 8.

Dr. Graham Martin suggests a possible physiological aetiology, but it has nothing to do with the brain: "Since partial deafness may be a hidden cause of inattention, audiometry should be seriously considered."[292]

The New South Wales Commission Inquiry "received submissions advocating the use of alternatives including *diet management, behavioural modification* and *Tai Chi* for children with behavioural problems such as ADD/ADHD."[293]

The wide variety of interventions available for children identified as "ADHD" points up the lack of identity of a real clinical entity. Parents have found "answers" in many different forms and places, and this underscores why it is possible, practical and necessary to avoid the one potentially deadly intervention: drugging children with powerful stimulants.

CONCLUSION

Clinicians, educators and reseachers sometimes tend to equivocate and "sugar coat" in an effort to sound really "professional". When our children's physical health and emotional well being are in danger, it is time to be very direct. It is time "cut to the chase", look at the facts, and tell the truth.

We are giving powerful and dangerous drugs to Queensland children for a "disorder" that has never been shown to exist.

We are allowing Queensland preschoolers to be drugged with stimulants despite the fact that they are not recommended for use in children under 6 and no one knows the potential long-term damage.

We are allowing such a proliferation of stimulants that it is being sold and shared by Queensland children like candy.

We are exposing our children to these dangerous drugs despite evidence that they have no positive effect and only "work" by creating more obedient and docile children.

We are failing to provide parents with meaningful informed consent, and we are failing to give competent children any informed consent in violation of ethical medical practice, the common law and international law.

There is very little that everyone can agree upon in the controversial area of ADHD, but most would agree that further research needs to be done. At this point there are too many unknowns, and anyone who claims there is "proof" is not telling the truth.

It is bad science to attempt to treat something before we know what it is. Given the acknowledged dangers of stimulant drugs to children, families and society, it is

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[292] Martin, Graham, Powrie,Rosalind and Ashforth, Peter. (1997, February). ADHD in Children and Adolescents. *Current Therapeutics,* p. 34.

[293] New South Wales Commission for Children and Young People. Issue Paper No. 6, p. 6.

common sense to stop using them until we have identified what, if anything, ADHD really is.

The following three recommendations are made in the spirit of protecting the physical health and emotional well-being of Queensland children:

1) Declare a moratorium on stimulant use until such time as researchers are able to identify a specific organic etiology for ADHD, show that stimulants are effective in remediating the discovered pathology and show that stimulants are safe for growing children to use long-term. Alternately, call an immediate moratorium on the use of stimulant drugs in children under 6.

2) Ensure that parents AND children are fully informed of BOTH sides of the ADHD debate, and require that they both have to sign meaningful informed consents before receiving any stimulant drugs.

3) Require review by a child guidance professional prior to beginning any child on medication, and require reasonable trials with other suggested interventions prior to initiating the use of stimulant drugs.

Putting the clamps on the runaway ADHD train will not be popular with parents, who in large numbers rely on stimulants to control their children and absolve themselves of guilt or responsibility at the same time. It will not be popular with teachers, who rely on stimulants to subdue difficult children in the classroom. It will not be popular with children's physicians, who may not know any other way of being helpful in these situations besides offering stimulant drugs for behavioural control. It will certainly not be popular with the drug companies, who will see any open and honest discussion as a potential threat to their billion dollar golden goose.

This report is a plea to all concerned Queenslanders to take a hard and honest look at a controversial issue. It is a plea to protect our children who cannot protect themselves from these harmful and needless labels and drugs. Finally, it is a plea to celebrate the creativity, spontaneity and energy of childhood and to embrace the unique beauty of every Queensland child.

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