

Say "no" to Drugs!

Subject: Just Say No To Drugs

Date: Sun, 04 Mar 2001 21:05:48 -0600

From: Freedom Page <freedompage@mindspring.com>

Friends,

Let's just all say no to drugs !

That is, unless your child is in a government school and the government school wants to make a little extra money by distributing drugs to your child. Since schools receive extra money for ADHD students and courts are now ordering that your child take drugs, what are parents to do?

Well, if you want to condemn your child as a drug user that even the US military will not accept, just go along. But, at some point, you will be faced with the evaluation in our own heart of what kind of parent you are.

Jim Hardin

This is happening here in Canada too. ...administered by "teachers" after problem is diagnosed by "teachers"!

The Freedom Page

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Subject: Are parents being pressured to medicate their kids?

Just say yes to Ritalin!

Are parents being pressured to medicate their kids?

Jean Mayes describes how life is while her son, Alex takes the medication Ritalin.

By Lawrence H. Diller, M.D.

SPECIAL TO MSNBC

Feb. 27 — Public school administrators, long the enthusiastic adherents of a "Just Say No!" policy on drug use, appear to have a new motto for the parents of certain tiny soldiers in the war on drugs: "Medicate or Else!" It is a new and troubling twist in the psychiatric drugs saga, in which public schools have begun to issue ultimatums to parents of hard-to-handle kids, saying they will not allow students to attend conventional classes unless they are medicated.

With a 700 percent increase in the use of Ritalin since 1990, parents have been repeatedly told that their kids probably have ADHD and that Ritalin is the treatment of choice.

IN THE MOST extreme cases, parents unwilling to give their kids drugs are being reported by their schools to local offices of Child Protective Services, the implication being that by withholding drugs, the parents are guilty of neglect.

At least two families with children in schools near Albany, N.Y., were reported by school officials to local CPS offices when the parents decided, independently, to stop giving their

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children medication for attention-deficit hyperactivity disorder. (The parents of one student pulled him from school; the others decided to put their boy back on medication so that he could continue at his school.)

Meanwhile, class-action lawsuits were filed in federal courts in California and New Jersey, alleging that Novartis Pharmaceuticals Corp., the manufacturer of Ritalin, and the American Psychiatric Association had conspired to create and expand the market for the drug, the best known of the stimulant medications that include the amphetamines Adderall and Dexedrine. The suit appears to be much like another lawsuit brought against Novartis in Texas earlier this year.

As a doctor with a practice in behavioral pediatrics — and one who prescribes Ritalin for children — I am alarmed by the widespread and knee-jerk reliance on pharmaceuticals by educators, who do not always explore fully the other options available to deal with learning and behavioral problems in their classrooms. Issues of medicine aside, these cases represent a direct challenge to the rights of parents to make choices for their children and still enjoy access to the public education they want for them — without medication. These policies also demonstrate a disquieting belief on the part of educated adults that bad behavior and underperformance in school should be interpreted as medical disorders that must be treated with drugs.

Unfortunately, I know from the experience of evaluating and treating more than 2,500 children for problems of behavior and school performance that these cases represent only a handful of the millions of Americans who have received pressure from school personnel to seek a “medical evaluation” for a child — teacher-speak for “Get your kid on Ritalin.”

Most often, evaluations are driven by genuine concerns first raised by a teacher or school psychologist. But too frequently the children are sent to me without even a cursory educational screening for learning problems. With a 700 percent increase in the use of Ritalin since 1990, parents have been repeatedly told that their kids probably have ADHD and that Ritalin is the treatment of choice. More and more often, the parents who buck this trend are being told they must put their children in special restricted classrooms or teach them at home.

Patrick and Sarah McCormack (not their real names) came to my office in a panic last year because a school wanted them to medicate their 7-year-old son. Sarah tearfully explained that the principal and psychologist at Sammy’s school in an upscale Bay Area town were absolutely clear that the first-grader should be on Ritalin. An outside private psychologist who had previously tested Sammy did not find any learning problems but concluded that he had ADHD and was defiant of authority. She suggested medication. The school psychologist, in his report on Sammy, was straightforward in recommending “psychopharmacological therapy” for the child.

The McCormacks were told, in no uncertain terms, that unless Sammy’s behavior changed, he would be transferred to a special class for behavior-problem children at another school or the McCormacks would have to consider alternatives to public education like home schooling.

Pro: Effective treatment of ADHD

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Patrick and Sarah had few problems with their son at home, though they conceded he was a “handful” and sometimes had problems getting along with other children. They deeply valued his outgoing personality and feared that Ritalin would change him. They also worried about the immediate and long-term side effects of the drug. They acknowledged that Sammy struggled at school but felt school personnel had not done enough and were using the wrong approaches with their kid. They hoped he could continue at the neighborhood school where he had made friends despite his problems. They wanted my opinion and support for their point of view at the school. When I met Sammy in my office, he was full of life and reasonably focused, chatting at length about activities at home and at school.

Though he was in first grade, he could read at a fourth-grade level. I got a better picture of his problems when I met him with his parents. When they were there he acted impulsively, getting up and down from his seat and moving about the room when we tried to have a family conversation. Sammy regularly interrupted his parents and bossed them around, especially Sarah. His lack of respect troubled me, but I felt optimistic that Sammy could be successful without medication, especially after I spoke with his teacher.

She was more positive about him than others who had reported on his conduct at school. She felt he had made progress in her classroom but still wondered how she could help him better stay on task. She was open to ideas. I suggested that Sammy be immediately rewarded for good behavior and given chips for finished work that could be exchanged for prizes at the end of the day. She was comfortable with giving him tangible consequences for not meeting her expectations.

I suspected that medication would probably help with Sammy’s self-control, but, as I told the McCormacks, it was not absolutely necessary. I told them that children of Sammy’s age never become addicted and that the drug’s effects on his behavior would last only four hours per dose. But it was more important that they work on their parenting, and I referred them to a counselor. I couldn’t say for sure whether changes at home and school would make the difference for Sammy, but I certainly felt it was up to the parents to decide on the medication. I said I would support their decision either way.

A year later the McCormacks returned, frustrated and embittered. Sammy had a very good end to first grade, but second grade with an unsympathetic, unyielding teacher had been disastrous. The principal and school district were now insisting that Sammy be on medication if he was to stay in a regular third-grade classroom. The school said it “could not meet the child’s needs within the regular classroom setting without medication.”

He was disrupting the classroom. Other parents had complained about his behavior. A one-on-one aide assigned to Sammy had not worked. Sarah thought the aide was nothing more than a snitch who regularly recorded Sammy’s misdeeds for the principal.

If the family refused to give Sammy medication, the boy would be transferred to a different school, a bus ride from their home, to be in a special class with four other “disturbed” children. They could also home-school him or challenge the school’s decision in a hearing. Ultimately they could go to court, but a final decision could take years — by then Sammy might be in

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middle school. The parents were loath to move Sammy to a new school. However, they still were against using medication with their son.

Families like the McCormacks, who reject medication and face a loss of access to conventional public school classrooms, are increasing in numbers. In May, I testified before a congressional subcommittee hearing on ADHD and Ritalin organized by several congressmen who had received letters from distressed parents pressured by their local schools to medicate their children. The pressure has become so intense in some areas that resolutions urging teachers to restrain from recommending medical evaluations and Ritalin for students are under consideration in several states. One passed recently in Colorado.

Yet even as the issue of parents’ rights is being considered in some areas, the stakes have dramatically increased in others, where schools are seeking the intervention of CPS to get parents to medicate their kids. It is no longer simply an issue of which school or which class a child will attend. Instead, some parents are being threatened with the possibility of losing custody of their children if they refuse to comply with suggested treatment for an alleged medical condition.

Many doctors and educators would agree that withholding medication can be viewed as a form of child abuse or neglect. Dr. Harold Koplewicz, vice chairman of the New York University Child Study Center, said on “Good Morning America” last month that he felt a CPS referral was justified when a family refused to medicate a child for whom a diagnosis of ADHD had been made by an experienced evaluator. “Ritalin is simply the best treatment for this disorder,” he said.

I can’t agree. It is true that the courts have ordered medical intervention when a child’s life is threatened. Judges have overruled the wishes of Christian Scientist parents not to give antibiotics to children who face life-threatening infection. Similarly, blood products have been given to children in surgery over the objections of Jehovah’s Witnesses. But those situations are quite different from ones in which ADHD is diagnosed and Ritalin is prescribed, according to Dolores Sargent, a former special education teacher now practicing family law in Danville, Calif.

“ADHD children and families do not face immediate life-threatening situations,” she says, “and ADHD continues to be a ‘disease’ with multiple causes and no definitive markers. It’s unlikely any decision that insists on the use of Ritalin for ADHD could withstand a court challenge.” The existence of effective alternative treatments makes any forced decision to medicate children against parents’ wishes both legally and ethically shaky. Yet, the willingness of some CPS workers to pursue families unwilling to dose their children shows how strongly entrenched medication for behavior problems in children has become in our country.

A local CPS office cannot demand that a child be medicated — yet — but it can ascertain whether a child is safe in his or her parents’ home. Legally, CPS can alert parents that their child’s uncontrollable behavior, which puts the child at significant risk of abuse at home, must change. If they feel this advice is not being taken, the agency can remove children from their homes.

What seems to be overlooked in this simplistic, and seemingly convenient, way of dealing with hard-to-handle kids is that alternative strategies to medication exist, from family counseling to

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short-term respite care. The perceived superiority, rapid onset and inexpensive nature of Ritalin make it a very attractive choice for school administrators, who may pressure parents of students who threaten to drain their beleaguered schools

of time or money. As more and more families opt for the Ritalin fix, it becomes easier to insist that other families in similar situations try the drug, even though these families may not want their kids to take stimulants. I still prescribe Ritalin, but only after assessing a child’s school learning environment and family dynamics, especially the parents’ style of discipline.

But I continue to ask questions about Ritalin in a country where we use 80 percent of the world’s stimulants. I have no doubt that Ritalin “works” to improve short-term behavior and school performance in children with ADHD; however, it is not an equivalent to or substitute for better parenting and schools for our children.

I was surprised to see Surgeon General David Satcher quoted recently as saying that he believes Ritalin is under-prescribed in our country. I participated in last week’s Conference on Children’s Mental Health sponsored by his office and found that Ritalin is thought to be both under-prescribed and over-prescribed, depending upon the community being assessed and its specific threshold for ADHD diagnosis and Ritalin treatment.

Data shows, for example, that African-American families use Ritalin at rates one-half to one-quarter of their white, socioeconomic peers. Asian-American youth are virtually absent in statistics for Ritalin use. I happen to believe that Satcher’s comments were intended for these communities and, ironically, will not have any impact on them. Instead, I think, his statement will have perverse impact on white middle- and upper-middle-class families. In some communities, Ritalin use among boys in this group is as high as one in five.

After much agonizing, Sammy’s parents decided to put him in a special education class rather than give him Ritalin and, for the moment, things are going well for him. But they plan to move from the Bay Area, largely because of Sammy’s school experience.

With 4 million children taking Ritalin in America today, there are undoubtedly millions of other parents struggling with the decision of whether to medicate their children. The McCormacks’ story demonstrates the dilemmas and pressures many of these families face. Proponents of drug treatment for children’s behavior problems applaud those parents who choose Ritalin to improve their children’s learning experience. But civil libertarians — and doctors like me — worry about the specter of more families being forced against their will to put their children on psychiatric medication. These families, and their right to make choices for their children, deserve our support and protection.