The National Assault on Childhood Mental Disorders By E. Clarke Ross, D.P.A.

Note: Dr. Ross first presented this material in a public address before the Federal Assembly, Health Committee of the National Conference of State Legislatures (NCSL) on December 13, 2000. Dr. Ross served as a speaker at their recent meeting held in Washington, D.C.

At least five states 'Arkansas, Colorado, Maryland, Pennsylvania and Texas 'have had state boards of education (Colorado and Texas) or committees of the state legislature (Arkansas, Maryland, Pennsylvania) conduct public hearings on the use of psychiatric medications in schools. Four have been associated with a nationally organized, well-financed road show and public disinformation campaign designed to ban the use of psychotropic medications

in schools and label AD/HD and other childhood mental illnesses as 'frauds' and 'lies.' With each new hearing,

the same out-of-state spokespersons denying the existence of childhood mental disorders appear and espouse the same rhetoric.

Who Are These Individuals?

The persons aggressively campaigning to ban psychiatric medications in schools generally support the philosophies found in a publicly disseminated brochure titled, 'Psychiatry Betraying Families: The Hoax of ADD/ADHD and Other Learning Disorders.' The material, developed and circulated by the Citizens Commission on Human Rights (CCHR), a group established in 1969 by the Church of Scientology, claims that AD/HD and other learning disabilities are 'inventions, contrivances and a fraud.' The brochure also claims that 'psychiatrists and psychologists have thoroughly duped well-meaning parents, teachers and politicians into believing...that normal childhood behavior' requires the use of 'addictive, mind-altering, and potentially dangerous, psychiatric drugs.' The brochure further cites the opinions of various individuals, but references none of the science-based, evidenced-based research recognized, well-documented and used by our nation's leading science institutions.

Why Do School Boards and Legislators Listen?

During the past decade, America's public schools have experienced an increased incidence of publicly reported violence, illegal drug use and disruptive behavior. Meanwhile, there simultaneously has been a significant increase in the number of school age children diagnosed with AD/HD and a corresponding significant increase of stimulant medications used to treat it. The critics have attempted to link and posture these unrelated events into a misguided and extremely harmful cause-and-effect theme.

In December 1999, the Surgeon General of the United Statesi observed that 'children, particularly active boys, are being overdiagnosed with AD/HD and thus are receiving psychostimulants unnecessarily.' Further, a 1997 statementii made by the

National Institutes of Health (NIH) observed that 'there is no consistency in treatment, diagnosis, or follow-up for children with AD/HD.' The organized campaign mentioned above uses these two statements repeatedly in its efforts to invalidate the legitimacy of AD/HD. But the two statements are routinely and inappropriately used out of context, and ignore completely the findings, conclusions and implications referenced in the remainder of both scientific reports.

Missing: Research Based Multimodal Treatment Science

The most glaring omission in the critic's rhetoric is the current National Institute of Mental Health (NIMH)iii research, known as the Multimodal Treatment Study (MTA Study). MTA compared 14 months of treatment outcomes of 579 children with AD/HD randomly assigned to one of four treatment conditions 'medication management alone, behavioral treatment alone, a combination of medication and behavioral treatment, and standard treatment in the community. The conclusion: 'Carefully managed and monitored stimulant medication, alone or combined with behavioral treatment, is effective for AD/HD.' The organized campaign, denying the existence of AD/HD and successful treatments refuses to cite or even mention the findings of the NIMH MTA Study or the Report on Mental Health issued by the U.S. Surgeon General.

Denial of AD/HD Refuted

The organized interests claiming that AD/HD is a 'biological lie' also state that there are no 'biological imbalances' and 'no laboratory tests established as diagnostic' for AD/HD. They go on to claim that AD/HD is a '100 percent fraud.'

But science tells us a different story. The Surgeon General's report (page 144) concludes that 'AD/HD is the most commonly diagnosed behavioral disorder in childhood and occurs in three to five percent of all school-age children. The exact etiology of AD/HD is unknown, although neurotransmitter deficits (such as the dopamine transmitter), genetics, and perinatal complications have been implicated.' The NIH Panel Consensus statement declares: 'Although an independent diagnostic test for AD/HD does not exist, there is evidence supporting the validity of the disorder.' The citations used by the critics reference only the first half of this statement.

The NIMH MTA Study further documented that only 31 percent of the children with AD/HD have AD/HD alone with no other disorder. The study found that 40 percent of children with AD/HD had oppositional defiant disorder, 34 percent had anxiety disorder, 14 percent had conduct disorder and 4 percent had a mood disorder. Those dismissing the existence of AD/HD repeatedly ignore these characteristics.

Use of Medication Affirmed

Without citing any research, the critics in both their brochure and testimony claim that there is no value to prescription drug therapy and that such medications are harmful to all children. Again, where is the science?

The Surgeon General declares (page 145): 'Psychostimulants are highly effective for 75 to 90 percent of children with AD/HD. These medications have their greatest effects on symptoms of hyperactivity, impulsivity, and inattention and the associated features of defiance, aggression, and oppositionality.' The statistics clearly indicate that they are generally effective, but not effective for all.

The Board of Education and Legislative Issues of Debate

The organized campaign seeking to discredit the existence and treatment of AD/HD and childhood mental disorders enters a state with the same message, though the politics, personalities, involvement of CHADD, and involvement of the science and professional community have differed from state to state.

The critics always spotlight a handful of children who have experienced significant complications or side-effects from medications. But what about the millions of children who have been helped by medication? The critics also point to several aggressive schools which have infringed parental rights by supposedly insisting that the children take medication as a condition of remaining in school.

Most recently, the Texas State Board of Education issued a non-binding resolution declaring that 'tutoring, vision testing, phonics, nutritional guidance, medical examinations, allergy testing, standard disciplinary procedures and other remedies known to be harmless' are preferred as substitutes for medication and behavioral therapy. While most of these interventions are generally beneficial, they are not medically equivalent or necessarily preferred as an appropriate substitute to medication and behavioral therapy. The language adopted in the resolution ignores what the science tells us works.

Both the Colorado and Texas education boards initially considered radical resolutions, though through the discussion process the advisory resolutions adopted are much more modest than their original proposals. Yet, the two adopted resolutions contain problems. The Arkansas legislature, after conducting a public hearing, took no action on a resolution. And Pennsylvania merely conducted two legislative hearings, but had no resolution language before them.

Colorado began with a resolution to ban the use of Ritalin in school settings. It ultimately adopted a 'whereas, there are documented incidences of highly negative consequences in which psychiatric prescription drugs have been utilized for what are essentially problems of discipline' and resolved to 'encourage school personnel to use proven academic and/or management solutions to resolve behavior, attention, and learning difficulties.'

Arkansas began with a resolution declaring that 'the misuse of prescription/controlled drugs poses an immediate, serious, and continuing threat to the health of Arkansas' and that the legislature should immediately study the relationship between school violence

and the use of prescription/controlled drugs in Arkansas.' There was no action on this resolution.

Texas began with a proposal that 'No psychiatric disorder has been proven to be a disease caused by a demonstrable, diagnosable physical or chemical abnormality of the brain. This being the state of medical science, it cannot be argued that anything other than real-life situational factors in the home, family, school, or community life of the child are determinants of any perceived emotional, mental, educational, or behavioral problems.' As such, 'schools should focus on education.' The adopted resolution also states that 'there is no valid independent test for ADHD' and that 'stimulant drugs such as methylphenidate (Ritalin) result in little improvement in academic or social skills.'

Like Colorado, the adopted Texas resolution declares that schools should 'use proven academic and/or management solutions to resolve behavior, attention, and learning difficulties.' The Texas State Board of Education also 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.' Again, while these interventions certainly are valuable, they are not medically equivalent and by no means necessarily preferred or appropriate substitutions to medication or behavioral therapy.

Most of the resolutions contain a recommendation that communication between physicians, educators and parents be enhanced in order to more effectively recognize and treat AD/HD. The State of Maryland recently established an Advisory Council on AD/HD with appointments made by the governor and state legislative leaders. This is a positive and responsible model for public policy education and CHADD hopes other states will follow suit.

The Story of One 10-Year-Old Boy ' Andrew Ross

I am the father of a 10-year-old boy with AD/HD and several co-occurring conditions. According to the brochure previously cited, my son Andrew, and other children like him, needs only proper discipline, proper structure, and proper instruction in order to thrive. No one can dispute the benefits of such supports. But children with special needs require much more intensive and professional interventions than the ones described above.

Andrew was born during a complicated delivery. When, at age 11 months, he broke his ankle (which would not heal properly), follow-up assessments documented significant hypotonia and sensory integration challenges. At 21 months he experienced his first unprovoked seizure, and a pattern of seizures continued for the next several years. Two EEGs later, many problems were confirmed. By two and still not speaking, Andrew's pediatrician referred him to the State of Maryland's Early Education Program. For the next several years, he received intensive speech and language and sensory integration services, an expense that my wife and I personally incurred.

By four, when Andrew entered a more formal education program, teachers began noting significant learning problems stemming directly from his inability to focus. He received numerous independent professional assessments, each affirming that his disabilities were significantly impeding his ability to function at the level of his classmates. Andrew has always had difficulty with what now is referred to as 'executive functioning' 'brain actions of self control where he is unable to think ahead and consider 'if-then' behaviors and their consequences.

My son does not have an occasional problem with distraction and attention. He has ongoing daily problems that result in overwhelming difficulties in every area of his life. He not only has medically prescribed multiple diagnoses, but lives with significant functional challenges too.

No well-meaning parent sets out to medicate his or her child. Nor did we. But over time, given Andrew's learning and functional problems, we accepted the advice of child psychiatrists who felt our son would benefit from medication. Today, Andrew takes both a stimulant for attention issues and a medication designed to reduce his anxiety. A series of behavioral management and learning assistance programs are also used and an essential part of his overall treatment program.

Unfortunately, the medication Andrew takes has resulted in a significant loss of appetite, proof that there are continual tradeoffs in the beneficial use of medication and side effects from such use. But the good news is that, with the assistance of an aide and a multimodal treatment approach in place, Andrew can now better attend to learning in class, is less phobic, and demonstrates more socially appropriate behaviors with children his age.

As the parent of a child with multiple challenges, I resent those who suggest that my son needs only a little more discipline, structure and learning. My son's problems are neither 'lies' nor 'frauds,' nor the 'failures of his parents.' Andrew has a biologically-based brain disorder which we and an extensive network of dedicated clinicians face and address on a daily basis.

Andrew is making progress. The strides are slow yet steady. And like most families in similar circumstances, we are resolved to living life one day at a time. I share my story with the hope that those unfamiliar with AD/HD will appreciate the complexity and difficulty of identifying and implementing key medical strategies designed to help children like my son Andrew.

How You Can Help

The critics' dismissals of childhood mental disorders are overt attempts to delay or ignore serious medical conditions, thus increasing the possibility that such children will suffer significant lifelong consequences. This must stop.

In CHADD's letter to the Texas Education Board, we declared: 'According to every major federal agency and professional association which has studied AD/HD, including the Surgeon General of the United States, the National Institute of Mental Health, the Centers for Disease Control and Prevention, the American Medical Association, and the American Academy of Pediatrics, Attention-Deficit/Hyperactivity Disorder is a severe neurobiological condition that affects approximately three to five percent of school age children. The effects of AD/HD range from mild interference with a child's ability to pay attention, control impulses and engage in appropriate activities up through and including severe impact upon attention, impulsivity, hyperactivity and learning. CHADD stands behind the recognized scientific research on AD/HD.'

Your personal story, backed by current scientific data, must be used to counter this nationally organized campaign calling AD/HD and other childhood mental disorders 'biological lies.' You can make a difference. Tell your story. Share the science. Above all, don't stay silent.

Reference

i United States, Surgeon General. Report on Mental Health. Washington, DC: Department of Health and Human Services, 1999, page 150. ii United States, National Institutes of Health. 'News Release ' NIH Consensus Panel Statement Cites Inconsistencies in Care for Children with AD/HD.' iii United States, Surgeon General. Report on Mental Health. Washington, DC: Department of Health and Human Services, 1999, pages 148-149. And, CHADD, 'Study Explores Treatment Options for AD/HD.' In: ATTENTION!. Landover, MD: CHADD, March ' April 2000, pages 37-39. And American Psychiatric Association and Archives of General Psychiatry. Washington, DC: APA, December 1999.

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