School Policy on ADHD and Associated Psychotropic / Psychostimulant Drugs

Chris Jenner, December 13, 2007

What is ADHD?

http://www.kidshealth.org/parent/medical/learning/adhd.html
Because there's no test that can determine the presence of ADHD, a diagnosis depends on a complete evaluation.

http://www.mykidsdeservebetter.com/adhd/disease.asp
Perfectly normal children who are over-active (have a lot of energy), rebellious, impulsive, day-dreamers, sensitive, undisciplined, bored easily (because they are bright), slow in learning, immature, troubled (for any number of reasons), learning disabled (dyslexia, for example), can also be inattentive, impulsive, or hyperactive.

http://www.adhdfraud.org/frameit.asp?src=commentary.htm
…it [ADHD] is not a disorder/disease at all; children said to have it are entirely normal meaning they bear no objective, demonstrable, diagnosable, abnormality, meaning there is no justification for prescribing these or any other drugs for so-called ADHD--a wholly fictitious, wholly subjective entity. -- Fred Baughman, MD, board certified Neurologist and Child Neurologist

Drugs commonly used for treatment

Most commonly prescribed: methylphenidate (Ritalin), dextroamphetamine (Dexedrine), d- and l-amphetamin racemic mixture (Adderall)

http://www.tsbp.state.tx.us/consumer/broch2.htm
DEA categorization: Schedule II
Schedule II — drugs with a high abuse risk, but also have safe and accepted medical uses in the United States. These drugs can cause severe psychological or physical dependence. Schedule II drugs include certain narcotic, stimulant, and depressant drugs. Some examples are morphine, cocaine, oxycodone (Percodan®), methylphenidate (Ritalin®), and dextroamphetamine (Dexedrine®).

http://www.healthysource.com/ritalin.html
WARNINGS - Ritalin should not be used in children under six years, since safety and efficacy in this age group have not been established. Sufficient data on safety and efficacy of long-term use of Ritalin in children are not yet available.

Several articles attribute a number of child deaths attributed to Ritalin. While I was unable to find any *primary* source for the statistics, a father who believes his son died from Ritalin put up this web site: http://www.ritalindeath.com/

Expansion of identification, less thorough diagnoses

http://www.srmhp.org/0201/adhd.html
The 700% increase in psychostimulant use that occurred in the 1990s justifies concern about potential overdiagnosis and inappropriate treatment of child behavior problems. A critical review of epidemiologic research suggests that attention-deficit/hyperactivity disorder (ADHD) is not universally overdiagnosed; however, for some U.S. communities there is evidence of substantial ADHD overdiagnosis, adverse educational outcomes among children treated for the disorder, and suboptimal management of childhood behavior problems. Evidence of ADHD overdiagnosis is obscured when findings are reported without respect to geographic location, race, gender, and age. More sophisticated epidemiologic tracking of ADHD treatment trends and examination of associated outcomes is needed to appreciate the scope of the problem on a national level. Meanwhile, a public health approach to ADHD that includes the development and implementation of data-driven, community-based interventions is warranted and is underway in some communities. Guidelines for promoting judicious use of psychotropic drugs are suggested.
-- Abstract from "ADHD among American Schoolchildren: Evidence of Overdiagnosis and Overuse of Medication", Lefever et al, The Scientific Review of Mental Health Practice journal, Spring – Summer, 2003

http://www.post-gazette.com/pg/07322/834548-109.stm
Dr. Elizabeth J. Roberts, Child and Adolescent Psychiatrist
"In September 2007, researchers at Columbia University reported that there had been a 40-fold increase in the number of children diagnosed with bipolar disorder from 1994 to 2003 -- an increase which has shown no signs of slowing.

Worse than the current frenzy to diagnose children with bipolar disorder is the practice of medicating kids as young as 2 with the kinds of psychiatric medications that were once prescribed only to psychotic adults. The shocking reality is that the use of these potent anti-psychotic drugs in children increased more than 500 percent between 1993 and 2002."

"Yet a 4,000 percent increase in childhood mental illness, specifically bipolar disorder, is simply implausible and difficult to justify based solely on improved diagnostic techniques. To the contrary, in the 30-plus years that I have been treating, educating and caring for children -- half of that time as a child psychiatrist -- I have found that the approach to diagnostics in psychiatry clearly has deteriorated over time, not improved.

There was a time when doctors insisted on hours of evaluation with a child and his parents before venturing a psychiatric diagnosis or prescribing a medication. Today many of my colleagues brag that they can complete an initial assessment of a child and write a prescription in less than 20 minutes. Many parents have told me it took a previous doctor less than five minutes to diagnose and medicate their child."

Information from Children and Adults with Attention Deficit Disorders, aka CHADD

Much of the information schools use to develop administrative procedures comes from CHADD, which has been around for 20 years. CHADD receives significant funding from the makers of drugs prescribed for behavior disorders in children. From CHADD's web site: "Total pharmaceutical donation support of CHADD ($934,408) as of June 30, 2004 was 23% of CHADD's budget. … Pharmaceutical donations received by CHADD as of June 30, 2004 included support from Cell Tech, Cephalon, Janssen, Lilly, McNeil, Novartis, Pfizer, and Shire."

Can CHADD take a quarter of its funding from the makers of psychostimulant drugs and still provide completely objective information?

A psychiatric watchdog organization makes a more direct commentary about CHADD. From http://tinyurl.com/2zooye :
"…Citizens Commission on Human Rights is warning that consumers nationwide are being mislead by CHADD, which recently made fraudulent claims about the medical validity of "Attention Deficit Hyperactivity Disorder" (ADHD), calling it a "disease." CHADD attacked a Virginia school board for sending out valid information about ADHD and the drugs used to "treat" it, including a warning by the United Nations about the dangers of ADHD drugs. With more than $1 million in pharmaceutical funding in 2004-2005 alone, CHADD has a conspicuous vested interest in trying to convince parents of the validity of ADHD and the drugs used to "treat" it."

School code, federal law

Under what conditions will a school district recommend a student be screened for ADHD?
Is a district ever required to recommend an ADHD screening?

The Illinois Department of Human Services / ISBE "Recommended Guidelines for Medication Administration in Schools" -- http://www.isbe.net/SPEC-ED/pdfs/medication_administration.pdf -- provides some direction regarding policy. Section III covers what we *have* to do, section IV covers implementation options.

Federal and state law say government schools can't require treatment with psychotropic or psychostimulant drugs as a condition of attending classes. Illinois School Code is below.

School District Policy

Based on limited research, the only Illinois school districts I found that addressed the issue in policy used IASB boilerplate verbiage. The closest IASB boilerplate policy closest to addressing this is 6:65 - Student Social and Emotional Development. E.g.
http://www.bsd2.org/policy/SECTION6/0665.htm.

Chicago Public Schools have an entire ADHD Policy Manual -
http://www.oism.cps.k12.il.us/pdf/oss/adhd_manual.pdf
CHADD was highly influential in development of the CPS manual -
http://www2.uic.edu/~jwatli1/neal-adhd.pdf

Related CPS policies:
http://policy.cps.k12.il.us/documents/704.5.pdf
http://policy.cps.k12.il.us/documents/705.4.pdf

Portsmouth, VA, school board sends Warning home to parents about drugs used to treat ADHD -
- http://content.hamptonroads.com/story.cfm?story=135015&ran=160257.
From the Warning -
http://media.hamptonroads.com/media/content/pilotonline/2007/10/schoolmemo.pdf :
"The United Nations Committee on the Rights of the Child has issued a strong warning against falsely labeling youth with the psychiatric diagnosis of ADHD and administering powerful ADHD drugs. The committee urges that other forms of management and treatment be used to address difficult behavior in children. The Commission recommended against the prescription of these drugs for anyone under 18."

What is the right thing to do?

There is a model district policy in a 1993 report by a Michigan Center for Educational Networking Task Force. I haven't looked into this group's composition or support, but the verbiage looked like a reasonable starting point for a school district policy on this issue. Some of the model district policy may likely be considered procedural.

http://www.cenmi.org/uploaded%5C2002%5CNOV%5C2511898216_ADHDTF.rprt.pdf
APPENDIX P
MODEL DISTRICT POLICY
SUBJECT: Referral to Physician
Whenever there are students who display learning or behavior problems, the role of school personnel does not include medical diagnosis or the referral of students to individual physicians or clinics for treatment. Further it does not include making recommendations that medication is appropriate. The role of school personnel is to:

1. Identify behavioral/learning problems.

2. Measure the extent of the problem--stating the frequency, the intensity and the duration.

3. Develop appropriate instructional strategies and interventions which address identified behavior/learning problems.

4. Provide information to serve as part of the basis upon which a physician can make related decisions.

To implement this policy the administration will:

1. Inform staff members of the policy and its stipulations.

2. Support inservice designed to develop and enhance knowledge and skills in the following areas:

a. Identifying behavioral/learning problems.
b. Measuring the extent of the problem--stating the frequency, the intensity and the duration.
c. Developing appropriate instructional strategies and interventions which address identified behavioral/learning problems.
d. Providing information to serve as part of the basis upon which a physician can make a diagnosis. (Sample form attached.)

3. Develop and implement a system for keeping track of referrals to physicians.

Other Reading / Resources

Summary of a PBS show that interviewed experts with different perspectives - http://www.pbs.org/wgbh/pages/frontline/shows/medicating/experts/business.html

(105 ILCS 5/10-20.36)

Sec. 10-20.36. Psychotropic or psychostimulant medication; disciplinary action.

(a) In this Section:

"Psychostimulant medication" means medication that produces increased levels of mental and physical energy and alertness and an elevated mood by stimulating the central nervous system.

"Psychotropic medication" means psychotropic medication as defined in Section 1-121.1 of the Mental Health and Developmental Disabilities Code.

(b) Each school board must adopt and implement a policy that prohibits any disciplinary action that is based totally or in part on the refusal of a student's parent or guardian to administer or consent to the administration of psychotropic or psychostimulant medication to the student.

The policy must require that, at least once every 2 years, the in-service training of certified school personnel and administrators include training on current best practices regarding the identification and treatment of attention deficit disorder and attention deficit hyperactivity disorder, the application of non-aversive behavioral interventions in the school environment, and the use of psychotropic or psychostimulant medication for school-age children.

(c) This Section does not prohibit school medical staff, an individualized educational program team, or a professional worker (as defined in Section 14-1.10 of this Code) from recommending that a student be evaluated by an appropriate medical practitioner or prohibit school personnel from consulting with the practitioner with the consent of the student's parents or guardian.

(Source: P.A. 95-331, eff. 8-21-07.)