

White Paper

Citizens Commission on Human Rights UK

Dangers and Consequences of the
Misdiagnosis and Prescription of
Addictive Drugs to Children
for
Attention Deficit
Hyperactivity Disorder
(ADHD)



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Executive summary

***‘We do not know exactly what causes these disorders.’
The Royal College of Psychiatry, 2012¹***

In October 2011 the United Nations Committee on the Rights of the Child (UNCRC) expressed deep concern about children being misdiagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and for which powerful stimulants are prescribed. The UNCRC recommended that countries conduct research into the negative effects of psycho-stimulants and ‘that other forms of management and treatment be used as much as possible’ to address behavioural problems.²

Yet, UK children are being misdiagnosed at an alarming rate and prescribed psycho-stimulants that are more potent than cocaine and are scheduled controlled drugs in the same abuse category as amphetamine, methadone, and morphine.³

Between 2000 and 2011 there was an incredible 938% increase in NHS spending on drugs to treat Attention Deficit Hyperactivity Disorder (ADHD), with a cost to the taxpayer of almost £50 million in 2011.

Unlike medical conditions where there is an objective test to determine the presence of hostile bacteria or virus, an X-ray to determine a broken arm or a blood test that will determine the absence or presence of a toxin or nutrient, there has never been an objective test to establish the existence of ADHD.

The classification came about solely because psychiatrists literally voted on a list of behavioural symptoms and by consensus these became a ‘mental disorder.’

Clearly there are emotional and behavioural characteristics that can be observed in children and adolescents. However, putting certain characteristics together and giving them a scientific-sounding label suggests falsely that a distinct illness has been proven by science.

In 2008, the National Institute for Health and Clinical Excellence (NICE) commissioned a Guideline Development Committee (GDC) to write guidelines for ADHD treatment. Almost two-thirds of the GDC⁴ had financial affiliations with pharmaceutical companies as consultants, researchers receiving grants, or being funded to attend conferences. This conflict of interest might explain why the NICE guidelines recommend psycho-stimulants as a primary treatment, contributing to the ‘epidemic’ rate of children being drugged.

In 2011 the NICE reviewed the 2008 guidelines and concluded there was no need for change to them or for further review. Consequently, no further investigation into the

1 <http://www.rcpsych.ac.uk/mentalhealthinfo/mentalhealthandgrowingup/adhdhyperkineticdisorder.aspx>

2 *Consideration Of Reports Submitted By States Parties Under Article 44 Of The Convention*, Committee On The Rights Of The Child, Fifty-eighth session, October 6, 2011, p 8.

3 <http://www.ipnsm.hscni.net/library/MethylphenidateSCG2012.pdf>; <http://webarchive.nationalarchives.gov.uk/+http://www.homeoffice.gov.uk/publications/drugs/drug-licences/controlled-drugs-list?view=Binary>

4 ‘Diagnosis and management of ADHD in children, young people and adults.’ *National Clinical Practice Guideline Number 72, National Collaborating Centre for Mental Health*, commissioned by the National Institute for Health & Clinical Excellence, published by the British Psychological Society and the Royal College of Psychiatrists; <http://www.nice.org.uk/nicemedia/live/12061/42060/42060.pdf> – appendix 2 of the above NICE ADHD guideline

causes of ADHD or other treatments for it was recommended, ignoring the UNCRC's request and concerns as well as the large body of scientific evidence indicating treatments that do not require drugs to improve the condition.⁵

There is ample evidence to show that many symptoms collectively called 'ADHD' are often actually caused by a variety of external stimuli: *inter alia*, poor diet and other means of toxic ingestion into the body. However, there is a conflict of interest on the part of psychiatrists and drug companies who effectively control the major research money and deny the efficacy of these external stimuli in favour of drugs.

Consequently, tens of thousands of children are being diagnosed with a subjective disorder every year and their treatment is to be prescribed drugs for behavioural control, not to relieve any physical disease or identify nutritional, toxic or other causes. The MHRA warns that these drugs can affect blood pressure adversely and stunt growth, while also causing the 'onset or worsening of psychiatric symptoms (such as depression, suicidal thoughts, hostility, anxiety, agitation, psychosis, or mania) and symptoms suggestive of heart disease.'⁶

These factors effectively violate the informed consent rights of parents and put children at risk, and it is probable that most parents are not even properly warned about the dangers of the drugs being given to their children.

No psychiatric, medical or medicine regulatory authority appears to have acted against the mass prescription of these drugs to toddlers and under-6-year-olds, for whom the drugs are not licensed.

The social cost of misdiagnosing and mistreating these symptoms in children and adults, both in human and monetary terms, is enormous. The potential for litigation arising from negligence, neglect and harm to the children subjected to these drugs increases by the year. It is not out of the question that legal remedies may be levelled at government agencies for complicity in perpetuating a system that benefits pharmaceutical companies and psychiatrists, yet often harms citizens the government is supposed to protect.

It is therefore vital to point out this vast waste of money and resources and identify the factors causing such waste. We would then surely be better to concentrate on finding real solutions to the symptoms labelled as ADHD – whether they are caused by nutritional difficulties, environmental factors, proven medical conditions or social or educational factors (or are just normal childhood behaviour) – rather than spend huge sums of money on expensive drugs which, at best, temporarily suppress the symptoms of the real problem, and at worst cause short-term and long-term harm to those so treated.

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5 <http://www.nice.org.uk/nicemedia/live/12061/57052/57052.pdf>

6 <http://www.mhra.gov.uk/Safetyinformation/DrugSafetyUpdate/CON087740>

Diagnosis or misdiagnosis?

Two of the most fundamental questions to ask about ADHD are ‘What is it?’ and ‘How is it diagnosed?’

Its definition has changed from the 1960s to present day, but it is currently known as Attention Deficit Hyperactivity Disorder or ADHD. It is a collection of observed behaviours listed as symptoms, gathered together ‘under one roof’ and erroneously labelled as a specific mental *disease*. The symptoms include, but are not limited to, inward daydreaming, lack of focus, impulsivity, inattention and hyperactivity. The actual classification of ADHD came into effect in 1987 when the American Psychiatric Association (APA) officially *voted* it into existence.⁷ There were no actual tests to determine its existence. It was based on the *opinion* of the APA Committee members.

To this day there is no physical test that can identify the so-called condition and whilst there is no doubt that some or all of the above manifestations can be observed in children, the simple fact of lumping together different phenomena does not make it a disease. Factually, there is no objective scientific evidence that proves this to be the case.⁸

‘There are no specific treatments for ADHD, with the most widely debated treatment (methylphenidate) being known to have similar effects on otherwise normal children. There is no established prognosis, and association and cause frequently are confused in the literature. ADHD has generated huge profits for the pharmaceutical industry against a background of poor-quality research, publication bias and payments to some of the top academics in this field. Thus, the mainstream dogma on ADHD is contaminated and misleading.’⁹

– Dr Sami Timimi, UK psychiatrist, 2002

When SSRI antidepressants were launched in the late 1980s, psychiatrists then theorised that the cause of ADHD was a chemical imbalance in the brain or a neurobiological dysfunction. The treatment ‘logic,’ therefore, is that another chemical could correct this imbalance. This theory has never been proven and in fact, in 2005 the President of the APA admitted that there is no laboratory test to confirm a chemical imbalance in the brain, while the President of the American Psychiatric Association admitted in July 2005, that there is no way to test for a ‘chemical imbalance’ as the cause for mental disorders.¹⁰

Ritalin was first introduced on the market in the 1960s as one of the first medications to treat the supposed condition – then called *minimal brain dysfunction*. At the time the diagnosis was only applied to a small proportion of children. As a stimulant medication, Ritalin has earned the title ‘kiddie-cocaine,’ as its chemical construction

7 The condition of ADHD was voted into existence in the DSM-III-R (DSM is the Diagnostic and Statistical Manual – an official listing of psychiatric diseases) by a show of hands of APA (American Psychiatric Association) committee members.

8 “‘Biological psychiatry’ has yet to validate a single psychiatric condition/diagnosis as an abnormality/disease or as anything “neurological,” “biological,” “chemically imbalanced” or “genetic.” – Dr. Fred A. Baughman Jr., Pediatric Neurologist, *Malpractice and Violation of Informed Consent*; ‘ADHD is not like diabetes and Ritalin is not like insulin. Diabetes is a real medical condition that can be objectively diagnosed. ADHD is an invented label with no objective valid means of identification.’ – Dr Mary Ann Block, author of *No More ADHD*.

9 *British Journal of Psychiatry* 2004, 184:8–9.

10 *PEOPLE* magazine, quoted Dr Sharfstein conceding, ‘We do not have a clean-cut lab test.’
<http://www.webwire.com/ViewPressRel.asp?aId=3180>

is similar to that of cocaine.¹¹ The other main drug on the market used to subdue children and adolescents in the UK is Concerta (also with the same active ingredient, methylphenidate).

There have been many vocal experts critical of the diagnosis of ADHD. To quote but two:

*'We suggest that adult ADHD represents one of the latest attempts to medicalise ordinary human difficulties, and that its popularity is partly dependent on marketing and the reinforcing effects of stimulants.'*¹²

– Dr Joanna Moncrieff, Department of Mental Health Sciences, UCL and Dr Sami Timimi.

*'ADHD is not like diabetes and Ritalin is not like insulin. Diabetes is a real medical condition that can be objectively diagnosed. ADHD is an invented label with no objective valid means of identification.'*¹³

– Dr Mary Ann Block, Medical Director of the Block Center and author of *No More ADHD*

To date, no clinical drug trials have claimed to *cure* ADHD. They are all focused 'at best' on suppressing the symptoms, whilst Moncrieff and Timimi report, citing numerous studies, that, '*The evidence from randomised trials in adults and children therefore provides little basis for the sort of long-term drug treatment that is now being implemented for adults presenting with ADHD de novo, or for those with a continuation of a childhood presentation.*'¹⁴

There is a robust body of evidence pointing to a range of factors that can cause many of the symptoms that are wrongly classified as ADHD. Many of these examples are covered in the following sections.

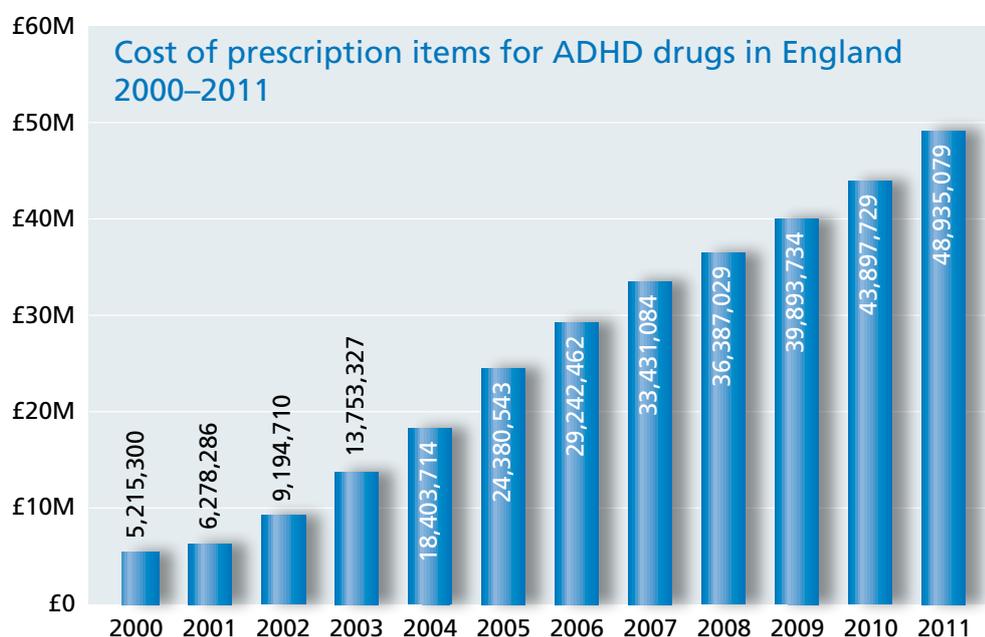
11 The World Health Organization (WHO) concluded that Ritalin was pharmacologically similar to cocaine in the pattern of abuse it fostered and cited it as a Schedule II drug – the most addictive in medical use. The US Department of Justice also cited Ritalin as a Schedule II drug under the Controlled Substances Act, and the US Drug Enforcement Agency (DEA) warned that 'Ritalin substitutes for cocaine and d-amphetamine in a number of behavioral paradigms.'

12 *The Psychiatrist* (2011) 35: 334–338

13 Author of *No More ADHD*

14 *The Psychiatrist* (2011) 35: 334–338

Increased use of ADHD drugs



Source: Prescription Cost Analysis 2000–2011¹⁵

UK statistics on the number of children currently taking ADHD drugs are obscure and apparently not kept. However, the cost of, and number of, prescription items for all ADHD drugs are.

These statistics show an almost 1000% increase in the cost of prescription items for ADHD over an 11-year period. This massive increase includes a rise in unit cost of prescription items for ADHD drugs from £21.66 in 2001 to £52.63 in 2011.¹⁶

The Government has consistently stated that whilst the drug information (cost and number of prescriptions) is kept, there is no figure for the actual number of children receiving ADHD prescriptions. Why this is the case is somewhat of a mystery and shows a serious lack of transparency.

However, in an answer to a Parliamentary Question relating to this, it was stated that in October 2000, NICE estimated the prevalence of all types of ADHD at around 5 per cent of school-aged children, or approximately 345,000 6- to 16-year-olds in England.¹⁷

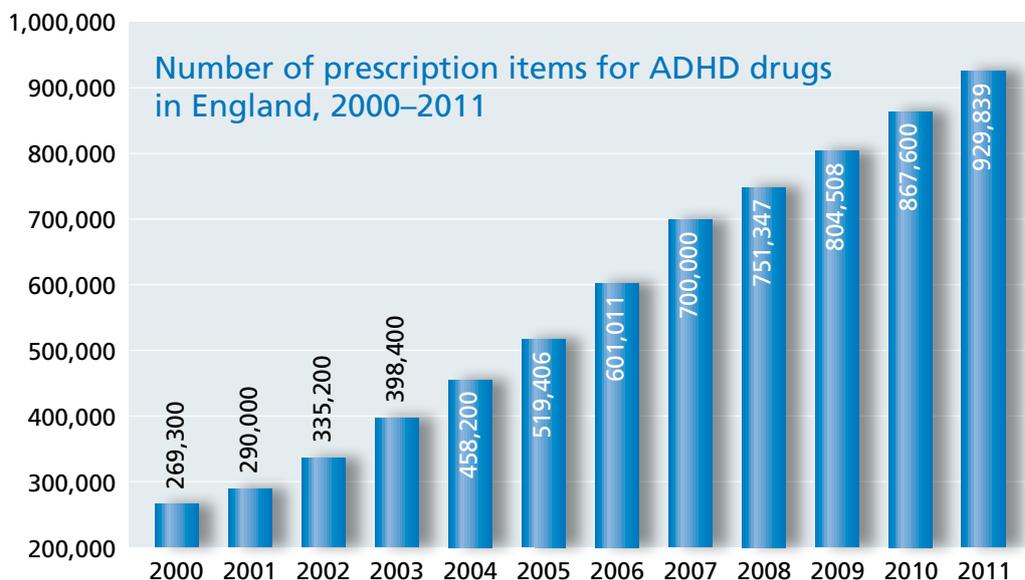
Whatever the numbers of children on ADHD drugs, there is an extremely alarming trend, simply based on the number of prescription items. That such a 'disease' can be diagnosed in such proportions without any sound diagnostic criteria and is apparently 'spreading' at such an alarming rate, would mean that it had reached epidemic proportions were it really a disease.

However, it is more likely that common childhood phenomena are simply being diagnosed as ADHD – with potential adverse consequences for hundreds of thousands of children.

¹⁵ NHS Business Services Authority

¹⁶ *Ibid.*

¹⁷ *Hansard* source (Citation: HC Deb, 7 July 2005, c573W)



Source: Prescription Cost Analysis 2000–2011¹⁸

When pressed on the subject of the dangers arising from ADHD drugs, government responses are to fall back on the NICE guidelines (see later section on NICE), which are lacking in thoroughness and tainted by conflicts of interest.

Furthermore, in a response to Citizens Commission on Human Rights' raising its concerns about this trend, the Department of Health has responded stating that *'evidence suggests'* the number of cases of ADHD may be under-diagnosed and therefore under-treated, and refers to *NICE Guidelines CG72 Attention deficit hyperactivity disorder: Diagnosis and management in children, young people and adults*. Upon review of this document, no evidence was presented that showed there was a problem with under-diagnosis.

However, what is mentioned in this reference is a short paragraph on the change of diagnostic criteria from the *International Classification of Diseases 10* (ICD 10) to the *Diagnostic and Statistical Manual of Mental Disorders IV* (DSM–IV). These are two systems of psychiatric diagnosis (one from the US Psychiatric Association and the other from the World Health Organisation), often closely linked and with the same diagnostic flaws. The DSM–IV criteria are far broader and are so general that it would be possible to diagnose most children, if not any child, with ADHD.

Research on the likely causes of symptoms labelled as ADHD

Whilst it is fully acknowledged that a great deal more research can be done into what actually causes the different symptoms classed as ADHD, it is absolutely clear that diet, nutrition, chemical additives, environmental pollution, pesticides, endocrine function and other external stimuli are amongst some of the factors that can precipitate them. We have focused on a number of these factors but do not exclude others not mentioned here. What is clear, however, is that dietary and environmental factors can play a significant role in dealing with these symptoms and, if they were pursued, the harmful drugging of children on a broad scale would significantly reduce while, more importantly, improving their lives.

Faulty diagnoses by many psychiatrists and funding directed mostly into research focusing on the 'drug model,' have prevented proper scientific analysis and deduction from occurring.

The following are a number of relevant studies:

Poor diet

Experts cite poor diet, high sugar intake, fast foods, processed meats, high-fat dairy products and confectionery as causal factors of symptoms associated with ADHD.

1. A study, conducted by Dr Lidy M Pelsser and others, to determine if there is any connection between diet and childhood behaviour found that 64 per cent of the children in the study group labelled with ADHD, had symptoms that were caused by food hypersensitivity:

'Food is the main cause of ADHD,' Pelsser said, adding, 'After the diet, they were just normal children with normal behaviour. They were no longer more easily distracted, they were no more forgetful, there were no more temper-tantrums.'

Dr Pelsser also reported, 'The teachers thought it was so strange that the diet would change the behaviour of the child as thoroughly as they saw it. It was a miracle, the teachers said.'

The researchers concluded that 'dietary intervention should be considered in all children with ADHD, provided parents are willing to follow a diagnostic restricted elimination diet for a five-week period, and provided expert supervision is available.'¹⁹

2. A trial using an elimination diet with 140 behaviourally disturbed children found that nearly two-thirds (61%) improved significantly and that a suitable diet could usually be devised for each child within three months.²⁰
3. In 2003 at the Dingle School in Cheshire, UK, a group of 6-year-olds was asked to eat only additive-free food (eliminating 39 food additives in their diet) at home and at school for two weeks while another 'twin' in the class ate as usual. Professor Jim Stevenson from Southampton University monitored both groups. At the end of two weeks, 57 per cent of parents reported an improvement in their child's behaviour and 56 per cent recorded better sleep patterns and cooperation in the additive-free class. Also, the IQ of the twin on the additive-free diet had improved by 25% while the additive-eating twin's IQ had only improved by 10%.²¹
4. Nine children with persistent anti-social, disruptive and/or criminal behaviours were assessed and treated for food intolerance and allergies. All were found to have a number of food allergies or intolerances and mineral imbalances, particularly in zinc. Three showed marginally raised cadmium while one had considerably raised cadmium. The children remained at home in the care of their parents while undergoing a restrictive dietary regimen with the avoidance of identified problem foods. The health and behaviour of all nine subjects improved both physically and psychologically. Of the three children that abandoned the dietary regimen, two re-offended while the third moved home and accepted a specific diet to follow. He and the other six continued to improve in health, behaviour and school performance over six months. After two years, five of the nine had not re-offended.

19 *The Lancet*, Volume 377, Issue 9764, pages 494–503, 5 February 2011

20 Swain A, Soutter V, Loblay R, Truswell AS, 'Salicylates, oligoantigenic diets, and behaviour.' *Lancet* 1985;2(8445):41–2.

21 Nicole Martin. 'Food additives affect concentration: twin study.' *The Daily Telegraph*, 1/5/2003, page A14. <http://www.telegraph.co.uk/news/uknews/1428657/Twin-outshines-brother-on-additive-free-diet.html>

The feasibility of applying nutritional and biochemical assessment and treatment in the community to divert young offenders and disruptive schoolchildren from criminal behaviour was demonstrated, according to the researchers. Criminal justice, education and health agencies could incorporate and develop this approach.²²

5. The introduction of a diet policy which lowered sucrose, synthetic food colours and flavours, and two preservatives (BHA and BHT) over four years in 803 public schools was followed by a 15.7 per cent increase in mean academic percentile ranking above the rest of the nation's schools who used the same standardised tests. Prior to the 15.7 per cent gain, the standard deviation of the annual change in national percentile rating had been less than 1 per cent. Each school's academic performance ranking was negatively correlated with the percentage of children who ate school food prior to the diet policy changes. However, after the new dietary foods being implemented, the percentage of students who ate school lunches and breakfasts within each school became positively correlated with that school's rate of gain.²³
- 6.. Numerous studies conducted in juvenile correctional institutions have reported that violence and serious antisocial behaviour have been cut almost in half after implementing nutrient-dense diets that are consistent with the World Health Organization's guidelines for fats, sugar, starches and protein ratios. Two controlled trials tested whether the cause of the behavioural improvements was psychological or biological in nature by comparing the behaviour of offenders who either received placebos or vitamin-mineral supplements designed to provide the micronutrient equivalent of a well-balanced diet. These randomised trials reported that institutionalised offenders, aged 13 to 17 years or 18 to 26 years, when given actual supplements, produced about 40 per cent less violent and other antisocial behaviour than the placebo controls. However, generalisation could not be made to typical schoolchildren without a controlled trial examining violence and antisocial behaviour in public schools.²⁴
7. High sugar intake is also associated with hyperactive and other behaviour labelled as ADHD, and to aggressive and destructive behaviour.²⁵ A large study by Langseth and Dowd found 74 per cent of 261 hyperactive children manifested abnormal glucose tolerance in response to a sucrose meal.²⁶
8. Probably the most significant broad study on health was conducted in Australia and reported on in 2011. Researchers in a project known as the *Raine Study* collected a large amount of health, developmental and environmental information on 2,868 children in Australia from birth. The information on the children's diets, and whether they had a diagnosis of ADHD, was analysed. Dr Wendy Oddy, Leader of Nutrition Studies at the Perth Telethon Institute for Child Health Research reported: *'When we looked at specific foods, having an ADHD diagnosis was associated*

22 'The Shipley Project: Treating Food Allergy to Prevent Criminal Behaviour in Community Settings.' Bennett CPW, McEwen LM, McEwen HC, Rose, EL, *Journal of Nutritional & Environmental Medicine*, Vol. 8, No. 1, Mar.1998, pp.77-83

23 'The Impact of a Low Food Additive and Sucrose Diet on Academic Performance in 803 New York City Public Schools.' Schoenthaler SJ, Doraz WE, Wakefield JA, *Int J Biosocial Res.*, 1986, 8(2); 185-195.

24 *The effect of vitamin-mineral supplementation on juvenile delinquency among American schoolchildren: a randomized, double-blind placebo-controlled trial.* Schoenthaler SJ, Bier ID. <http://www.ncbi.nlm.nih.gov/pubmed/10706231>

25 Murray MT, Pizzorno JT, *Encyclopedia of Natural Medicine*. Rocklin, CA: Prima Publishing; 1998; Crook WG, 'Sugar, yeast and ADHD: fact or fiction?' in: Bellanti JA, Crook WG, Layton RE, eds. *Attention Deficit Hyperactivity Disorder: Causes and Possible Solutions (Proceedings of a Conference)*. Jackson TN, International Health Foundation, 1999; Prinz RJ, Roberts WA, Hantman E *et al.*, 'Dietary correlates of hyperactive behavior in children.' *J Consult Clin Psychol* 1980;48:760-769

26 Langseth L, Dowd J. 'Glucose tolerance and hyperkinesia.' *Fd Cosmet Toxicol* 1978;16:129- 133.

with a diet high in takeaway foods, processed meats, red meat, high fat dairy products and confectionery. She further reported, *'We suggest that a Western dietary pattern may indicate the adolescent has a less optimal fatty acid profile, whereas a diet higher in omega-3 fatty acids is thought to hold benefits for mental health and optimal brain function.'* The researchers also concluded that those children raised on stimulants for the treatment of ADHD, did not progress academically.

9. The Centre for Autism and Integrative Health, LLC has done extensive research into this field. Dr Nancy O'Hara, MD, MPH, FAAP and Gail Szakacs, MD reported that subtle dietary changes can promote significant behavioural and cognitive changes. The impact of early poor nutrition depends on timing in relation to critical brain development, but, if poor nutrition continues or develops later, it can have profound negative effects. Liu, *et al.* showed a 15.3 point IQ deficit in a prospective, longitudinal study of malnourished children at age 3.²⁷

Vitamin, mineral and other nutrient deficiencies

Medical research indicates that vitamin, mineral and other nutrient deficiencies correlate with symptoms of ADHD and show that supplementation can improve symptoms.

Nutrient deficiencies are common in ADHD-labelled children. Medical and healthcare experts have found supplementation with minerals, the B vitamins, omega-3 and omega-6 essential fatty acids, flavonoids and the essential phospholipid phosphatidylserine can ameliorate ADHD symptoms.²⁸

The role of other nutrients is widely covered in the available literature. The following are a few examples that relate to ADHD symptoms:

Iron

- Children with moderately severe iron-deficiency anaemia as infants had lower scores on tests of mental and motor functioning at school entry.²⁹
- Low iron was associated with changes in serotonin, noradrenaline, and dopamine levels; iron supplementation has short- and long-term benefits in behaviour and psychomotor development.³⁰

Essential fatty acids:

Essential fatty acids are the 'good fats' such as Omega 3s found in cod liver oil and flaxseed oil.

- Drawing on a number of studies, Dr Randi Fredricks, PhD reports that fish oil improves the symptoms of ADHD without the side-effects of drugs such as Ritalin and Concerta and is more effective, according to a study by the University of Adelaide in Australia. Other studies have found evidence supporting the use of the omega-3 fats found in fish oils to address effectively the underlying deficiency that is present in most of these children and appears to be contributing to the ADHD. According to one of the studies, when 130 children between the ages of 7 and 12 with ADHD were given fish oil capsules daily, behaviour dramatically improved within three months. In addition, the study revealed the following:

27 Centre for Autism and Integrative Health Care, Dr Gail Szakacs, <http://www.epidemicanswers.org/wp-content/uploads/2010/05/ADHD-Without-Drugs.pdf>

28 'Attention Deficit/Hyperactivity Disorder (ADHD) in Children: Rationale for Its Integrative Management.' Parris M Kidd, PhD, *Altern Med Rev* 2000;5(5):402-428

29 Lozoff, *et al.*, 1991, *NEJM*;325(10):687-694

30 Parks, *et al.*, 1989, *Acta Paediatr Scand Suppl*;361:71-7

- After seven months, the children were less restless and showed improvements at school
 - Improvements in concentration and attention improved by one-third
 - After 15 weeks, 30 to 40 per cent of the children taking fish oil had improvements
 - After 30 weeks, 40 to 50 per cent improved
 - Children who had been taking the placebo capsules were later switched to fish oil and subsequently also experienced improved behaviour
 - Improvements were still being seen after the study ended, which indicates the fish oils may have long-term effects. When the researchers compared their results to studies of Ritalin and Concerta for ADHD, they found that fish oils were more effective.³¹
- Omega-3 fatty acids (especially DHA) are the building blocks a child needs to build a healthy brain. Insufficient omega-3 levels are common in children with ADHD, and there is evidence that omega-3 supplementation, especially in combination with the omega-6 fatty acid gamma-linolenic acid (GLA is found in borage oil and evening primrose oil) improves behaviour and ADHD symptoms.³²

Phosphatidylserine

Phosphatidylserine is important for synaptic membrane and neurotransmitter function. A Study of 21 patients with ADHD, ages 4 to 19 during a four-month trial helped approximately 90% with attention and learning.³³

Toxins in the environment

Toxic metals and allergens can cause oxidative stress, increased burden on the immune system, and behavioural and cognitive changes. Infections, trauma or injury, stress and poor diet can all further increase oxidative stress.

Many chemicals and metals are recognized causes of neuro-developmental disorders and subclinical brain dysfunction. Exposure during early foetal development can trigger brain injury at doses much lower than those affecting adult brain function. The information below from various studies highlights the importance of exploring causes of oxidative stress as contributing factors in symptoms assigned to ADHD.

- i. Children exposed to higher levels of insecticide were more likely to experience Psychomotor Development and Mental Development Index Delays, attention

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31 Burgess JR, Stevens L, Zhang W & Peck L (2000), 'Long-chain polyunsaturated fatty acids in children with attention-deficit hyperactivity disorder.' *Am J Clin Nutr*, 71(1 Suppl), 327S–330S.
Fredricks R (2008), *Healing & wholeness: Complementary and alternative therapies for mental health*, Bloomington, IN: Author House.
Hamazaki T, Sawazaki S, Itomura M, Asaoka E, Nagao Y, Nishimura N, Yazawa K, Kuwamori T & Kobayashi M (1996), 'The effect of docosahexaenoic acid on aggression in young adults. A placebo-controlled double-blind study.' *J Clin Invest*, 97(4), 1129–1133.
Richardson AJ & Montgomery P (2005), 'The Oxford-Durham study: A randomized, controlled trial of dietary supplementation with fatty acids in children with developmental coordination disorder.' *Pediatrics*, 115, 1360–1306.
Sinn N (2008), 'Nutritional and dietary influences on attention deficit hyperactivity disorder.' *Nutr Rev*, 66(10), 558–568.
Stevens LJ, Zentall SS, Abate ML *et al.* (1996), 'Omega 3 fatty acids in boys with behaviour, learning and health problems.' *Physiology and Behaviour*, 59, 915–920.

32 Antalis CJ, Stevens LJ, Campbell M *et al.*, 'Omega-3 fatty acid status in attention-deficit/hyperactivity disorder.' *Prostaglandins Leukot Essent Fatty Acids* 2006;75:299–308.
Transler C, Eilander A, Mitchell S *et al.*, 'The impact of polyunsaturated fatty acids in reducing child attention deficit and hyperactivity disorders.' *J Atten Disord* 2010;14:232–246.

33 (Ryer *et al. Lancet* [letter], 'Benefits of PS against attention deficit in a preliminary study').

problems, ADHD and pervasive developmental disorder problems at 3 years of age.³⁴

- ii. Prenatal environmental tobacco smoke is a risk factor for ADHD.³⁵
- iii. Lead exposure can manifest in the symptoms of ADHD.³⁶
- iv. In a Texas report – on average, for each 1000 lbs of environmentally released mercury, there was a 43% increase in the rate of special education services and a 61% increase in the rate of Autism.³⁷
- vi. Pollen exposure is a cause of regression in neurobehavioural function in children with Autism and ADHD.³⁸
- vii. Three large German studies suggest a strong and independent association between atopic dermatitis and ADHD – one of the studies (by Schmitt, *et al.*) reported a 2.67-fold increased likelihood of ADHD in those with atopic dermatitis and parent-reported sleep problems.³⁹
- viii. More than 80 per cent of schools in America use toxic pesticides as a preventative measure, whether it's needed or not. Mark Lame, an entomologist and professor at Indiana University's School of Public and Environmental Affairs, believes this is an entirely unnecessary practice that carries more risks than benefits to students and faculty. The most widely used pesticides are, in fact, nerve poisons. They cause uncontrolled nerve firing, and disrupt the delicate hormone systems. The link between pesticide exposure and health problems in children is already well established. Research has connected these endocrine-disrupting pesticides to health problems such as ADHD, autism and infertility – all of which are on the rise.
- ix. There is preliminary evidence that certain pesticides (called organophosphates) commonly found on some fruits are associated with ADHD.⁴⁰

Artificial colouring in food and drinks causes hyperactivity

A randomised, double-blinded, placebo-controlled trial study into food additives and hyperactive behaviour was carried out on 3-year-old and 8/9-year-old children in the community.⁴¹ The researchers undertook to test whether intake of artificial food colour and additives affected childhood behaviour. 153 3-year-old and 144 8/9-year-old children were included in the study. The conclusion was that artificial colours or a sodium benzoate preservative (or both) in the diet result in increased hyperactivity in 3-year-old and 8/9-year-old children in the general population.

A meta-analysis of double-blind placebo-controlled trials conducted by *Pediatric J Dev Behav* with regard to food additives and dyes found that many coloured foods are

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34 (Rauh *et al.*, 2006, *Pediatrics* 118:e1845–1859)

35 (Braun JM *et al.*, Dec 2006, *Environ Health Project*;114(12):1904–1909)

36 (Braun JM *et al.*, Dec 2006, *Environ Health Project*;114(12):1904–1909)

37 (Palmer *et al.*, *Health & Place* 12, 2006:203–209)

38 Boris MJ *et al.*, 2004 *J of Nutritional and Environmental Medicine* 14(1):47–54

39 Article by Bruce Jancin in *Internal Medicine News*; studies from *JAMA* and *Pediatric Allergy Immunology* journals cited in this article.

40 Bouchard MF, Bellinger DC, Wright RO *et al.*: 'Attention-deficit/hyperactivity disorder and urinary metabolites of organophosphate pesticides.' *Pediatrics* 2010;125:e1270–1277.

41 University of Southampton. The study was carried out by Donna McCann, Angelina Barrett, Alison Cooper, Debbie Crumpler, Lindy Dalen, Kate Grimshaw, Elizabeth Kitchin, Kris Lok, Lucy Porteous, Emily Prince, Edmund Sonuga-Barke, John O Warner, Jim Stevenson. *The Lancet*, 370, (9598), 1560–1567.

marketed to children, and hyperactivity in children following ingestion of food dyes is well documented in placebo-controlled studies.⁴²

Television and video games

Excessive time spent before the television or playing video games can also lead to behavioural symptoms associated with ADHD. Guidelines from the American Academy of Pediatrics recommend no 'screen time' for children less than 2 years old, no more than 1 to 2 hours a day of quality television and video for older children, and no electronic media in young children's rooms. Yet a recent survey found that 43% of children less than 2 years old watch television every day, and 26% have a television in their bedrooms. The study also showed that 68% of children less than 2 years old spend slightly less than two hours a day using screen media.⁴³ Somehow, the considered message of the American Academy of Pediatrics is not hitting the target.

Endocrine imbalance

The thyroid gland regulates all the processes to do with releasing energy from cells and the body as a whole. Symptoms such as anxiety and irritability, fatigue, memory loss, poor concentration, slow thinking and depression⁴⁴ are attributed to poor thyroid gland function.⁴⁵ (This excerpt being only a partial list of selected symptoms to demonstrate that those classed as ADHD can have cause in a malfunctioning thyroid gland.) The condition of hypothyroidism has traditionally been among the most widespread and under-diagnosed. As early as 1933, a Dr Kimball stated that there is 'no more important under-diagnosed condition than hypothyroidism.' In his 1976 book Dr Barnes stated that, 'Hypothyroidism was the most frequent and often overlooked chronic condition affecting people residing all over the US.'⁴⁶

The adrenal glands are known as 'the stress glands' and their job is to help the body deal with stress from every possible source – ranging from bereavement, relationship problems, emotional upsets, trauma, pain, injury and disease. Hormones secreted by the adrenal glands influence all major physiological processes in the body and malfunction includes anxiety, memory loss, confusion, low blood sugar and salt or sugar cravings – again symptoms that can be classed as, or lead to the classification of, ADHD.^{47, 48}

Whatever the source of stress on the individual, the stress response from the adrenal glands will not vary⁴⁹ but follow the same pattern: high output of cortisol, followed by a period of adaptation, then, if the stressor persists, a gradual descent into adrenal fatigue followed by eventual exhaustion.⁵⁰

'The tendency of the medical profession to ignore this syndrome results in many unnecessary health problems for millions. Even if you are aware that you have adrenal

42 'Artificial food colouring and hyperactivity symptoms in children.' *Prescribe Int* 2009;18:215; Schab DW, Trinh NH: 'Do artificial food colors promote hyperactivity in children with hyperactive syndromes? A meta-analysis of double-blind placebo-controlled trials.' *J Dev Behav Pediatr* 2004;25:423–434.

43 Rideout VJ, Vandewater EA, Wartella EA, *Zero to Six: Electronic Media in the Lives of Infants, Toddlers, and Preschoolers*. Menlo Park, CA: Kaiser Family Foundation; 2003.

44 Joffe RT (1990), 'A Perspective of the thyroid and depression.' *Canadian Journal of Psychiatry* 35: 375–378

45 Durrant-Peatfield BJ (1996), 'Aspects of a missed diagnosis: Thyroid dysfunction and management.' *Journal of Nutritional and Environmental Medicine* 6(4) 371–378

46 *Hypothyroidism, The Unsuspected Illness*, Dr Broda Barnes

47 Durrant-Peatfield,(2006) *Your Thyroid and How To Keep It Healthy*. London: Hammersmith Press Ltd.

48 Tintera JW (1967), 'Endocrine aspects of schizophrenia: hypoglycaemia of hypoadrenocorticism.' *Journal of Schizophrenia* (5): 150–181

49 Selye H (1984), *The stress of life*. New York: The McGraw-Hill Companies Inc.

50 *Adrenal Fatigue: The 21st Century Stress Syndrome* by Dr James Wilson (2007)

fatigue, you may not find any sympathy or understanding from your doctor. Medicine only officially recognizes Addison's disease as hypo-adrenia.⁵¹

All roads lead to misdiagnosis

The above is a very small representation of the many studies and findings that show that symptoms classed as ADHD can be the manifestation of deficiencies, poor diet, toxins and other factors with definable causes that can lead to effective treatments. Furthermore, a lack of parental discipline and poor education can also cause or contribute to disruptive behaviour, lack of focus or learning difficulties. In fact, there are so many variables that it makes the current psychiatric diagnostic system for ADHD negligent when all these variables are not first ruled out.

Whilst the existence of ADHD as an actual verifiable disease is unfounded, the confusion and consequent misdiagnosis around the condition are compounded even further, as shown in a recent study published in the *Journal of Consulting and Clinical Psychology*.⁵² The study found that 16.7 per cent of diagnoses were wrong – and this alarming figure was even higher if the child was a boy. The report states that cases of ADHD have risen dramatically over the last 10 years along with prescriptions for pharmaceuticals, yet diagnosis is alarmingly unscientific, random and biased.

Psychotherapists and psychiatrists are routinely wrongly diagnosing ADHD. The study found that boys were diagnosed up to three times as often as girls as having ADHD, even though both had exactly the same symptoms.

Clearly, diagnosis is highly subjective, which only substantiates further the lack of any real scientific evidence to support the existence of the condition.

51 *Ibid.*

52 Source: *Journal of Consulting and Clinical Psychology*, 2012; 80: 128–38



Psychiatrists mislead the public and Government on ADHD

The government stance on ADHD follows that of NICE – the National Institute for Health and Clinical Excellence – a body established to provide advice on medical matters. There are a number of concerns and inconsistencies on NICE’s position on ADHD.

The title of this section refers to psychiatrists misleading the government and public. This is to indicate that it is the psychiatric diagnosis that gives legitimacy to the drugging of our children and as such, when it has no scientific basis, is the cornerstone of maltreatment.

National Institute for Clinical Excellence – NICE

As covered in the Executive Summary, in 2008, NICE commissioned a Guideline Development Committee (GDC) to write guidelines on ADHD – which were subsequently adopted by NICE as official policy. Almost two-thirds of the GDC were affiliated with and/or had received funds personally (e.g. consultancies/attending conferences) or professionally (e.g. grants for projects) for activities carried out on behalf of pharmaceutical companies, including those manufacturing methylphenidate and other ADHD drugs.⁵³

Declarations of interest were correctly made in the advice – but nonetheless, a strong bias towards a ‘drug solution’ for ADHD can be implied from this.⁵⁴

In 2011 the NICE reviewed the 2008 guidelines and concluded there was no need for any change to, or further review of, the 2008 guidelines. As a consequence, this meant that no further investigation into the causes of, or other treatments for, ADHD were recommended and that drugging children was considered to be a suitable first-line treatment.⁵⁵

This is surprising, especially in the light of the following :

1. NICE acknowledges that:

‘There is no single definitive psychological or biological test for ADHD. Diagnosis is the outcome of several strands of investigation . . .’

Its description of the diagnostic method necessary to identify ADHD is tortuous in complexity and vague in direction – hardly inspiring confidence that they have it right:

‘The complexity of assessment requires cooperation among a number of professionals employed by different agencies and using a wide variety of techniques – in other words, a multi-modal, multi-professional and multi-agency approach.’⁵⁶

53 <http://www.nice.org.uk/nicemedia/live/12061/42060/42060.pdf> – appendix 2 of the above NICE ADHD guideline

54 *Ibid.*

55 <http://www.nice.org.uk/nicemedia/live/12061/57052/57052.pdf>

56 *Ibid.*

2. The NICE guidelines acknowledge that diet and nutrition can play a part in causing ADHD, yet there is no recommendation that this be followed through. Their reasoning for forwarding the biological/drug model rather than exploring other alternatives is particularly difficult to understand insofar as:

- a) The orthodox medical and drug establishments have no real explanation for what they call ADHD.
- b) The cost of this drug treatment is almost 50 million pounds a year (2011 in England alone) to the taxpayer – just for drugs alone – and will be many times more when the cost of ‘diagnosis’ and ‘treatment’ are taken into account. This money would be far better spent on finding actual causes.
- c) Children and adults are subjected to a drug regimen based on an unscientific diagnosis when all they may need to do is switch to a healthy diet.

There is clearly more than enough evidence available in the scientific community to propose *minimally* that extensive trials be done into the areas of poor nutrition, toxic chemicals in our foods and in the environment. Yet these causes were given a mention in NICE’s 2008 report and the 2011 review, and then effectively dismissed.

‘The influence of dietary factors in ADHD has attracted much public attention: food additives, sugar, colourings and ‘E’ numbers are often regarded as causes of ADHD, and elimination and supplementation diets are widely used, often without professional advice.

‘Nevertheless, epidemiological research indicates a link between additives and preservatives in the diet and levels of hyperactivity (McCann et al., 2007); and at least a small proportion of children with ADHD demonstrate idiosyncratic reactions to some natural foods and/or artificial additives, and may be helped by a carefully applied exclusion diet (see Chapter 9).

‘Richardson (2004) reviewed the evidence on associations between ADHD and longchain polyunsaturated fatty acids (PUFA) and commented on the brain’s need throughout life for adequate supplies, a relative lack of omega-3 PUFA, and a possibility that males may be more vulnerable because testosterone may impair PUFA synthesis. Scientific uncertainties remain, however, concerning the physiological significance of different measures of PUFA metabolism and they are not used in practice.’⁵⁷

It is hard to understand why a lack of follow-through exists when we could be radically altering the lives of hundreds of thousands of children for the better by taking them off drugs and addressing the actual cause of their problem.

The NICE report even goes on to state that supplements of fatty acid are *not recommended*.

‘Recommendations

...

‘Dietary fatty acid supplementation is not recommended for the treatment of ADHD in children and young people.’⁵⁸

NICE does not appear to have conducted any kind of independent robust examination of behaviour said to constitute ADHD or the factors, dangers and consequences of the ever-increasing drugging of generations of children, and has slanted any recommendations in the direction of continued drug use.

57 *Ibid.*

58 *Ibid.*

Side-effects of ADHD drugs

The following is taken from the official list warning patients about the risks of taking Ritalin, one of the most commonly used stimulant drugs. Other similar drugs (methylphenidate hydrochloride) used to treat ADHD have effects. Prescribing doctors or psychiatrists rarely inform parents and children of all of these side-effects.

Under 'Very Common' (1 in 10) the side-effects are **Psychiatric disorders:** insomnia, nervousness and **Nervous system disorders:** headache.

Under 'Common' (a 1/10 to a 1/100 chance) your child risks **Infections and infestations:** nasopharyngitis (common cold); **Metabolism and nutritional disorders:** anorexia, decreased appetite, moderately reduced weight and height gain during prolonged use in children; **Psychiatric disorders:** anorexia, affect lability, aggression, agitation, anxiety, depression, irritability, abnormal behaviour; **Nervous system disorders:** dizziness, dyskinesia, psychomotor hyperactivity, somnolence; **Cardiac disorders:** arrhythmia, tachycardia, palpitations; **Vascular disorders:** hypertension; **Respiratory, thoracic and mediastinal disorders:** cough, pharyngolaryngeal pain; **Gastro-intestinal disorders:** abdominal pain, diarrhoea, nausea, stomach discomfort and vomiting (you'll be glad to know that these last ones usually occur at the beginning of treatment and may be alleviated by concomitant food intake), dry mouth; **Skin and subcutaneous tissue disorders:** alopecia, pruritis, rash, urticaria; **Musculoskeletal, connective tissue and bone disorders:** Arthralgia; **General disorders and administration site conditions:** Pyrexia, growth retardation during prolonged use in children; **Investigations:** changes in blood pressure and heart rate (usually an increase), weight decreased.

'Uncommon' risks (1/100 and 1/1000) include **Immune system disorders:** hypersensitivity reactions such as angioneurotic oedema, anaphylactic reactions, auricular swelling, bullous conditions, exfoliative conditions, urticaria, pruritis, rashes and eruptions; **Psychiatric disorders:** auditory, visual, and tactile hallucinations, anger, suicidal ideation, mood altered, mood swings, restlessness, tearfulness, tics, worsening of pre-existing tics or Tourette's syndrome, hypervigilance, sleep disorder; **Eye disorders:** diplopia, blurred vision; **Nervous system disorders:** sedation, tremor; **Cardiac disorders:** chest pain; **Respiratory, thoracic and mediastinal disorders:** dyspnoea; **Gastro-intestinal disorders:** constipation; **Hepato-biliary disorders:** hepatic enzyme elevations; **Skin and subcutaneous tissue disorders:** angioneurotic oedema, bullous conditions, exfoliate conditions; **Musculoskeletal, connective tissue and bone disorders:** myalgia, muscle twitching; **Renal and urinary disorders:** haematuria; **General disorders and administration site conditions:** chest pain, fatigue; **Investigations:** cardiac murmur, hepatic enzyme increased.

The 'rare' category (1/1000 to 1/10000). Your child will risk **Psychiatric disorders:** mania, disorientation, libido disorder; **Eye disorders:** difficulties in visual accommodation, mydriasis, visual disturbance; **Cardiac disorders:** angina pectoris; **Skin and subcutaneous tissue disorders:** hyperhidrosis, macular rash, erythema; **Reproductive system and breast disorders:** gynaecomastia

At the top end – 'very rare' (more than 1 in 10,000 – though better hope your child is not one of these). **Psychiatric disorders:** suicidal attempt (including completed suicide), transient depressed mood, abnormal thinking, apathy, repetitive behaviours, over-focusing; **Nervous system disorders:** convulsions, choreo-athetoid movements, reversible ischaemic neurological deficit, neuroleptic malignant syndrome (NMS): Reports were poorly documented and in most cases, patients were also receiving other drugs, so the role of methylphenidate is unclear; **Cardiac disorders:** Cardiac

arrest, myocardial infarction; **Vascular disorders:** Cerebral arteritis and/or occlusion, peripheral coldness, Raynaud's phenomenon; **Hepatobiliary disorders:** abnormal liver functions, including hepatic coma; **Skin and subcutaneous tissue disorders:** erythema multiforme, exfoliate dermatitis, fixed drug eruption; **Musculoskeletal, connective tissue and bone disorders:** muscle cramps; **General disorders and administration site conditions:** sudden cardiac death; **Investigations:** blood alkaline phosphatase increased, blood bilirubin increased, platelet count decreased, white blood count abnormal.

Deaths and negative effects

In 2009, a study was published in the *American Journal of Psychiatry* entitled 'Sudden Death and Use of Stimulant Medications in Youths.' The study showed a seven-fold increase in the incidence of sudden death in children who were on stimulant medications (Concerta, Ritalin, Adderall, Focalin and Dexedrine).⁵⁹

Attempting to play down the findings following its publication, the US Food and Drug Administration (FDA) urged 'caution' in interpreting the study due to parents' 'bias' in reporting the medications their children were on. The study screened parents by asking them what medications their children were on at the time of death. The FDA Director Dr Robert Temple, MD, stressed the screening was 'subject to recall bias' and that the results should not serve as a basis for parents to stop medicating their children due to other 'risk behaviour associated with ADHD.'

However, the lead author, Dr Madelyn Gould, PhD stood by the research and rebutted the argument stating that, 'This study had enough statistical power to detect an association. My confidence in the results is not diminished, since it has been peer-reviewed [and published].' (The FDA and the National Institute of Mental Health funded the study.)

In the UK it is difficult to find information about deaths and harm caused by ADHD drugs – further evidence of a serious lack of transparency. The cause of death is often obscured and official figures are not kept or clearly linked to the cause. Nevertheless, there is anecdotal evidence and the following case illustrates the dangers involved.

Taken from a June 2011 *Mail* article, it covered the story of 10-year-old Harry Hucknall, who killed himself whilst on a cocktail of Prozac and Ritalin.

'Home Secretary Theresa May has said that enough is enough. As the Shadow Leader of the House of Commons before the last election, she warned of the dangers of the ADHD drugs. 'They are powerful prescription drugs and we don't know what their long-term effects on a child will be.'

'She related to Parliament the story of a six-year-old on Ritalin. "He experienced low moods and marked depression and tried to throw himself out of a window within two months of starting treatment. He only recovered once the drug had been withdrawn."

'Sadly, Harry Hucknall never had the chance to stop taking Ritalin, or the antidepressant Prozac. Now his father is asking difficult questions about why his son died. On the fateful weekend last September, Harry was staying at the home in Dalton-in-Furness of his mother, Jane White, 33, his brother David, and his two step-siblings.

59 'Sudden Death and Use of Stimulant Medications in Youths' by Madelyn S Gould, B Timothy Walsh, Jimmie Lou Munfakh, Marjorie Kleinman, Naihua Duan, Mark Olfson, Laurence Greenhill, Thomas Cooper, *Am J Psychiatry* 2009;166:992–1001. doi: 10.1176/appi.ajp.2009.09040472

‘The coroner ruled out a deliberate suicide, but said that the influence of Ritalin and Prozac could not be excluded as a factor in Harry’s death. “What a child with ADHD is prescribed by his doctor is mind-altering drugs of a powerful nature,” he added.

‘But Harry’s father believes drugs had a huge part to play in the tragedy. “Harry was put on Prozac first, and without my knowledge,” he told me. “I only found out about it when he came to stay for the weekend and his mother told me what dose to give him: one in the morning and one at night. ‘Are you crazy?’ I asked her. ‘That’s an antidepressant.’”’⁶⁰

In the United States the evidence seems to be more readily available. McGuire Woods, a US legal firm representing pharmaceutical companies [see following section on Legal issues and responsibilities] reported that:

‘A summary of clinical trials of ADHD medications showing adverse psychiatric events put together by the product manufacturers for the FDA at its request showed that in studies lasting under one year:

- *In double blind studies of 383 children taking Ritalin LA (the extended release formulation), there are reports of two psychosis/ mania events, two aggression events, and no suicidal events. In open studies involving 125 children on Ritalin LA, one suicidal event was recorded, and no psychosis/mania events or aggression events were reported.⁶¹*

- *Out of 2,824 children taking Concerta, eight were said to have experienced psychosis/mania events; six suicidal events, and fifty-two aggression events (five of which were deemed serious).⁶²*

- *In a double blind study of children taking Metadate CD, three aggression events were reported out of 493 participants. In the open label trials, six aggression events were reported out of 322 participants. All aggression events occurred in boys. One of them was deemed serious. No psychosis/mania events or suicidal events were reported in any of the clinical trials involving Metadate CD.⁶³*

- *MTS use by children suggested that out of 471 participants in a double blind trial, four experienced psychosis/mania events, six experienced aggression events, and none experienced suicidal events. Out of 617 participants in an open trial, there were six psychosis/mania events, one suicidal event, and seven aggression events (two of which were deemed serious).⁶⁴*

- *In a double blind study of 1,236 children and adults taking Adderall XR (methylphenidate hydrochloride), there were no psychosis/mania events, one suicidal event, and twenty aggression events. In an open study involving 5,177 adults and children, fourteen had psychosis/mania events (nine children), eight had suicidal events (all children), and 166 had aggression events (150 children).⁶⁵*

60 ‘Child victims of the chemical cosh: Boy who killed himself after taking Ritalin,’ *Mail Online* Thursday, 13 June 2011 by Sue Reid

61 *Mosholder*, 22

62 *Ibid.*

63 *Ibid.*

64 *Ibid.*

65 *Ibid.*



Human rights

United Nations Committee on the Rights of the Child

In October 2011 the United Nations Committee on the Rights of the Child (UNCRC) expressed deep concern about children being misdiagnosed with ‘Attention Deficit Hyperactivity Disorder’ and prescribed powerful stimulant drugs as potent as cocaine. The UNCRC recommended that countries conduct research into the negative effects of psycho-stimulants and ‘that other forms of management and treatment be used as much as possible’ to address behavioural problems.⁶⁶

Informed consent and the parent’s right to choose

Informed consent requires that the patient (and in the case of children, the responsible parents) be fully informed, not only of the consequences of taking any specific drug, but also that they have information about and access to all other possible solutions to their child’s problems. This would include not only the solutions mentioned above but also educational solutions such as additional tutoring for their children.

From feedback CCHR has received, parents are not routinely informed about all the potential side-effects of the drugs recommended for their children.

As the government has emphasised – it is the patient’s right to choose (and in this case the parents being the responsible adults) yet the options open to them through the NHS are very restricted and heavily biased towards a dangerous drug model.

Psychiatrist and lead editor of the DSM–IV (*Diagnostic and Statistical Manual of Mental Disorders* – Fourth Edition), Dr Allen Frances, made statements and revelations that threw further aspersions on the integrity of the ADHD diagnosis and raised the spectre of human rights abuse. For several years the DSM–IV has been under review with the aim of updating it with a range of new psychiatric illnesses and revisions. Dr Frances has been a vocal critic of the process.

His admissions in an interview with *Wired* magazine were revealing with regard to the poor quality of diagnosis when referring to mental illness. Dr Frances stated, ‘These concepts are virtually impossible to define precisely with bright lines at the boundaries.’ He went on to say with regard to DSM–IV, ‘We made mistakes that had terrible consequences,’ and explained that diagnoses of autism, ADHD and bipolar disorder skyrocketed. Frances thinks he inadvertently facilitated these epidemics – and, in the bargain, fostered an increasing tendency to chalk up life’s difficulties to mental illness and then treat them with psychiatric drugs.⁶⁷

66 *Consideration Of Reports Submitted By States Parties Under Article 44 Of The Convention*, Committee On The Rights Of The Child, Fifty-eighth session, October 6, 2011, p 8.

67 *Wired Magazine*, ‘Inside the Battle to Define Mental Illness’ by Gary Greenberg, December 27, 2010

The *Wired* article went on to say,

*'This new disease [referring to a new psychiatric disorder being proposed for the DSM-V] reminded Frances of one of his keenest regrets about the DSM-IV: its role, as he perceives it, in the epidemic of bipolar diagnoses in children over the past decade. Shortly after the book came out, doctors began to declare children bipolar even if they had never had a manic episode and were too young to have shown the pattern of mood change associated with the disease. Within a dozen years, bipolar diagnoses among children had increased 40-fold. Many of these kids were put on antipsychotic drugs, whose effects on the developing brain are poorly understood but which are known to cause obesity and diabetes. In 2007, a series of investigative reports revealed that an influential advocate for diagnosing bipolar disorder in kids, the Harvard psychiatrist Joseph Biederman, failed to disclose money he'd received from Johnson & Johnson, makers of the bipolar drug Risperdal, or risperidone. (The New York Times reported that Biederman told the company his proposed trial of Risperdal in young children "will support the safety and effectiveness of risperidone in this age group.") Frances believes this bipolar "fad" would not have occurred had the DSM-IV committee not rejected a move to limit the diagnosis to adults.'*⁶⁸

Human rights for children

Ultimately, parents must have the right to choose their child's education and medical needs based on understanding the correct and adequate information, and this clearly is not the standard of practice in the UK.

Legal issues and responsibility

A key factor often overlooked in relation to psychiatric diagnosis and treatment is accountability. Government advisers have promulgated the notion of ADHD as a *disease*, without empirical scientific evidence to support their claims. Accountability must lie with those who have disseminated propaganda on this subject to well-meaning parents, teachers and politicians alike.

If, indeed, the public have been misled by unsustainable scientific 'theories,' blatantly unscientific diagnosis, neglected research and even deliberate suppression of facts about the true causes, then those responsible have a lot to answer for.

There can be no excuse whatsoever in subjecting patients (and particularly children) to a heavy drug regimen when the real cause of the condition would only require proper scientific research, not a fixed idea that drugs can remedy the problem – a 'solution' tainted by financial gain and held in place to bolster the prestige of practitioners who have backed the 'drug solution.'

It is reported by McGuire Woods (ADHD Litigation White Paper)⁶⁹ – a legal company in the United States representing drug manufacturers – that litigation arising from ADHD drug prescription is becoming an ever-increasing threat for the drug companies. Simple black-box warnings are not adequate to divert responsibility for damage caused

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⁶⁸ *Ibid.*

⁶⁹ McGuire Woods ADHD Litigation White Paper,
http://www.mcguirewoods.com/news-resources/publications/products_liability/adhd.pdf

by the drug itself, especially in light of significant penalties recently imposed on drug companies. Examples of legal cases against drug companies abound, but two of the most recent ones are drug manufacturer Johnson & Johnson (and its subsidiary Janssen) who received fines for downplaying the risks of its antipsychotic drug amounting to \$1.5bn,⁷⁰ whilst GlaxoSmithKline agreed to plead guilty to criminal charges and pay \$3 billion to settle what government officials described as the largest case of healthcare fraud in US history.⁷¹

There is a growing, documented body of evidence demonstrating that profits have overruled reason and ethics. Drug companies have raked in billions of pounds and dollars in profit and are being punished for their illegal motivations.

As reported in the previous section, McGuire Woods listed a number of trials and studies covering serious side-effects including suicide. As a result of these findings, the FDA Pediatric Advisory Committee met in March 2006 and urged the use of new warnings about the possible risks of psychosis or mania associated with ADHD drugs.⁷² The Committee noted that the most important finding of the review of adverse events was that the signs and symptoms of psychosis or mania, particularly hallucinations, can occur in some patients with no identifiable risk factors, at usual doses of any of the drugs currently used to treat ADHD.⁷³

According to the FDA's Division of Drug Risk Evaluation (DDRE), a substantial portion of psychosis-related cases were reported in children age 10 or younger, a population in which such hallucinations are highly uncommon.⁷⁴ The DDRE went on to note that the predominance of patients reporting hallucinations, both visual and tactile, that involved insects, snakes or worms is striking and deserves further evaluation. In many patients, reportedly, the events ceased after they stopped taking the drug.

Dr Kate Gelperin, one of the FDA reviewers noted, *'[i]t was striking how often young children described various insects, bugs and worms, both visual and tactile – which we haven't seen elsewhere.'*⁷⁵

According to some physicians, it is no surprise that ADHD medications have these effects since they are 'exactly the same chemicals' as popular street drugs known to trigger psychosis.⁷⁶

McGuire Woods go on to say that *'For those manufacturers of ADHD drugs, now is the time to really prepare for the possible onslaught of litigation. Lawsuits over the use of such prescriptions and the side-effects looks to be the proverbial "perfect storm."*

McGuire Woods conclude that *'industry executives and in-house counsel are wise to watch the development of novel legal theories being used by the Plaintiffs' lawyers in bringing new product liability and toxic tort actions. These novel arguments, which appear to be gaining traction around the country, are being used to thwart statutory limitations limiting the old tried and true causes of action. As the science continues to evolve towards establishing a link between various ADHD drugs and medical problems it is certain to attract even more attention from trial lawyers around the country. No doubt this is an area where strategic*

70 BBC, 11 April, 2012

71 Reuters Mon Jul 2, 2012

72 '46 FDA Rx Safety Officials Urge New Psychosis Warnings on ADHD Drugs,' *Drug Industry Daily* 5, no. 53 (March 16, 2006).

73 Gelperin, Kate, MD, MPH, et al., *Psychiatric Adverse Events Associated with Drug Treatment of ADHD: Review of Postmarketing Safety Data* [FDA Center for Drug Evaluation and Research Memorandum], PID D050243, March 3, 2006.

74 *FDA Rx Safety Officials Urge New Psychosis Warnings on ADHD Drugs.*

75 Alonso-Zaldivar, Ricardo, A-12

76 Rubin, Rita, 'Re: Labelling ADHD drugs as psychosis/mania risk; advisory panel takes up question,' *USA Today*, March 21, 2006, p. 6D).

planning and preparation are required right now in order to prepare for the possible and likely onslaught of litigation.'

Of course, the legislative system in the USA is well known for its potential for bringing high-profile legislation for large sums in damages which may not be possible in the UK system. However, this does not lessen the liability of drug manufactures or those misdiagnosing and civil claims are currently under discussion in the UK where the likelihood of bringing successful cases is being examined.

Summary

- The ‘disease’ of ADHD was literally *voted* into existence by a panel of psychiatrists in 1987 with a show of hands. Over the last two decades, profits for this ‘voted-in’ disease have seen millions of children labelled whilst generating billions of pounds in profit.
- The now-debunked ‘chemical imbalance’ theory has given rise to an epidemic of prescription drugging of our children. Whilst this theorised cause has now partly shifted to other supposed causes (such as genetics) – the drug ‘treatment’ has inexplicably remained the same. None of these theories are supported by any credible scientific evidence, and this lack of credibility is further highlighted by the fact that the same drug is used even when the supposed cause changes. This, of course, makes no scientific sense either.
- ADHD drugs have close to one hundred acknowledged side-effects including violence and suicide.
- There is ample evidence, and has been for many years, that at least demonstrates that symptoms classed as ADHD have causal factors that, *inter alia*, lie in diet, nutrition and toxins in the environment.
- There has been a systemic failure, even neglect, by the psychiatric and drug industries to research properly and find correct causes of the phenomenon they have labelled as a childhood disease called ADHD. Whilst there is no scientific evidence to support the validity of giving addictive, mind-altering drugs (that are very similar to cocaine), these drugs which are commonly prescribed to children are marketed as safe and effective.
- Alarming, ever-increasing numbers of children are subjected to potentially harmful and debilitating drug treatments that can result in the child becoming addicted, violent, aggressive and even suicidal.
- Ever-increasing numbers in future generations are at risk. A responsible society would never sanction giving cocaine-like drugs to children for any reason, yet ADHD drugs (methylphenidates, amphetamines and dexamphetamines) are legally prescribed. They are made ‘acceptable’ by pharmaceutical marketing campaigns, pretending to treat a scientifically proven disease.
- While the prime responsibility for this situation lies with the profit-driven psychiatric and pharmaceutical industry, the government and government bodies such as the Department of Health and NICE have a responsibility for ensuring parents, teachers and social workers engaged in the care and well-being of children have all the available information so that fully informed decisions regarding the well-being of children can be assured.
- Parents have the right to know there are other workable solutions which do not require drugging their child and address the underlying causes for behavioural and emotional problems.
- Unless this matter is urgently addressed by those responsible, litigation is likely to be brought against all concerned parties. There have already been a number of cases, reported throughout the years, of children who have suffered and even died because of drug treatments. If nothing is done then the potential increases for another

disaster that will in all likelihood trigger a wave of civil litigation and even criminal charges brought against doctors, psychiatrists and drug companies.

Recommendations

1. Legislation is needed, similar to that enacted in other countries (for example the Netherlands, Italy, Mexico and the US), that ensures no school-age child (including kindergarten) can be forced to take a psycho-stimulant or other psychotropic drug as a requisite for their schooling or education. Further, no mental-health screening can be conducted on students in the school setting, and parents have the right to be fully informed that there is no medical test to confirm ADHD or other childhood psychiatric diagnoses as a mental *illness*.
2. A thorough investigation be held into the mass drugging of children with psycho-stimulants – and, indeed, all prescribed psychotropic drugs, which are also on the increase. The investigating committee must comprise experts with no conflicts of interest with drug manufacturers, as well as representatives of the alternative/complementary healthcare system and consumer/parent representation.

The investigation should include the following:

- a. The degree to which children under the age of six are being prescribed psycho-stimulants, which are not licensed for usage in this age group. Additionally, to what degree has the NHS been misused to cover the expenditure of this unapproved usage?
 - b. An examination of the main psychiatrists and doctors that are prescribing drugs to (a) children under the age of six and (b) children aged 6–16, and how much they have billed the NHS.
 - c. Whether conflicts of interest are behind the neglect of proper research into the correct diagnosis of symptoms of ‘ADHD’ and other childhood disorders – specifically the NICE guidelines for the treatment of ADHD and their role in perpetuating the continued drug protocol for ADHD.
 - d. Whether conflicts of interest are behind the neglect of NICE or other agencies as regards researching alternative and complementary medical and educational solutions for behavioural issues and learning difficulties in children.
3. That doctors and any other practitioners be required to inform parents of their right to have a thorough medical examination conducted of any child manifesting symptoms classed as ADHD (or other childhood mental disorders). This must be the first line of diagnosis, thereby eliminating any underlying physical or biological causes or any undetected physical or medical illnesses. Health-care professionals should conduct medical tests to exclude a range of deficiencies or toxins, allergy tests and analysis for dietary deficiencies.
 4. An education campaign for doctors and other professionals must be undertaken to inform them of the range of actual causes of symptoms that manifest as ‘ADHD’ and any alternatives or complementary medical treatments and educational solutions.
 5. Full and clear disclosure of all the possible side-effects of ADHD drugs must be made clear in writing to any responsible parent or adult and the parent must sign stating that they have been given such a warning.
 6. Those psychiatrists or doctors prescribing powerful mind-altering psychotropic drugs to children under age six or to children whose parents did not give full informed consent be held criminally and civilly accountable for any damage the child might suffer.

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