Florida Association of School Psychologists

Position Statement

A Response to CCHR's "Psychotropic Drugging of Florida's Medicaid Children"

In 2006, the Citizens Commission on Human Rights (CCHR) developed and distributed via the internet a white paper entitled "The Psychotropic Drugging of Florida's Medicaid Children" [1]. First, critical thinking and fair-mindedness necessitate that one examine the potential biases and motives of the authors of the CCHR paper. The CCHR was founded by the Church of Scientology, which has been described in *Time* magazine as "the most ruthless, the most classically terroristic, the most litigious and the most lucrative cult the country has ever seen"[2]. Although the CCHR purports to target psychiatric abuses, it really has in its bull's-eye all of psychiatry, which it has attacked via international efforts. Through its misinterpretation of the research and its demonization of physicians, mental health workers, and school personnel who have devoted their careers to improving the welfare of youth, the CCHR has created a fear-driven campaign that seeks to confuse and to induce guilt in parents who are seeking help for their children as well as to impose the will of a religious organization on public schools. The white paper is CCHR propaganda, and thus its readers would be well-advised to understand more about the CCHR and the Church of Scientology before taking its information at face-value. Nevertheless, this paper will attempt to address the issues and data as reported in the CCHR white paper in order to provide readers with a balanced viewpoint on the use of psychotropic medications with children and adolescents, as well as a response to their proposed legislation.

According to the paper's introduction, the CCHR conducted its own investigation of the patterns of prescribing psychotropic medications to the population of Florida children receiving Medicaid in 2005. The investigation was reportedly prompted by a 2003 finding by the Florida Statewide Advocacy Council (SAC) that 55% of Florida's children in foster care were being treated with psychotropic drugs. As a point of clarification, a closer reading of the SAC report revealed that their findings were based on a sample of 1,180 case files (not a statistically valid sample) from foster children placed in Therapeutic Foster Care Homes, which is a specialized type of foster care provided to children who have experienced significant trauma in their lives and require on-going therapeutic support and 24-hour supervision. Children placed in Therapeutic Foster Homes are those with pre-existing emotional disturbances who require an intensive treatment program that incorporates behavioral, psychological, and psychosocial treatment. The alternatives to this type of foster care are inpatient and residential treatment programs [3]. Notwithstanding the unique and complicated nature of this group of foster children, the SAC rightly concluded that the State of Florida has a responsibility to ensure that the dispensing of psychotropic medications to foster care children is carefully monitored in order to prevent the unnecessary medication or over-medication of the state's most vulnerable children. Additionally, the report recommended

that the state ensure that "appropriate standardized written informed consent" be obtained prior to dispensing psychotropic medications, which should include "information about any risks and expected benefits, including possible side effects and alternative treatments" (p. 23) [4].

In 2005, the Florida legislature responded to the SAC report by creating a new law that includes procedures for obtaining informed consent from parents or guardians of foster children. The Florida Statute s. 39.407 (3)(a) requires that before the state department provides psychotropic medications to a child in its custody, the prescribing physician shall attempt to obtain express and informed consent from the child's parent. Express and informed consent is defined in s. 394.459 (3)(a), and includes reason for the treatment, a description of the proposed treatment, the dosage range, alternative treatments, and common risks, benefits, and side effects. When applied to psychotropics, it would be the prescribing physician's responsibility to obtain parental consent, just as with any medication.

Following the enactment of the aforementioned statutes, the CCHR focused on a study of Florida's Medicaid children, which encompasses a much larger population of children than found in foster care alone. In its white paper, CCHR repeatedly emphasized that there was a 528% increase in the number of Medicaid children prescribed psychotropic drugs over the course of five years (from 9,500 in the year 2000 to 59,697 in 2005). The 2000 data were reportedly obtained from the Florida Agency for Health Care Administration (AHCA) and were not available during the time of this writing. However, data from AHCA state that in 2005, over 1.4 million children in Florida received Medicaid. It is therefore important to note that the figure of 59,697 presented by CCHR represents a little over 4% of all children receiving Medicaid. To put that percentage into perspective, approximately 4% of all children receiving Medicaid received psychotropic medication in the year 2005, and, according to the American Psychological Association, approximately 6% of all children in the United States take some form of psychotropic medication [5]. Thus, *a smaller percentage* of Florida's Medicaid children take psychotropics as compared to the larger sample of all children and adolescents in the United States, a fact that is neglected in the CCHR paper.

However, this does not answer the question of whether psychotropic drugs are (a) effective, and (b) medically necessary and safe when treating emotional disturbances in children and adolescents. Because stimulants (e.g., Ritalin) and antidepressants (e.g., Prozac) were repeatedly mentioned in the CCHR paper, we will address the extant literature on the effectiveness and safety of these two classes of medication.

In 1998, the National Institute of Health (NIH) convened 13 panel members and 31 experts from the fields of psychology, psychiatry, neurology, pediatrics, epidemiology, biostatistics, education, and the public. The purpose of the conference was to collect state-of-the-art information regarding the effective treatments for Attention Deficit Hyperactivity Disorder (ADHD), with scientific evidence taking precedence over clinical anecdotal experiences. The result of the conference was the Consensus Development Conference Statement on the Diagnosis and Treatment of ADHD[6], a statement that specifically addressed the efficacy and safety of stimulant medication. They concluded that, "Overall, these studies support the efficacy of stimulants and psychosocial treatments for ADHD and the superiority of stimulants relative to

psychosocial treatments". In other words, although a variety of strategies have been used to treat ADHD--including various psychotropic medications, psychosocial treatment, dietary management, herbal and homeopathic treatments, biofeedback, meditation, and perceptual stimulation/training--only stimulants and psychosocial treatment have scientific evidence of effectiveness. Furthermore, in terms of psychosocial treatments, some interventions have more evidence than others. Clinical behavior therapy, parent training, contingency management, and intensive direct interventions with children with ADHD seem to be the most beneficial. The Consensus Statement also identified areas in need of further research, including the long-term outcomes related to prolonged treatment with psychotropics or psychosocial intervention, as well as how best to address the behavioral, social, and academic difficulties experienced by children with ADHD.

In terms of safety, the following appears in the Consensus Statement:

> *Although little information exists concerning the long-term effects of psychostimulants, there is no conclusive evidence that careful therapeutic use is harmful. When adverse drug reactions do occur, they are usually related to dose. Effects associated with moderate doses may include decreased appetite and insomnia. These effects occur early in treatment and may decrease with continued dosing. There may be negative effects on growth rate, but ultimate height appears not to be affected.*

As with any medications, very high doses that go unmonitored by physicians can result in deleterious side effects. Thus, as with any medication, appropriate dosage and monitoring of stimulants is imperative.

A review of the literature since the 1998 Consensus Statement provides additional support for and strengthens the original findings. Stimulants are now thought to be effective not only in the short run, but also for a period of up to at least five years [7]. The positive effects are seen in the core ADHD symptoms of inattention, distractibility, and hyperactivity, as well as academic productivity and accuracy; teacher, parent, and peer interactions; and antisocial behavior. Current studies are investigating the effectiveness of stimulants for periods over five years. In terms of safety, the FDA last year debated whether to require a "black box" warning on stimulant medications following the deaths of 7 children and adolescents who, at the time of death, were taking methylphenidate (e.g., Ritalin, Concerta), and 12 patients taking amphetamines (e.g., Adderall). After careful consideration and debate, the FDA decided against the black box warning, as there was no evidence to suggest that the medications were the cause of death. Furthermore, 19 reported deaths out of the 2.5 million children and adolescents currently prescribed these medications mirrors expected fatality rates in the general population.

The CCHR also addresses the use of antidepressants in treating children and adolescents. They requested the case histories of 252 children or adolescents, age 18 or under, who committed suicide between 2000 and 2004. They found that 52% of those who committed suicide during this five-year period either used psychotropic drugs or had a history of psychiatric treatment. Their suggestion is that the psychotropic medication, or psychiatric treatment, "caused" the suicide, which is a nonsensical conclusion. Antidepressants are prescribed to treat depression---a disabling condition that by

definition often includes feelings of hopelessness, despondence, and suicidality (thoughts of ending one's life). Therefore, many individuals who seek treatment for depression are already contemplating suicide, and unfortunately, in spite of treatment, 35-50% of youth who are depressed made, or will make, a suicide attempt [8]. This does not mean, however, that the treatment *caused* suicide. Large-scale epidemiologic studies have actually identified a *negative correlation* between antidepressant prescriptions and suicide rates across the populations[9]. More specifically, for children ages 5-14, studies reveal that counties with *higher* rates of SSRI prescriptions (e.g., Prozac) had *lower* rates of suicide. These empirical findings are in direct contrast to the assertions made by CCHR. Two years ago the FDA required a black box label on SSRI's, warning of possible risk of increased suicidality (thoughts, not behaviors). However, many are now concerned that the black box warning is actually responsible for the recent increase in youth suicides, as the public has become more reluctant to try antidepressants[10]. Furthermore, a recent reanalysis of the FDA data demonstrate that the risk of increased suicidality is only half of what was originally thought (1%, versus 2% as reported by the FDA in 2004)[11].

The CCHR paper appends draft legislation that would require parents to read and to sign an expanded informed consent prior to allowing their child to be evaluated for an emotional, behavior, or mental disorder by the public school system. This new informed consent would suggest to the parents that they should consult with a medical doctor to rule out physical causes before pursuing a psychological or psychiatric evaluation; that psychological and psychiatric evaluations and diagnoses are based on "subjective interpretation"; that recommended treatment for their child's disorder may include psychotropic medication which "may have potential dangerous side effects including suicide and psychotic behavior"; and that there are alternatives to psychotropic medications in the treatment of mental and behavior disorders.

By way of explanation, FAC 6A-6.0331 specifies that the school board shall be responsible for the evaluations of students who are suspected of being exceptional students, by competent evaluation specialists. The child is assessed in all areas related to the suspected disability, and if it is determined that the child has a disability and needs special education and related services, then a special education program is developed for that individual child. Who are these children who receive special education services? Fifty-three percent (53%) have a speech impairment, a language impairment, or a learning disability[12]. Many of these students are referred for an evaluation because of primary difficulty in learning how to read. Psychotropic medications are irrelevant in treating these disorders. Therefore, suggesting that all parents of students referred for an evaluation first consult with a medical doctor would unnecessarily distract parents from helping their children to receive the educational assistance they need. Of the 47% of children who receive special education for disabilities other than speech impairments, language impairments, or learning disabilities, 6% have an Emotional Handicap, 1% has a Social or Emotional Disturbance, and 3% are classified as Other Health Impaired[13]. In total, this represents approximately 10% of children in special education. These are the students who are most likely to receive psychosocial interventions such as smaller classroom settings, behavioral contingency plans, and individual or group counseling. These types of empirically-supported interventions, in fact, are typically considered and implemented first when treating social, emotional, and behavioral difficulties. In only a small percentage of these cases is it suggested to the parents of these students that they

may wish to consult a physician for possible pharmacological intervention. It is important to note that medications are prescribed and monitored by physicians, not school personnel; thus, informed consent for psychopharmacological treatment should reside with the physician, not the school. Ultimately, the choice to medicate a child resides completely with the parent, and schools are prohibited from coercing families into accepting treatment. The United States Congress passed an amendment to the Individual with Disabilities Education Improvement Act of 2004 (IDEA 2004), prohibiting state and local educational agency personnel from requiring a student to obtain a prescription as a condition of attending school, receiving an evaluation, or receiving services[14]. However, parents should also have the right to make decisions about the best course of treatment for their children based on current best practice, not propaganda. They should be able to access psychoeducational evaluations and treatment through the school system without having to incur the time and financial costs of first seeing their family physician. If they choose to consider psychotropic medication for their child, they should be informed of the scientifically-demonstrated benefits of such treatment, yet also have an open dialogue with their doctor about the potential risks and side effects. They should not be subjected to scare tactics long before they are in the position of even needing to consider medication as a treatment option.

The CCHR states that the "psychological and psychiatric evaluation and diagnosis of mental and behavioral disorders are based on subjective interpretation and not on objective medical tests of physical markers, such as blood tests, brain scans, or X-rays." The suggestion is that psychological and psychiatric disorders are somehow less valid than are the more "physical" disorders, an archaic and unsubstantiated view. A review of the literature on Alzheimer's disease reveals that there are no physical markers, brain scans, or X-rays that can determine Alzheimer's prior to death[15]. Rather, doctors make the diagnosis by assessing and interpreting behaviors such as memory, language abilities, and changes in mood. Do these "subjective interpretations" of behavior necessary for diagnosis therefore mean that Alzheimer's is somehow less valid of a disease than say, tooth decay, which is visible to the naked eye?

In sum, the CCHR white paper should be considered within the context of the organization's overall goal of eradicating psychiatry. At best, it misinterprets data provided in the 2003 Statewide Advocacy Council report. At worst, the white paper is a calculated and thinly disguised effort to prevent parents from seeking mental health assistance for their children; assistance whose effectiveness and safety have been documented in the research literature.

References

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